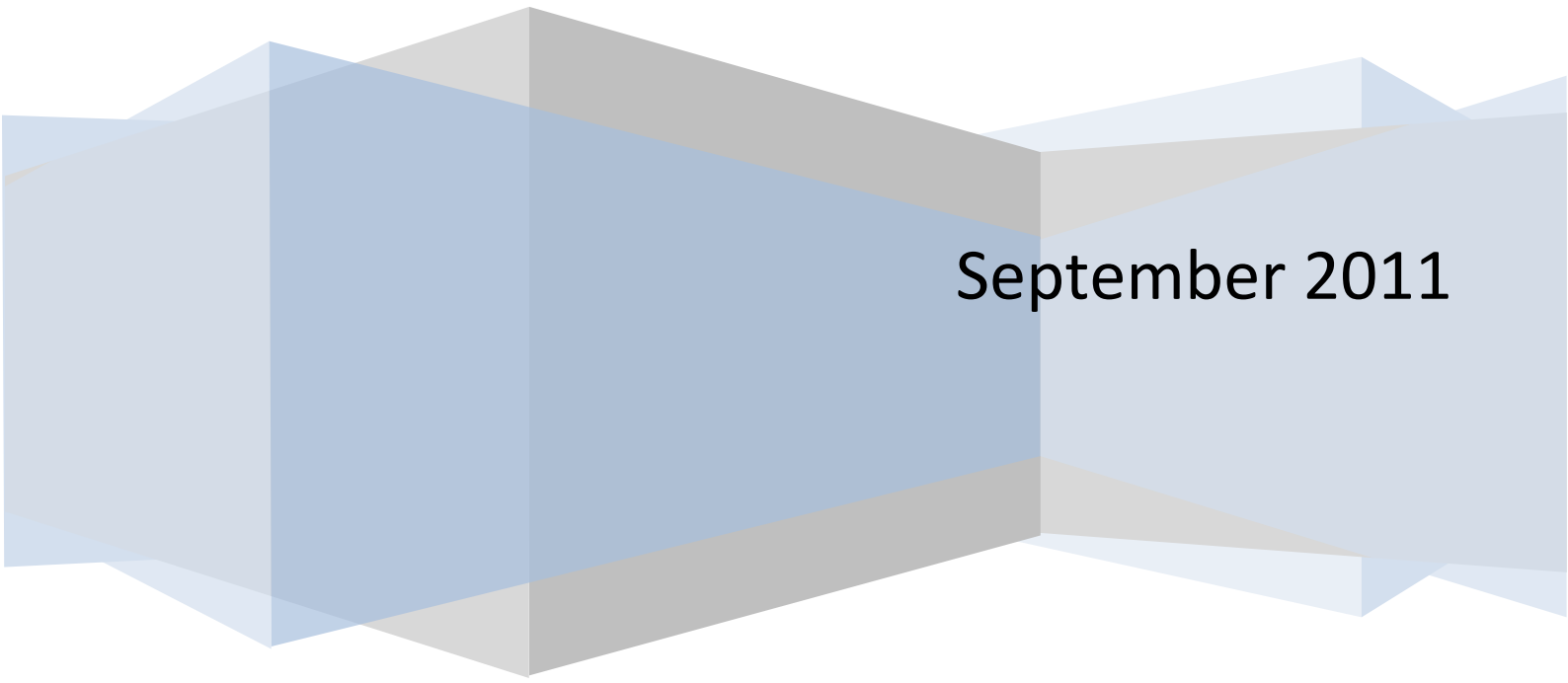
Western Interstate Commission for Higher Education:
Mental Health Program

Alaska Psychiatric Institute Consultation Report & Project Management Plan



September 2011

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Interim Executive Summary

The Mental Health Program of the Western Interstate Commission for Higher Education (WICHE) is providing consultation services to the Alaska Psychiatric Institute (API) / Department of Health and Social Services (DHSS) from August 2011 through June 2012. The WICHE project lead, Deb Kupfer participated in a project kick-off meeting June 27-28, 2011, which resulted in preliminary findings and supported the development of the FY 2012 consultation project.

The objective of this consultation is to identify critical areas of need (staffing) and efficient use of resources in clinical and administrative areas. WICHE was specifically asked to develop recommendations for 1) clinical staffing effectiveness and identify possible staff reallocations and, or other changes; and 2) administrative staffing effectiveness and identify possible staff reallocations and, or other changes. Additionally, WICHE was asked to 3) identify programmatic needs to support a recovery-focused acute care treatment model that includes person-centered treatment and discharge planning.

WICHE staff engaged in several project-planning calls with the API leadership staff; met with key informants from API leadership as well as other staff; reviewed financial, quality improvement and other administrative documents; toured the campus; and reviewed clinical documentation including the electronic health record (EHR). Several consistent themes surfaced during the course of interviews with staff and document reviews. The themes include the need for:

- Clearly articulated roles, responsibilities and accountability for leadership staff and other staff including greater use of benchmarking performance expectations.
- Direct care staffing patterns based on typical treatment and programming needs.
- Interprofessional team approach for staffing, programming and interventions.
- Transformation focused on a commitment to active treatment within a therapeutic trauma-informed recovery culture.
- Workforce development and training in behavioral health, boundaries, trauma-informed care, etc., as well as enhanced crisis intervention training and skills development.
- Timely management reports that assist leadership with monitoring key clinical, operational and financial functions and activities.
- Improved coordination and discharge planning activities with community providers and other support systems.

These themes provide a framework for opportunities that exist for API and recommendations that support them. Taken together, the issues identified indicate a need for improvements in clinical approaches to patient engagement and active treatment, a better focused and more transparent decision making process, improved use of data to support decision making and staff performance and tracking systems so that the implementation of these recommendations can be monitored. WICHE would like to thank employees at all levels at the API for being open in their communication. A great foundation for success is in place at the facility. These recommendations should not be viewed as criticisms of the facility, employees, or administration but rather as opportunities identified through communication and problem solving at all levels. It is important to note that the recommendations will need to be implemented incrementally, which will require an implementation plan. This implementation plan will be developed as part of this project. However, in response to the urgency of some of the changes needed, a number of recommendations have already been

implemented. Due to the staging of the project during the course of the year and the implementation of both immediate and incremental changes during this period and beyond, a steadfast commitment to change management and system improvement will be critical from leadership.

This report is being developed in stages; the first stage was a review in June 2011, which resulted in initial findings and recommendations (Appendix I.) Recommendations for the subsequent reviews of clinical staffing effectiveness, administrative staffing effectiveness and programmatic needs to support a recovery-focused acute care treatment model will be added to this report as they are developed.

Consultation Report

A. Purpose and Consultation Process

Purpose

The Western Interstate Commission for Higher Education's Mental Health Program provided consultations to the Alaska Department of Health and Social Services/Alaska Psychiatric Institute from August 2011 through June of 2012.

The objective of this consultation was to identify critical areas of need related to staffing and efficient use of resources in clinical and administrative areas. WICHE was specifically asked to develop recommendations for clinical and administrative staffing effectiveness and identify possible staff reallocations and/or other changes. Additionally, WICHE was asked to identify programmatic needs to support a recovery-focused acute care treatment model that includes person-centered treatment, and discharge planning.

At the onset of this project API was experiencing significant use of staff overtime resulting in premium pay expenditures that were on target to quickly exceed its allocated budget. Due to the significance of this, WICHE was also asked to look at available financial and staffing information to identify possible ways to better align operations with the allocated budget.

Consultation Process

WICHE staff engaged in several project planning calls with the API and DHSS leadership staff, researched other facility treatment and operational models, met with key informants from API, toured the campus, reviewed clinical records, policies and procedures and other key documents, and observed activities on the unit and in the Recovery Mall. WICHE staff Deb Kupfer, M.H.S. and Dennis Mohatt, MA, met with API leadership staff on August 18, 2011, and another visit occurred September 19-21, 2011 with Deb Kupfer and the following consulting team members:

- Dave Wanser, Ph.D.; Senior Clinical Consultant, Intellica
- Terri Couch, RN, BSN, MA; Chief Nurse Executive, Austin State Hospital

In November of 2011, WICHE will report on additional observations and recommendations regarding administrative staffing effectiveness.

As recommendations are developed, WICHE will work with the API leadership staff to provide any additional information or clarifications that are needed.

B. Overview and General Findings

The Alaska Psychiatric Institute (API) is operated under the aegis of the Alaska Department of Health & Social Services-Division of Behavioral Health. API first opened its doors in 1962 as Alaska's only state-operated psychiatric hospital and has operated in Anchorage since then. Construction of an entirely new and smaller hospital was completed in July 2005. Currently, API operates as an 80 bed acute care inpatient psychiatric facility. API is accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services.

API operates the following treatment units:

- Susitna - 26 Bed Adult Acute Care Unit
- Katmai - 24 Bed Adult Acute Care Unit
- Denali - 10 Bed Adult Intermediate / Long-Term Unit
- Taku - 10 Bed Adult Forensics
- Chilkat -10 Bed Adolescent Unit

Alaska Mental Health System Data

Utilization data from the 2009 CMHS Uniform Reporting System Output Tables indicate that Alaska has significantly higher state hospital utilization (1.29) than the U.S. average (0.54). [Note: 2009 is the most recent year that U.S. comparable rates are available.] The number of states noted in the comparisons includes territories and the District of Columbia.

Utilization Rate/Number of Consumers Served	Alaska Rate	U.S. Rate	States
Penetration Rate per 1,000 Population	23.14	20.85	58
Community Utilization per 1,000 Population	19.43	19.95	58
State Hospital Utilization per 1,000 Population	1.29	0.54	53
Other Psychiatric Hospitalization per 1,000 Population	1.41	1.50	42

Readmission data from this same source indicate overall higher 30 and 180 day readmission rates for the adult population served and lower rates for the children served at API, as illustrated in the table below:

Readmission Rates: Civil, non-Forensic Individuals	Alaska Rate	U.S. Rate	States
State Hospital Readmissions: 30 Days	13.2%	9.2%	52
State Hospital Readmissions: 180 Days	29.0%	20.9%	52
State Hospital Readmissions: 30 Days - Adults	14.2%	9.3%	51
State Hospital Readmissions: 180 Days - Adults	30.7%	21.5%	51
State Hospital Readmissions: 30 Days - Children	3.0%	7.5%	25
State Hospital Readmissions: 180 Days - Children	11.1%	16.1%	27

It is important to note that the U.S. readmission rates include programs that provide acute as well as intermediate and longer inpatient services, which may impact readmission rates. Typically, readmission rates are indicators of both the 'success' of the inpatient treatment as well as the 'success' of the discharge plan and transition back to community-based services. The high utilization rate of API coupled with the high readmission rates for adults in Alaska raise concerns about both continuity of care from inpatient to community-based services as well as the availability and

adequacy of community-based behavioral health services. Based on the data presented, this appears to be much less an issue for the child/adolescent population. However, it is unclear if the small number (10) of beds for this population impacts comparison with other states, or if the community transition and services available for this population are better developed. Therapeutic Foster care and Multisystemic Therapy, two evidence-based practices for children are available in Alaska at rates significantly higher than the national averages, which may account for the lower readmission rates.

Seclusion and restraint utilization - API has an increase in the use of restraint (both mechanical and physical) and seclusion, which represents failure to effectively intervene and treat patients during potential crises. Individual mechanical restraint and seclusion events are trending longer and more likely to last the length of the standard order times (2 hours adolescents, 4 hours adults). The use of seclusion and restraint may be a reflection of a lack of robust early intervention training and role modeling opportunities, lack of coordinated team intervention skills, loss of institutional knowledge as events are more likely to occur with less developed or poor engagement skills of newer staff, or it may be an indication of the culture on the units and the lack of support for the recovery model and trauma-informed care. It is likely that it is due to a combination of many of these issues. This also is reflected in increasing patient and staff injuries.

Seclusion data indicate that there was only one more seclusion episode in CY 2010 than CY2009, however the **duration of the seclusion episodes increased by 22.5 %** during this time period. It is presumed that when seclusions occur, many will be preceded by a restraint. It is unclear whether these data are captured as a separate incident. A focused effort to reduce the use of restraint and seclusion does not appear to be in place. Monitoring the numbers of seclusion and restraint episodes that extend to the full duration of the order may indicate that some of these events are going the full allowable time due to staffing pressures or convenience more than the patients' need to continue in this restrictive setting.

Restraint data indicate an expected increase in restraint reporting in 2nd quarter CY 2010 as API began to include physical restraints in nationally benchmarked data (API was cited by its data vendor for not reporting manual holds as physical restraints, both CMS and TJC surveyors had missed this over several years). So, while API did see a significant increase in restraint in relation to that change; there has been a sustained rise that is not totally accountable by this change.

Patient injuries vary significantly between Susitna and Katmai; however, the majority of injuries on Susitna are reported as requiring 'No Treatment' and 'First Aid', which raises the possibility of inconsistencies in reporting. It is noted that Susitna also reported a higher incidence of 'Self Harm' and 'Falls' as compared to Katmai. A drill-down on the specifics of these incidents may identify target areas for improvement.

Across all units, the greatest number of patient injuries is attributed to 'Self Harm'. This is in spite of an increase in the number of 1:1s, from 3.85% (July 2010) to 6.45% (June 2011). It is recommended that more specific data related to 1:1s by unit, ordering physician and reason for 1:1 be collected and analyzed for further action. For example, if 1:1s are being ordered for patients who are identified as being at risk for falls, there may be a correlation to staff injuries and interventions other than 1:1 may be more appropriate and cost-effective.

Ultimately, patient and staff injuries related to aggressive behavior are indicative of problems with patient engagement and meaningful programming as well as issues with the milieu and unit culture. Absent a focused effort to address these issues there are limited other interventions from a safety or risk management perspective that can lead to a sustained reduction of this trend.

Utilization Review and Management

The Utilization Review/Utilization Management (UM/UR) process at the API begins at Day 14 of the patient's stay and is reviewed every seven (7) days thereafter. The focus of the review is for medical necessity and treatment planning; however, only MEDITECH is used as the source of the review. The patients' Wellness Recovery Plans (WRP -treatment plan) are not part of MEDITECH and are maintained in the hard copy chart on the units. The WRP is not considered in the continued stay determination, which differs from common UR/UM practice.

The Utilization Review (UR) staff person reports finding approximately 25% of all reviews do not meet admission and continued stay criteria; these specific cases are reported to API leadership. It would be beneficial to review Providence psychiatric emergency room data to learn about the disposition of individuals they serve and to better collaborate the most suitable admissions for API. Additionally, although the UR staff acknowledged not having a medical background, he noted that it appears that medications are not being utilized as aggressively as may be indicated for a rapid stabilization protocol in an acute care setting.

A report concerning admissions with discharge dates within three days was created during the site visit and indicated that on a monthly basis between 10 and 26 percent of admissions fall into this category. As a general rule, individuals who can be stabilized this quickly should be amenable to community-based crisis intervention services and not admitted to a state psychiatric hospital. However, the court system and judges impact admission to API when individuals are ordered to API, who may not be appropriate for inpatient psychiatric services. Opportunities to provide training to judges might be beneficial in reducing the number of 'inappropriate' API commitment orders.

While there are limitations with the availability of community- based crisis intervention services across the state, the volume of API admissions not only contributes to a considerable workload with limited value when 'inappropriate' admission occur, but is also a significant drag on the API budget. Additionally, there are always a number of patients who are discharge ready and unable to be placed back into the community. Strengthening the contractual requirements of community-based providers to be more responsive to requests for community-based services supporting timely discharges may result in fewer patients remaining at a higher level of care than is needed.

During the utilization review process it is sometimes noted that patients are refusing medications. If they are voluntary and they refuse to follow the treatment plan, which likely include medication interventions, they should be discharged. If committed, which most patients are, the court should be petitioned for Court Ordered Medications. An increased emphasis on medication education can be useful and this is an area in which peer support specialists can be very helpful.

Concerns about the numbers of patients refusing medications should be subject to a rapid cycle process improvement approach. Developing a clear understanding of how patients are engaged by staff regarding medication use and at what point in the admission and treatment plan development process the patient is asked to consent should be evaluated. There should also be protocols developed, introduced and evaluated regarding how the need for a specific medication was communicated to the patient including the expected benefits as well as side effects, who can best

provide medication education, how often and in what modalities. In addition, ensuring that medication education materials are understandable and medication and illness specific may improve patients understanding of the benefits of medication.

Recommendations from the June 2011 Review

The June 2011 recommendations summarized below have been further developed as more information is gathered for this report. WICHE will focus on additional recommendations in these and other areas as this project proceeds. The complete June 2011 report is in Appendix I.

- **Explore opportunities to more efficiently manage admissions.**
- **Develop unit and program specific budgets**.
- **Monitor and manage the API budget by unit and program areas through a quality improvement process.**
- **Develop regular reports that track acuity, staff overtime, budget expenditures, and existing quality and utilization indicators by unit and program areas.**
- **Seek opportunities to learn from other states how to operate an acute care treatment model.**
- **Enhance recovery oriented and person-centered treatment and discharge planning and integrate trauma-informed care throughout API**.

August 2011 Meeting – Identification of low hanging fruit to address premium pay issues:

Due to the increased overtime use resulting in significant increases in premium pay, several interventions were implemented immediately to begin addressing budget overage concerns. Some of these included:

- ✓ Reduce escorts to only those that are medically or otherwise 'necessary'
- ✓ Enforce staff taking their breaks to eliminate this cause of overtime
- ✓ Increase interdisciplinary/inter-professional support & structure on the units
- ✓ Re-structure Rehab to be assigned to units (with programming responsibility)

It should be emphasized that these suggestions, and ones made previously, may have incremental impact on budget issues but that most of the low hanging fruit has now been picked. Improvements recommended in this report suggest that there is a need to focus attention on fruit growing higher in the tree and it always takes more effort and proper tools to get to these fruit.

C. Clinical Area Report - Programmatic Needs to Support Acute Care Model with an Emphasis on Recovery

Key issues:

The pressures created by the combination of resource limitations, staffing shortages, recruitment challenges, admission and census increases, and limited access to decision support tools all combine to increase risk for the facility and the patients and staff of API. This set of challenges has reached crisis proportions and it is not realistic to approach these issues with modest adjustments to existing processes.

No single issue, unit, discipline or procedure can be adjusted such that the issues identified previously and during the clinical area review will be resolved. What is evident is that there is a need for improvements in many interrelated areas of the clinical program at API. Some issues, particularly the lack of staff psychiatric availability, create additional difficulties, but there appears to be a need for many existing processes to be changed, improved or eliminated. Addressing the needed changes will be difficult in an environment fraught with existing demands and will require significant commitment on the part of executive leadership to obtain buy in and to actively support the change process.

It appears that one of the reasons that these issues have defied resolution is that the problem statements have been constructed is such a way as to defy resolution or workable solutions. For example, some of the choices that have been articulated are whether or not staff should develop detailed treatment plans or manage the milieu; focus on documentation requirements versus clinical programming; balance the amount of time spent in treatment teams versus providing treatment and milieu management or focus on increasing the efficiency of the treatment teams. These should not be dichotomous decisions. It is a reasonable expectation that detailed and effective treatment plans can be developed and the milieu managed to optimize therapeutic potential. It is also reasonable to expect that there is a relationship between clinical programming effectiveness and good documentation. The functions of an effective treatment team include ensuring that focused and individualized treatment is provided. Solutions on improving the efficiency of the treatment team may be found, but only with a better understanding of the goals of the treatment program, and redesign of the clinical program and documentation requirements.

Areas where improvement opportunities exist include:

- Developing and implementing a coherent treatment philosophy that permeates how patients are engaged and treated;
- Reconfiguring lines of authority to foster treatment teams that are better focused on individualizing patient recovery and ensuring effective transitions to less restrictive care;
- Reconfiguration of units and work processes to accurately reflect facility and patient goals, and improve efficiencies;
- Clearly articulating lines of authority and accountability at all levels of the facility and increasing transparency in decision making and communication processes; and

- Fundamentally changing the approach for documentation processes and requirements, including current and future use of the electronic health record.

As is often the case, work flow processes have evolved more than they have been designed. In any number of instances during the review, staff being interviewed reported that the way things were done relative to a particular policy or unit behavior were the result of procedures in place before the current facility was constructed. These same staff often noted that the process as it was being done was not effective or efficient, yet it persisted. Consequently any new processes created in response to an identified issue tend to be additive rather than replacing prior practice. At each instance there is resulting confusion, ineffective implementation or ignoring of the new process. Policy and procedure changes are often communicated by email or informally and therefore the rationale for the change is not clearly justified, nor is there an opportunity for the root causes leading to the change to be thoroughly understood.

The current pressures of many admissions, often several at a time, the pressure to discharge patients and crowding on the units all contribute to challenges in providing good care. API is frequently dealing with patients who are not appropriate for admission, or could be discharged except for availability or willingness of community providers to agree to see the patient. The result, over time, has been that what was envisioned as a relatively contained admission unit (Denali) has been expanded to two large and diverse admission units where patient mix cannot be easily managed and where varying levels of acuity create additional risk conditions for both patients and staff. The core issue of rapid growth in admissions has heretofore primarily been addressed by considerations of how to best make assignments for the responsibilities of the Admission Services Officer (ASO). In fact, the issue is more fundamental than that and touches on everything from the point the patient is accepted for admission until they are discharged. Working more closely with the Providence psychiatric emergency room staff and clarifying the best use of their resources as well as those of API may result in more efficient use of state resources and more appropriate admissions to API. Additionally, having a distinct and staffed admissions office could also help addresses issues of appropriate admissions, and allow limited dedicated staff to develop working relationships with community providers and the courts.

The basics of the current admissions workflow is that a packet of information needs to be completed by the ASO. Some of this information is computerized and a part of the electronic health record but much is not. While the admission process should be focusing on the clinical issues contributing to the admission, much of the admission paperwork is clerical in nature. Admissions can take up to two hours, and it is not uncommon for several patients (particularly from outlying areas) to be brought to API at the same time, resulting in two or three simultaneous admissions. Staffing the admissions office, therefore, is less an issue of who performs these functions and whether or not a social worker or a nurse should conduct the function. Rather, the issues include how to address the clinical needs of patients as the primary focus on the initial contact with them, how to control preventable admissions, how to delegate documentation requirements, how to ensure only essential information is collected at that point, and how to begin the process of engaging the patient.

The use of Katmai and Susitna units as admission/acute treatment units operating with only limited use of intensive stabilization protocols often appears to result in chaotic milieus and an unfocused clinical program. There was wisdom in the original configuration of the Denali as an

admissions/triage unit. However, given the current volume of API admissions coupled with the complex individuals with intellectual/ developmental disabilities, Alzheimer's and other disorders now being served on the Denali unit due to a lack of more appropriate alternatives for these individuals, it is not feasible to revert back to using Denali as an admission/triage unit at this time.

There needs to be a rapid stabilization protocol developed possibly for Providence and, particularly for the 60+ percent of API admissions from the Anchorage area. Additionally, accessible step down community-based alternatives and aggressive clinical follow up are also needed. There should be a planning process developed for defining optimal patient mix for the Katmai and Susitna units based on patients' level of need for quiet, suicide risk, psychosis and other factors that allow for better therapeutic interventions and more homogenous patient characteristics.

Nursing Services:

One of the primary issues identified at API was the need for increased understanding and utilization of the Recovery Model, which in order to be successful requires the implementation of Trauma-Informed Care (TIC). Ensuring a successful transition to TIC requires that leadership be fully committed to it and provide the tools necessary to effect a change, not only in behaviors, but in attitudes and organizational culture.

Direct care staff appear to be accustomed to working within a medical model in which 'staff know best'. This approach has been known to quickly deteriorate into power struggles with patients, which contributes to escalation of maladaptive behaviors and frequently results in some sort of physical intervention. To avoid these types of scenarios, staff need to receive the conceptual education about TIC, but they also must have concrete examples of how to practice this. A good place to start is with individualized Safety Plans, in which each patient, on Admission, identifies the following: 1) What upsets you? (What are your triggers?); 2) How do you know (and how will we know) when you're getting upset/out of control; and, 3) What helps to calm you down/get you back in control? (Sample Safety Plan – Appendix II) Developing individualized Safety Plans with patients is much more effective than requesting patients to '*contract for safety*'. As staff become more comfortable and skilled in practicing the principles of TIC, the need for physical intervention will decrease, the environment will be less chaotic and patient and staff injuries will decline. This will lead to changes in staffing requirements for the hospital.

Currently, API has a Director of Nursing (DON), an Assistant Director of Nursing (ADON), Shift Supervisors (SSs) and Unit/Nurse Managers. [The Unit/Nurse Managers will be referred to in this report as Nurse Managers (NMs) as their current job responsibilities are aligned more to those of a typical nurse manager than a unit manager.] The DON, ADON and NMs work four 10-hour days. This configuration should be explored further to ensure that all of these positions are available at the hospital the maximum number of days in a week to manage the administrative details necessary in a complex organization.

There are five SSs and one Clinical Coordinator who supervises them. These positions were described as performing the following tasks: managing all schedules in ResQ, the scheduling software; calling people to come in to work; adjusting staffing as projected by the nurse on the unit on the previous shift; tracking sick leave and overtime; handling personnel issues; and, performing

evaluations on on-call PNAs and RNs. This is not an all-inclusive list, but with the exception of the last two tasks, administrative/clerical staff could handle these functions. The Clinical Coordinator stated that he does not work on the units; other SSs can, but do so infrequently.

Each of the five service areas or units has a NM. The NMs report that they frequently are called upon to work the floor, rather than attending to the myriad duties of managing their unit. Additionally, the current job description for unit/nurse managers does not clearly articulate their role as a leader/manager. Some of the issues identified by the NMs include: 'What is missing is a focus on what is at the core of this hospital's mission; PNAs are not getting the tools they need to manage the patients or the milieu; Locum Tenens are not medicating as proactively as needed; orders are required to be audited every shift; night audits are cumbersome and are being performed across disciplines (nursing, social work, physician); and, NM is frequently pulled to process new admissions.

Interviews with PNAs revealed a similar disconnect with lines of communication. They did not appear to have any advance notice of the interview with WICHE, nor did they have any understanding about the purpose of the visit. Additionally, they were scheduled at what is, for them, the busiest time of day. The PNAs had similar issues with the Locum Tenens that were verbalized by the NMs, adding that the Locum Tenens doctors do their discharges late in the day so that it does not allow them to process any new admissions prior to their leaving for the day. Most discharges occur between the hours of 1:00 and 3:00 PM. The PNAs believe that there are duplicative, non-value added processes (Team Solutions, Role Recovery), and verbalized frustration that they have no input into processes or changes at API.

It is important to ensure that all of these staff perform tasks aligned to their training and expertise and do not get overly engaged in performing clerical and other tasks. A re-alignment of tasks and a review of the organizational structure may be helpful in streamlining administrative functions, reducing 'top-heavy' leadership, improving communication and increasing efficiencies.

Other observations:

- One of the duties of the night nurses is to print a 70 plus page document that constitutes 'morning report'. This currently provides detailed reporting significant events; e.g., restraints, seclusions, medical emergencies, injuries, unauthorized departures, admissions and discharges. Leadership finds the information provided through this reporting process very helpful, however it may be possible to streamline this reporting mechanism in the future.

- Although API has an electronic Medication Administration Record (eMAR) that utilizes bar code technology, there are no scanners being used to input the bar codes. This is an added safety feature that is usually integral to an eMAR process.

- The two Adult Admissions units, Katmai and Susitna, have similar patient populations, relatively equivalent census and identical minimum staffing policies. Yet the negative outcomes for Susitna are markedly higher than Katmai's. It was noted that Katmai has adopted day-to-day routines and operations that enhance organizational efficiencies (checklists, etc.). There appears to be a tension and, or distance between Rehab staff and Nursing staff accompanied by a general disregard for the other's role. This may improve as

Rehab staff decentralize some services and are assigned to work primarily on specific units and incorporated into the Treatment Teams.

API and Other State Hospital Staffing Patterns and the API Use of Overtime

API's staffing policy identifies the minimum nursing staffing levels for each of the units as identified below. The tables that follow show the adjusted staffing for each of the units for three days in August 2011.

API Minimum Staffing Levels per Policy

API	Days	Evenings	Nights
Chilkat – 10 Beds	1 RN, 1 PNA	1 RN, 1 PNA	1 RN, 1 PNA
Denali – 10 Beds	1 RN, 3 PNAs	1 RN, 3 PNAs	1 RN, 2 PNAs
Katmai – 24 Beds	*2 RNs, 3 PNAs	*2 RNs, 3 PNAs	*2 RNs, 2 PNAs
Susitna – 26 Beds	*2 RNs, 3 PNAs	*2 RNs, 3 PNAs	*2 RNs, 2 PNAs
Taku – 10 Beds	1 RN, 2 PNAs	1 RN, 2 PNAs	1 RN, 2 PNAs
API Total per Shift	**7 RNs, 12 PNAs**	**7 RN, 12 PNAs**	**7 RN, 9 PNAs**

* 1 LPN/1 RN is acceptable, or 2 RNs

Data Summary Based on 4 Consecutive Shifts, August 9 – August 10, 2011

- Day Shift: 10 additional non-scheduled staff – including for 3 1:1s (2.6 ratio)
- Evening Shift: additional 8.5 non-scheduled staff– including for 5 1:1s (2.4 ratio)
- Night Shift: additional 5.5 non-scheduled staff– including for 1 1:1 (3.4 ratio)
- Day Shift (August 10): additional 10.5 non-scheduled staff - including for 6 1:1s (2.5 ratio)

8/9/11 API Staffing	Days	Evenings	Nights
Chilkat – 10/9/8	**1 RN, 4 PNAs(2- 1:1s)**	**1 RN, 5 PNAs(3- 1:1s)**	**1 RN, 3 PNAs (1- 1:1)**
Denali – 10/9/10	**1 RN, 4 PNAs**	**1 RN, 3 PNAs**	**1 RN, 2 PNAs**
Katmai – 24/23/23	**2 RNs, 6 PNAs**	**3 RNs, 5 PNAs**	**2 RNs, 4.5 PNAs**
Susitna – 26/23/25	**3 RNs, 6 PNAs**	**3 RNs, 5.5 PNAs**	**2 RNs, 4 PNAs**
Taku – 10/10/10	**1 RN, 4 PNAs (1- 1:1)**	**1 RN, 4 PNAs (2- 1:1s)**	**1 RN, 2 PNAs**
API Total per Shift	**8 RNs, 24 PNAs**	**9 RNs, 22.5 PNAs**	**7 RNs, 15.5 PNAs**

Additional Staffing data for August 30, 2011

- Day Shift: 6 additional non-scheduled staff – including for 1 1:1 (2.6 ratio)
- Evening Shift: additional 4 non-scheduled staff– including for 3 1:1s (2.7 ratio)
- Night Shift: additional 7.5 non-scheduled staff– including for 1 1:1 (3.3 ratio)

8/30/11 API Staffing	Days	Evenings	Nights
Chilkat – 11/11/11	**1 RN, 3 PNAs(1- 1:1)**	**1 RN, 3 PNAs(1- 1:1)**	**1 RN, 2 PNAs**
Denali – 10/10/10	**1 RN, 3 PNAs**	**1 RN, 3 PNAs**	**1 RN, 2.5 PNAs**
Katmai – 22/21/22	**3 RNs, 5 PNAs**	**2 RNs, 5 PNAs (1-1:1)**	**2 RNs, 5 PNAs (1-1:1)**
Susitna – 24/19/21	**3 RNs, 5 PNAs**	**3 RNs, 4 PNAs**	**2 RNs, 4 PNAs**
Taku – 10/10/10	**1 RN, 3 PNAs (1- 1:1)**	**1 RN, 3 PNAs (1- 1:1)**	**1 RN, 2 PNAs**
API Total per Shift	**9 RNs, 19 PNAs**	**8 RNs, 18 PNAs**	**7 RNs, 15.5 PNAs**

Additional Staffing data for August 31, 2011

- Day Shift: 3.5 additional non-scheduled staff - no 1 1:1s (2.7 ratio)
- Evening Shift: additional 3.5 non-scheduled staff– including for 4 1:1s (2.4 ratio)
- Night Shift: additional 7.5 non-scheduled staff– including for 1 1:1 (2.7 ratio)

8/31/11 API Staffing	Days	Evenings	Nights
Chilkat – 11/10/9	1 RN, 3 PNAs	1 RN, 3 PNAs(1- 1:1)	1 RN, 3 PNAs
Denali – 10/10/10	1 RN, 3 PNAs	1 RN, 3 PNAs	1 RN, 2 PNAs
Katmai – 23/19/18	2 RNs, 6.5 PNAs	3 RNs, 6.5 PNAs (2- 1:1s)	2 RNs, 5 PNAs (1-1:1)
Susitna – 21/16/17	3 RNs, 4.5 PNAs	3 RNs, 4 PNAs	2 RNs, 4 PNAs
Taku – 10/10/9	1 RN, 3 PNAs	1 RN, 3 PNAs (1- 1:1)	1 RN, 2 PNAs
API Total per Shift	8 RNs, 20 PNAs	9 RNs, 19.5 PNAs	7 RNs, 16 PNAs

Patient Acuity and Observation

Nurses are required to complete an Acuity Sheet prior to the oncoming shift that assigns 'levels' of acuity. This Acuity Sheet has established ratios for each acuity level and, once calculated, is multiplied by a factor of 0.06375 to obtain the number of staff needed. It is unclear how the ratios and/or the multiplication factor were determined. The 'number of staff needed' arrived at is frequently changed to an 'Adjusted Staffing'", which basically renders the formulas moot.

API uses an Acuity System to assist in determining staffing needs on each shift. As with many of the Nursing Policies and Procedures, this procedure is overly detailed and prescriptive; for example:

- The RN will sign the block indicated for signature;
- The acuities must be called in to the NSS at extension #7177 before the end of the shift as noted below
    - Night shift must call before 0400 hours;
    - Day shift must call before 1300 hours;
    - Evening shift must call before 2100 hours.
- If the patient's acuity is decreased, staff are required to notify the NSS within 30 minutes of the change.
- There is an additional rating system, the Close Observation Status Scale (COSS), which assigns an additional rating to those patients requiring more frequent monitoring. Acuity Level II may be associated with COSS 1; acuity level III may be COSS 2; acuity level IV may be COSS 3. Although this seems confusing, the nurses at API seem comfortable and accustomed to these separate rating systems, however it may not be the most efficient way to manage patient safety and oversight. An example of observation precautions specifying elopement, suicide, fall and medical used in Colorado is in Appendix III.

The API Nursing Procedure Manual does provide specific criteria by which to apply the Acuity Levels and the COSS; however, there is still opportunity for interpretation and subjectivity. Clearly, an increase in either of these domains will result in an upwardly adjusted staffing requirement, which is generally desirable at a unit level.

The staffing formula does not appear to take into consideration a presumption of moderate level of acuity for persons being served, thereby driving up the adjusted staffing levels beyond what is actually necessary to maintain a safe and effective treatment milieu. Additionally, the process of nursing staff completing the Patient Acuity/Staffing System forms each shift and submitting them to a Nurse IV for review and staffing adjustments is an inefficient process when compared with developing reasonable core staffing levels.

If more reasonable core staffing levels were adopted, the Director of Nursing, Assistant Director of Nursing, or Unit/Nurse Manager (once given additional responsibility/accountability for staffing, budget, etc.) would then review and approve or deny requests for additional staffing. Requests of approved additional staffing, only under extreme situations based on acuities and census, would be reported to the API CEO, Hospital Administrator, Clinical Director and Medical Director within 24 hours of occurrence. These data would be tracked and reported monthly for management staff by day, shift and unit. [Note: More frequent reporting (weekly) may need to be reviewed initially.]

Other Nursing Issues:

Currently direct care staff at API work eight hour shifts with a 30 minute break, which does not allow change of shift reporting without staggering the times that staff report to work(with the exception of some staff who work 10-12 hour shifts). Staggering reporting times requires multiple report times (inefficient use of staff time) or the taping of report so that incoming staff can receive necessary information; however, taping limits the discussion/planning opportunities that are offered by a more structured change of shift report with all of the incoming staff present. Additionally, if change of shift report is accomplished via taping, incoming staff would need to sign off that they have received report, which is an additional task that would have to be monitored for compliance. [Note: Hand-off communication is a National Patient Safety Goal identified by The Joint Commission as a key element of performance]

Another option would be for direct care staff to move to 8.5 hour work shifts with a 30 minute break. Labor Relations would need to be involved and the union would need to agree to such a change. If this was to occur and API went to 8.5 hour work days, staff would have to clock out for a break but also receive pay for a 40 hour week as opposed to the current 37.5 hour week. This would require a 6.25% increase in staff salaries to accommodate the increase in work hours. Given the approximate 134 nurses and PNAs at API, the annual additional cost would be $3,750 per staff for a total of approximately $502,500, based on an average salary of $60,000. (This 134 number of nurses assumes all staff within the nursing and PNA classifications would move to a 40 hour work-week). The cost would be partially off-set by decreased overtime occurrences and eliminating approximately six (6) direct care positions. [A calculation of $75,000/FTE was used to conservatively account for benefits and approximate savings associated with eliminating FTEs.] Currently for **direct care staff** there are approximately 63 PNA I-IIIs, 3 LPNs and 53 Nurse I-IIIs for a total of **119 direct care FTEs for 80 beds**.

Rehab Services and Unit Programming

Rehab staff have provided centralized services at API for several years, with most of the programming occurring in the Recovery Mall. Over time it appears that the treatment focus of the services offered have diluted to an activity orientation not related to identified issues requiring

resolution in order for the patient to be discharged and meet treatment plan goals. Rehab staff no longer routinely complete patient screens or assessments at admission, nor are they involved in the Treatment Team meetings. Therefore, they have little if any clinical information about the patients' strengths, resources and treatment goals. This has been problematic for some time, however is more apparent given the focus on acute care and shorter lengths of stay on the Katmai and Susitna units. Given the short average lengths of stay on these units of two to three weeks, Rehab staff have little opportunity to impact treatment relying solely on the Recovery Mall approach, especially when:

- Assessments of rehab needs are seldom completed;
- Rehab services are not incorporated into the Wellness Recovery Plans;
- Rehab staff are not active members of the Treatment Teams; and
- Rehab staff routinely document class participation, however this is not directly connected to any treatment goals.

Rehab Data Summary January – July 2011

Additionally, an analysis of services data from January through June of 2011 indicated the following:

- Recovery Mall programming currently occurs approximately 4 hours per day (with some simultaneous groups occurring). Some of this programming could continue but staff assigned to units and responsible for unit programs;
- 62-77 percent of the non-forensic patients attended one or more groups;
- Average classes or groups per patient per month was 6.42 – 9.66;
- Average classes or groups per patient per week was 1.6 – 2.4; and
- Of the 42 classes identified by Rehab, 17 or 40 percent were well-attended, and the highest attendance was for the Computer Lab (patients like to check email and Facebook), Mall Walking and Personal Fitness.

On-Unit Programming

On-unit programming is limited, especially on the Katmai and Susitna Units, where only Team Solutions, Gym/Outside and Community/Evening Meetings were identified on their schedules. Other findings included:

- Services data on attendance and program consistency are not captured for on-unit programs/groups;
- There is currently not an interdisciplinary approach to treatment programming; and
- There is not an identified responsible and accountable staff for unit programming.

Psychology Services

API has two Ph.D. psychologists who primarily conduct competency evaluations and related legal tasks as well as provide some psychological testing services. There are four Master's level psychologists and a post-doctoral individual was recently added to the staff. There are also two

psychology interns receiving training and providing some services. Other than the competency evaluation and restoration services provided on the Taku unit, the psychology services are centralized and staff are not assigned to specific units. However, the clinical director did express that treatment was enhanced when psychology, social work and rehab staff were assigned to specific units and better engaged in treatment planning and programs. Having the psychology staff more closely associated with the treatment units could help build more robust treatment programs and clinical interventions.

Social Work Services

API has eight Social Work FTEs (2 current vacancies) and usually have 10-12 consumers assigned to them. One social worker is assigned to each of the three 10 bed units and two social workers are assigned to the 24 and 26 bed units, which typically receive about six combined admissions per day. Currently the social workers engage in treatment and discharge planning in addition to their admission tasks. Opportunities to increase discharge planning efficiencies, such as contacting potential community placements and initiating community transition warrant exploration especially given the volume of admissions and discharges on the Katmai and Susitna units.

Admission Screening Officer (ASO) Functions -Social Work and Nursing Staff

Admissions to Taku and Chilkat are managed by the clinical social workers assigned to these teams. Denali does not receive direct admissions, with the exception of some readmissions. The majority of the admissions go to Katmai and Susitna, the two adult admission units. These admissions are managed by a combination of social work and nursing staff taking the lead with psychiatric nurse assistants providing some support and assistance. There is a dedicated evening staff that handles the evening admissions along with on-call staff, as scheduled. On the night shift a registered nurse functions as the ASO. During the day shifts the ASO function is primarily managed by social workers, however nursing staff assist when needed. As noted in API's admission procedure, the screening and admission of a patient takes priority over clinical and other functions of the ASO and the on-call licensed independent practitioner (LIP) or officer of the day (O.D.).

The intake/admission process typically takes 45-90 minutes after which the person is escorted to the unit. During this time information from the referral source as well as from the patient is gathered and documented. Additionally, all of the patients clothing is collected and washed. While the patients change into hospital pajamas, the physical condition of their body is observed for signs of bruising or other injury. Once these processes are complete, the patients are escorted to the designated unit for nursing and other staff to begin their admission tasks.

The fundamental challenges confronting API in terms of admissions and discharges are that the community-based mental health system does not accept responsibility for diverting patients from the hospital to the extent that their peers do in other states, timely discharges are constrained by a lack of incentive or imperative that patients are discharged when they have achieved maximum hospital benefit, and residential placements are not compelled to create interventions for patients

with challenging behaviors. These deficits have resulted in pressure on the admission process and necessitate excessive levels of documentation for patients who are discharged shortly after admission. While recommendations are contained within this report regarding improvements to the admission processes and unit configuration to support rapid stabilization, ultimately the issues confronting API will require policy and contractual changes outside of the scope of authority of API. One consideration may be for API to engage in continuity of care activities and support identified individuals as they reintegrate back to the community. Specially trained social work associates and, or peer specialists may be well-suited for this and it may be possible for API to be reimbursed for these case management or related services. The staff could function as community liaisons and work closely with community providers.

It was recommended previously that API obtain access to the AKAIMS data system in order to identify at admission any clients who are known to the system, and may be currently active clients of local community mental providers. API staff would then utilize this information to contact these providers and initiate efforts to either divert the admissions, when appropriate, or to facilitate continuity from the point of the initial assessment.

Medical Staff

There clearly are challenges with recruiting and retaining psychiatrists to API and, since these challenges seem to be predictable and persistent, alternative approaches may be indicated. Currently, the only employed psychiatrists are assigned to two of the smallest units (although one is a child psychiatrist assigned to the Chilkat Unit) and the Locum Tenens physicians are assigned to the highest risk and most intensive treatment units. Given their temporary status, they may be reluctant to utilize clinical guidelines and utilize rapid symptom stabilization medication protocols. The staff on the units seem to defer decisions to them, when they may be the member of the team with the least historical knowledge of the patient.

Many of the patients admitted to API have multiple prior admissions and are also patients at the community mental health centers in the state. There is limited communication with the patients treating physician in the community, and thus, limited use of existing knowledge of what has and has not been effective in managing the patients' illness. Increasing the role of the staff psychiatrists to build these communication bridges may improve engagement with community providers, provide insights that will educate community-based providers about appropriate admission decisions, and strengthen recruitment options. There are also many community health centers throughout the state and they undoubtedly see many of the same patients that end up being admitted to API. Opening lines of communication with these providers may also prove worthwhile.

Current best practice in medical (and nursing) education settings is to focus on the contributions of all of the professionals making up the treatment team. These interprofessional team approaches recognize that there are not only defined areas of expertise that these individuals bring to bear, but that there is also improved communication and better attention to patients' strengths and needs by open communication, including emphasizing the role of the patients in managing aspects of their

recovery. Leadership in this model is not a function of discipline and when responsibility is delegated, authority should be as well.

Electronic Health Record (EHR) / Wellness Recovery Plan (WRP)

The MEDITECH electronic health record (EHR) was reportedly selected by API from among only two options; the other option being the VISTa system utilized by the Veteran's Administration. Neither option was optimal given the size, clinical configuration and mission of API. Like the VA system, MEDITECH is written with a programming language that has become nearly obsolete and is also accompanied by a proprietary database with limited flexibility. The system has been in a continuous implementation process for three years, yet still lacks the essential functionality needed in order to allow for an integrated paperless system and it is unlikely to obtain this goal for several years without considerable expense. MEDITECH is primarily an application designed for acute care hospitals and therefore had virtually no behavioral health functionality at the time it was selected, and the process of creating such functionality has not gone well for a number of reasons.

Currently, various parts of the clinical record are maintained on paper, including the treatment plans and admission and discharge documents. In addition, the system has very limited relational capabilities so that issues identified in one part of the record can trigger actions in another part of the record, as in critical issues identified during the assessment triggering specified treatment plan issues. At the time of the visit, API was in the training phase of a new release of the MEDITECH system, release 5.6. While some of the staff familiar with the system noted that this new release has many improvements over the current release, it was also noted that the standard release utilized by acute care hospitals is 6.0.

The system was configured to capture a wide number of assessments that had been a part of the legacy paper system of API, thus, there was not an effort to re-engineer these documentation requirements during the requirements analysis phase of the implementation. In addition, the various forms are each in separate screens, which necessitates excessive opening and closing of various screens, confusing saving and lookup capability, and arrays of many data points requiring the user to click on a specific term rather than having automated anticipation of spelling or field intent by the system. The system is not intuitive, particularly for clinical staff, and requires considerable levels of familiarity in order to navigate, and even then it is a time consuming process. The result has been that various parts of the clinical record receive insufficient attention. In some cases, staff ignore the electronic content and in other areas the paper content is ignored. For example, the individual charged with conducting utilization management activities for the hospital does not review the paper based treatment plan as a condition for approving additional lengths of stay and unit staff rely on limited parts of the electronic record in order to minimize their documentation load.

The EHR does not have the ability to access historical record content from previous admissions and integrate this information into current assessments and other documentation, which results in staff either ignoring this information, retyping it or finding the previous electronic document and cutting and pasting this content into the current screens. There are virtually no clinical decision support capabilities, extremely limited ability to access reporting functionality, and no access to on-the-fly reporting capabilities. Simple edits regarding whether or not documentation has been completed is missing which leads to nursing staff wasting countless hours conducting record audits. The system

does have prescribing and pharmacy capabilities, but does not warn of medication errors and API has not invested in bar code scanning technologies that reduce errors and increase efficiency of medication administration.

There is not an organized governance and EHR management process and decision making regarding all aspects of operation, enhancement, and vendor management area hoc. There is a nurse informaticist position, although this individual focused most of her time on staff training and involvement with contractors supporting the system's implementation and modification. In fact, the vast majority of the modifications being made to the system are made by contractors and not the vendor.

At a minimum, there should be an operational working group charged with the day-to-day management of the resource and an executive governance group to address future direction, policy issues and resource allocation decisions. Processes for identifying and establishing priorities for enhancements and fixes should be formalized, structured and incorporate time and cost estimates in this process of determining how to phase in improvements. Routine dashboard reports and clear identification of issues being escalated to the governance group should be utilized as well. The governance group should begin with determining whether or not continuing to utilize this application is in the best interests of API and whether or not they will be able to afford the changes needed in order to make the application support the facility's needs. A cost estimate for achieving a paperless system with sufficient decision support capabilities, and capable of being certified by the Office of the National Coordinator for Health Information Technology should be developed and utilized to support the decision process.

It should be noted that the treatment planning process at API is fundamentally flawed, and not due to the EHR. The document that is created is lengthy, lacks individualization, does not adequately identify the roles of each discipline, does not associate interventions with the highest priority issues needing resolution in order to allow for discharge, does not account for past treatment or placement failures, does not reflect treatment progression, would be extremely difficult for patients to understand, and there is a lack of evidence of patients contributing to its development and content.

Finally, there are technical capabilities that improve efficiency, reduce risk and control costs that some staff have been reluctant to utilize. For example, utilization of the Dragon Speak integrated dictation system eliminates the need for transcription, which is quite time consuming and occupies staff time better spent on other responsibilities.

D. Clinical Services Recommendations

The following list of recommendations is based upon information gained through key informant interviews; review of policies, procedures, quality improvement data, clinical records and other documentation; and best practices within psychiatric settings and models recognized by state and federal authorities as appropriate practices. These recommendations are intended to improve treatment and services along with operational effectiveness and efficiency at API.

Two important preconditions exist, however, for how these recommendations should be approached. First, there is not a focused treatment and program design in place so implementing these recommendations absent that road map will not serve the intended purpose. The executive staff would benefit from targeted assistance in two areas: a facilitated retreat to develop the overall program and management design for the future; and hands on coaching to improve the effectiveness of management team meetings and decision making processes. The second issue is the lack of actionable information to guide leadership. Specifically, the quality improvement process is not viewed as an executive and clinical staff responsibility and there is a lack of ownership for process improvements related to quality. Quality models where a single individual is tasked with managing facility-wide quality activities are no longer utilized and timely access to data intensive decision support tools is the norm. Quality management should have designated executive, middle management and direct care staff engaged utilizing structured processes to detect, identify, define, intervene and evaluate quality improvement issues and interventions. This too is an area where focused assistance in the design and implementation phases would be beneficial.

Additionally, it is important to note that there are numerous recommendations presented in this report and it is recognized that they may not all be viewed as a priority, desirable, or even feasible. Non-clinical recommendations will be added to this report in November of 2011. Therefore, WICHE will continue its work with API leadership as they review and identify the recommendations for action. Upon this determination an implementation plan and outcomes will be established and then selected recommendations will be prioritized and numbered as they are incorporated into an Implementation Plan.

Leadership & Accountability

- Articulate leadership/management roles and responsibilities – specifically including unit managers and other clinical leads
- Increase accountability to support employee role clarity, self-responsibility, and consistency.
    - Clearly identify unit managers with specified leadership and managerial responsibilities;
    - Increase accountability among clinical staff through clear delineation of roles focused on interventions involving the implementation of treatment protocols;
    - Undertake a method for improving the performance evaluation processes emphasizing patient engagement and team-based expectations;
    - Identify staff (charge nurse) to be responsible for coordinating incident de-briefings;

- Review and refine existing policies and procedures to ensure fit with the acute care model. New policies and procedures are not indicated for every issue that arises, rather, existing policies should be evaluated for clarity and appropriateness based on quality and safety issues identified. Policy approval should be formalized and the executive team should be informed of the need for the policy based on issues of patient and staff safety and well-being and efficient resource utilization. Rapid proliferation of detailed policies and procedures may indicate a lack of clarity for organizational policy development. Avoid overly prescriptive and unnecessary policies and provide opportunities for nursing staff to utilize their professional skills, coupled with expectations of and support for utilizing their clinical judgment.
- Enforce policies and procedures while also formalizing revision processes and determining if non-adherence is a systematic personnel issue, an isolated incident or a resource influenced issue.

- Implement initial and ongoing steps to reduce premium pay and other budget overages through efforts such as limiting unnecessary overtime, enforcing breaks, reducing escorts and other off-campus activities, re-visiting staffing protocols, limiting purchases, etc. Monitor whether or not these efforts are having the intended result as well as any unintended consequences that impact patient care. Identify and capture data that are needed for the reporting of key metrics, track such data by unit, program, etc. in order to effectively make decisions and make these data available across the organization.
- Routinely (monthly) review financial reports and variances by unit and program areas.
- Hold managers accountable for managing premium pay within their scope of authority.
- Institute a process to implement data based decision making. This will entail the development of a data collection and analysis strategy, development of best practice dashboard reports, timely access to information and prompt turnaround times and focused efforts within management team, clinical staff and other facility staff meetings.
- Track the appropriateness of admissions capturing the average length of stay for 'inappropriate admissions' and attribute a cost per admission per month and per year.
- Track extended lengths of stay beyond maximum treatment benefit from treatment and develop a mechanism for leadership staff to routinely review and develop plans of action to facilitate appropriate and timely discharges.
- Develop an operational working group to oversee EHR management and decision making processes.
- Develop workgroups tasked with policy and procedure review, reduction and alignment with recovery and trauma informed care; and the development of financial, quality improvement and other management reports.

Treatment Quality – Clinical Programs, Services and Staffing

- Evaluate unit configuration, programs and activities to assess compatibility with the current patient population and treatment model – including applicability to the acute care and intensive stabilization model.
- Enhance program structure and accountability by assigning Rehab staff to the treatment units, with responsibility for their role in individualized patient programming clearly

articulated and integrated with other disciplines responsibilities, while still allowing for some programming to occur in the Recovery Mall.

- Assign clinical staff (psychology, social work and rehab) to specific units – incorporating them in the unit organizational charts, with the understanding that their clinical expertise may be needed on other units as well;
- Ensure that treatment planning processes take into account ways to increase the autonomy patients have in anticipation of discharge to the community
- Align direct care staffing with successful practices at other state hospitals and assign appropriate staff to address functions such as admissions, community liaison efforts, etc.
- Engage unit staff in the interviewing and selection of direct care staff. Each unit and sometimes various shifts have a different 'culture' and it is important to select staff that are a good fit for the primary team with which they will work.
- Identify and address workforce development needs and identify best education strategies based on considerations of topic, staff needs and efficiency.
- Implement workforce training to enhance the implementation of programs that support recovery, more active treatment processes and community focused goals; including assisting unit managers and other clinical staff as an interdisciplinary/interprofessional treatment approach progresses. Some suggested trainings include:
  - Trauma informed care (See Appendix A-5)
  - More training for PNAs – to include medication side effects and group facilitation skills
  - Fall mitigation training; and
  - Behavioral and crisis intervention training, with an increased focus on early and anticipatory interventions.
- Establish, communicate and monitor goals of reducing and restraint episodes along with reducing patient and staff injuries.
- Increase supervision/mentoring/coaching (decrease mistakes) and improve overall performance. Identify, incentivize and reward staff who are role models for other staff members.
- Initiate a rapid cycle quality improvement process to address concerns about the numbers of patients refusing medications and develop, introduce and evaluate protocols regarding how the need for a specific medication is communicated to the patients including the expected benefits as well as side effects, who can best provide medication education, how often and in what modalities. In addition, ensuring that medication education materials are understandable and medication and illness specific may improve patients understanding of the benefits of medication.

Nursing Recommendations:

- Provide intensive and ongoing training to all staff, at all levels of the hospital, on Trauma Informed Care and Recovery Models.
- Develop work groups representative of all levels of staff with the charge of implementing TIC/Recovery hospital-wide and create incentives for these individuals to serve as "champions" for this transformation.

- Ensure consistency of day-to-day routine on like units; this will assist staff who are working more than one unit.
- Develop fall risk protocols that will allow staff utilization that is more efficient than 1:1 observation.
- Ensure consistency of reporting incidents.
- Provide expectations to Locum Tenens physicians that API follows a treatment team model and while these physicians are key members of the teams, the programs and processes developed by the team do not shift with each incoming physician.
- Provide expectations to Locum Tenens physicians that, as an acute care facility, appropriately and aggressively medicating patients is critical, not only for the patients' well-being, but for staff and patient safety, as well.
- Initiate Safety Plans with each patient on admission, providing a copy to the patient.
- Hire or contract with Peer Support Specialists to assist with implementation of TIC and Recovery Model, support medication education, act as advocates for patients and participate in Treatment Team meetings, community transitions and critical incident debriefings.
- Evaluate the Nurse Manager functions on all of the units to ensure they are functioning as unit managers and not simply another nurse to assist with nursing functions on their unit. Every effort should be made to ensure that the organizational structure is not 'top heavy' and is one that supports effective communication and accountability.
- Review job descriptions and tasks of Unit/Nurse Managers and Shift Supervisors to ensure they are working at the top of their competency and are being given commensurate authority, responsibility and accountability.
- Monitor the 'morning report', which is currently being prepared by night nurses for Administration, to ensure relevant information is shared through an efficient process.
- Review scope and purpose of audits being performed by night nurses. Results of the audits should be distributed in summary form and areas identified as problematic subject to personnel supervision or quality improvement processes.
- Complete full implementation of electronic MAR by purchasing and deploying scanners.

Rehab and Unit Program Recommendations:

- Re-structure unit and Recovery Mall classes/groups by determining which better serve patients within a unit versus centralized. There is an economy of scale and an opportunity to allow for more socialization when some activities are centralized – and such activities can be treatment-focused, if the rehab staff know the patients, including their treatment, community placement and recovery goals.
- Assign specific Rehab staff to be responsible and accountable for the programming for each of the units – working with an interdisciplinary team to identify the programmatic needs for the patient populations, identifying the lead and supporting staff for each class/group and monitoring the consistency of the program occurrence and attendance.
- Establish a weekly baseline amount of time for patients to be engaged in active treatment activities and therapies. Clear definitions of what constitutes active treatment should accompany this expectation and active treatment should be provided seven (7) days a week

and by all disciplines. Active treatment can be defined as a group or individual activity that is associated with a specific treatment plan goal and objective.

- Provide individualized treatment and privileges. All patients on all the units tend to be treated the same in terms of the degree of autonomy that they have to be off the units and to make decisions about how to structure their time. Without increasing amounts of responsibility and autonomy, patients' transitions from the locked inpatient units to the community are compromised.
- Minimize transfers between units in order to support engagement with a consistent staff team on the patients' assigned unit.
- Increase activity, particularly physical and social activities off the units simply for the purpose of patients being allowed to spend time off the units and to interact in a less structured environment. These opportunities could be part of the routine unit programs or offered during leisure time by any staff.
- Conduct an assessment of the demand for, and benefits of, individuals representing the Wellness Improvement Center and other consumer directed organizations and efforts should be undertaken to expand the availability of these services especially on the Katmai and Susitna units.
- Develop a QI approach for Unit Managers to monitor critical incidents, seclusion and restraint, elopements, etc. by shift and day-of-the-week to assess patterns and trends. The Unit Managers will share this information with the interdisciplinary/ interprofessional team and make any programming or scheduling adjustments warranted based on the data. Note: These performance data should be tracked and monitored the same across all units and data reports should include unit-specific information for all of the API units. The transparency of this information supports a QI approach and allows for units with better performance in an area to share what is working well with other teams, thereby raising the overall performance at the API.
- Expect psychologists and social workers to play an active role in the interprofessional team effort required to develop an interdisciplinary treatment plan and provide assigned treatment interventions.
- Consider enhancing the therapeutic milieu on the units. There is a need to strike a balance between a stress reducing environment and making the environment so homelike that patients do not want to leave. A consumer driven effort to solicit input regarding how to best enhance the milieu could be the starting point in this process.

Social Work and Admission Recommendations

- Develop and staff an Admission Office employing a social worker as the director and staff with social work associates. This office could be staffed 8:00 AM to 8:00 PM, during which time most of the admissions would occur. Off-hours admissions could be handled by one of the admissions units.
- Evaluate all of the current intake and admission practices and determine what is necessary to occur in the Admission Office versus what could occur on the treatment unit. Activities that occur during the admission process should support the recovery and trauma informed care models.

- Provide basic intake functions in the Admission Office and transport patients to their assigned treatment unit as soon as feasible. Minimize patients being asked the same information repeatedly by various staff.
- Consider implementing a Social Work Associate staffing model (SWA) - train a PNA (or other classification) on each of these admission units to work with the social workers as social work assistants to assist with the discharge planning logistics and other activities.
- Enhance MEDITECH to import data from previous admission to minimize redundant work.
- Minimize evening and night admissions.
- Engage DBH to assist with promoting a mechanism to manage crisis call from the community.
- Consider routine admissions with dedicated staffing (SWA) and with night and weekend plans. On-calls have been difficult to manage (4 FTEs).
- Re-direct walk-ins (about 10 per month) to Providence Emergency Room for assessment/triage/treatment/ medical clearance.
- Continue efforts to educate judges about inappropriate ex parte admissions.

Direct Care Unit Nursing Staffing Recommendation

The table below displays the current API minimum staffing policy levels and staffing snapshot summaries of a few recent days at API. Typically API units operate with a few more nursing staff than the minimum levels require and they frequently have significantly more PNAs assigned to the units.

API Unit Staffing Information Summary	Days	Evenings	Nights
API Minimum Staffing Levels per Policy	**7 RNs, 12 PNAs**	**7 RN, 12 PNAs**	**7 RN, 9 PNAs**
8/9/11 API Staffing	**8 RNs, 24 PNAs**	**9 RNs, 22.5 PNAs**	**7 RNs, 15.5 PNAs**
8/30/11 API Staffing	**9 RNs, 19 PNAs**	**8 RNs, 18 PNAs**	**7 RNs, 15.5 PNAs**
8/31/11 API Staffing	**8 RNs, 20 PNAs**	**9 RNs, 19.5 PNAs**	**7 RNs, 16 PNAs**

* On Katmai and Susitna 1 LPN/1 RN is acceptable, or 2 RNs

Other State Hospital Staffing Information

Direct care staffing information for a few of the smaller western state hospitals is included in Appendix A-IV. Additionally, the Western Psychiatric State Hospital Association's Demographic Benchmarking FY 2011 – Budget and Staff captured information from 18 western state psychiatric hospitals. These data indicate a 'Direct Care Staff/Inpatient Bed Ratio' of 2.34, the highest reported. The second highest was Western State Hospital with a ratio of 1.77 in Washington and the average across the reporting hospital was a ratio of 1.32, significantly less than that of API.

Recommended Core Staffing for API

Based on a review of API's staffing policies and practices along with a review of staffing from several other western state hospitals, the following staffing is recommended for API. This staffing formula is based on higher consistent levels of staffing than the current minimum staffing levels. Even with these recommended staffing levels it is likely that when exceptional circumstances present, staff from one unit may be asked to temporarily cover another unit (API policy should address this) or an additional on-call staff may be necessary to provide additional coverage for part or all of a shift. This should clearly be the exception and not routine. Additionally, it is suggested that acuities continue

to be tracked for trending purposes, although periodic versus daily shift reporting may suffice and be a more efficient use of staff resources.

It is also recommended that the staff working the various shifts on each of the units be consistent, to the extent possible. Developing strong team cohesion on each unit and for each shift is an important function of unit managers. Additionally, an interprofessional team approach should result in more consistent coordinated treatment interventions and outcomes and a more therapeutic milieu.

API	Days	Evenings	Nights
Chilkat – 10 Beds	1 RN, 3 PNA	1 RN, 3 PNA	1 RN, 2 PNAs
Denali – 10 Beds	1 RN, 3 PNAs	1 RN, 3 PNAs	1 RN, 2 PNAs
Katmai – 24 Beds	*2 RNs, 4 PNAs	*2 RNs, 4 PNAs	1 RN, 2 PNAs
Susitna – 26 Beds	*2 RNs, 4 PNAs	*2 RNs, 4 PNAs	1 RN, 2 PNAs
Taku – 10 Beds	1 RN, 3 PNAs	1 RN, 3 PNAs	1 RN, 2 PNAs
API Total per Shift	**7 RNs, 17 PNAs**	**7 RNs, 17 PNAs**	**5 RNs, 10 PNAs**

* 1 LPN/1 RN is acceptable, or 2 RNs

- Construct new enhanced core staffing standards for each of the treatment units.
- Determine the number of nurses, LPNs and PNAs to be assigned as primary staff for each of the units, including adequate coverage for all shifts.
- Determine the on-call staff necessary to retain for coverage when emergency and extenuating circumstances present.
- Identify the number of nursing FTE no longer needed for unit coverage, some which may be assigned to other responsibilities such as admissions, training support, etc., while other positions may be reduced through attrition.

Operations Management, Services and Staffing Related to Clinical Services

- Develop a current and desired process map of the patient admission and patient flow processes at a level of specificity that it can be determined if all staff are operating at the top level of their license and not performing duties that could be performed by another staff member. On the basis of these data develop an integrated and comprehensive effort to improve patient flow across all hospital service areas. Develop mechanism to prioritize and schedule admissions (with exception clause – limit and optimally manage variability)
- Develop and utilize key metrics to manage patient flow and identify community resource gaps and needs and build consensus for system changes.
- Better manage patient flow through improved community relationships with mental health centers, courts, etc. Improved predictability of admissions leads to better milieu management and patient engagement, which results in better patient care.
- Track length of stay, discharge barriers and identify areas where inappropriate admissions, delays in discharge, premature discharges and other issues have increased costs for API. Assign a dollar value to these areas and share with DBH leadership
- Identify and implement redesigned processes to improve the workflow and efficiency of regular operations such as faxing information and record requests on the units and in an admissions office, if one is developed.

- Design and implement a formal process to escalate any issues identified that impact patient or staff safety, efficiency and effectiveness of any aspect of clinical care, resource utilization, staff retention and performance to the quality improvement program. Ensure processes are in place that can ensure accurate problem definition, access potential solutions, test these options and evaluate their effectiveness consistent with rapid cycle performance improvement models.

Sections to be completed later…

E. Hospital Support Area Report (November 20, 2011)

F. Final Recommendations (to meet necessary requirements of a hospital wide quality improvement project)

G. Implementation Plan and Outcomes

Appendix I: Preliminary Findings from the June 2011 Review

- API continues to serve as the sole state psychiatric hospital and as the 'last in-state treatment safety net' for other populations including persons with intellectual/developmental disabilities, traumatic brain injuries, and Alzheimer's and related Dementia's with associated behavioral manifestations.

- API continues to be available to accept admissions 24/7, based on bed availability. Offering this level of availability creates programmatic challenges and limits opportunities to efficiently utilize staff resources and manage operations.

- Increased demands for services at API and increased acuity levels of patients have resulted in expenditures over the FY 2011 allocation and this trend is continuing into FY 2012. While efforts to better control expenditures have been undertaken, additional opportunities exist to improve overall financial accountability and viability.

- As treatment models for various units at API continue to evolve, unit managers should have greater responsibility and accountability for the staffing and programming on their units. This includes the selection of new staff and oversight of therapeutic programming in the context of an overall vision for therapeutic programming, as well as ensuring adequate yet not unnecessary unit coverage.

- As API transitions to provide acute, shorter-term treatment, it is important for programming to be aligned with this model. Many other state hospitals have realized that a shift in a treatment approach also necessitates cultural and operational changes. Opportunities exist to utilize the interdisciplinary unit and rehabilitation staff, and the Recovery Mall to better incorporate active interventions into the treatment plans of the individuals served.

Initial Recommendations from the June 2011 Review

The recommendations identified below will be further developed as more information is gathered. WICHE will focus on additional recommendations in these and other areas as this project proceeds.

- **Explore opportunities to more efficiently manage admissions.** Considerations may include scheduling of admissions and changes to the internal admission and intake processes and staffing. If it is determined that scheduling admissions will occur, communication and coordination among various community agencies will be essential. Additionally, intensive treatment options within Alaska but outside of API for non-mental health populations should be developed.

- **Develop unit and program specific budgets**. Currently the API budget is managed by executive leadership with little delegated responsibility to the units and programs that drive much of the expenditures, especially the variable costs such as staff overtime and decisions to add staff due to patient acuity, which are determined by using the Close Observation Status Scale (COSS). In order for unit managers to successfully manage their budgets, they will need greater authority for the selection and hiring of unit-specific staff.

- **Monitor and manage the API budget by unit and program areas through a quality improvement process.** As this would be a new function for middle managers, pre-implementation training and regular review and support will be essential for successful transition to a de-centralized budgetary process. Additionally, since the API budget is not currently tracked by unit or program area, initial allocations will need to be estimates which may need to be modified during the first year. It may be beneficial to withhold a portion of the allocation (5-10%) in order to make adjustments based on emerging trends. However, as this budgetary process develops over time, it will be critical for managers to be held accountable for the management of their designated resources.

- **Develop regular reports that track acuity, staff overtime, budget expenditures, and existing quality and utilization indicators by unit and program areas.** Collecting these data by unit and program areas allows for better observation of trends, enhanced identification of outliers and more informed decision making. These data should be available for executive leadership on no less than a monthly basis.

- **Seek opportunities to learn from other states how to operate an acute care treatment model.** WICHE staff will provide guidance and support in this area. It will be helpful to API to look at treatment models that are desired and to review existing programs and practices to ensure that they continue to support the new model. A common misstep is to continually add new programs, services and processes without determining those that are no longer effective or necessary. It would be beneficial for leadership staff such as the Hospital Administrator, Nursing Director, Clinical Director and Quality Improvement Director to visit with another state hospital to learn first-hand the processes used and lessons learned when shifting to an acute treatment model.

- **Enhance recovery oriented and person-centered treatment and discharge planning and integrate trauma-informed care throughout API**. As the acute treatment model continues to develop, it will be important to adhere to desired treatment principles and employ evidence-based practices. Opportunities to provide more robust active treatment exists, which may indicate changes to the utilization of the Recovery Mall and the interdisciplinary staff. Workforce training will be necessary to enhance the implementation of programs that support recovery, more active treatment processes and community focused goals; including assisting unit managers and other clinical staff as an interdisciplinary treatment approach progresses.

Appendix II – Sample Safety Plan from the Austin State Hospital

Here is a sample of a Safety Plan (de-identified). This is completed on admission for every patient (when possible). If patient is not able to assist with completing in Admissions, staff on the unit start one asap.

The Safety Plan can be updated by basically anyone involved in direct care of the patient (nurse, PNA, social work, psychology, ed-rehab, etc.), but psychology "owns" it and is accountable for updating and completing it by the next business day following admission. Just as a side note, we hand out headset radios like candy. They get broken, lost, stolen, etc. but they're not that expensive and it's amazing how many patients respond to being able to listen to the music of their choice. They cost a lot less than a restraint.

Sample Form:

Name:	Unit:
Last Updated:	Author:

Triggers	Warning Signs	Calming Strategies
People in her space.	Isolates	Observe closely due to possible SIB
Being lied about.	Gets quiet	Interacting with others
Voices	Attempting SIB	PRNS (pills or shots)
People and it is noisy	(self-injurious behavior)	Music
		Go for a walk

Appendix III – Sample Observation Levels from the Colorado Mental Health Institute at Fort Logan

Policy & Procedure 26.01

COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN

POLICY & PROCEDURE

TITLE: OBSERVATION PRECAUTIONS

PURPOSE: To assure a safe and protected environment for patients at risk.

POLICY: OBSERVATION PRECAUTIONS – risk-specific observations and interventions ordered for patients at risk. These may include environmental restrictions, frequent monitoring, securing of dangerous objects and limitation of personal belongings.

PATIENTS AT RISK--typically patients who are assessed as actively self-destructive, patients assessed as dangerous to self or others and who are unwilling or unable to contain their dangerous behaviors, and patients with a history of or potential for elopement who present an immediate threat.

1. Observation precautions require a physician's order. (See below). In an emergency, the R.N. may initiate observation precautions without a physician's order, but must obtain a verbal/phone physician's order within one (1) hour to be followed by a written physician's order within twenty-four (24) hours. Orders will be obtained from either a staff physician or OD. These may be written for up to 72 hours by the attending psychiatrist.

2. Only a physician may discontinue observation precautions (in collaboration with staff).
   - ODs are not permitted to discontinue observation precaution orders without a review with the POD for approval.

3. If more specific limitations are needed or any modifications made for certain individual cases, these shall be outlined in the physician's order.

4. Observation Precautions may be utilized with voluntary patients with due consideration for the civil rights implications associated with this procedure. The patient should be placed on a 72-hour hold (under CRS 27-65) only when a voluntary patient refuses to comply with the observation precautions.

5. Observation precautions may involve restriction of a patient's right(s) (e.g., to retain and wear own clothes, keep personal possessions or money, have visitors) and if so, appropriate documentation is necessary per Policy 26.28.

6. Use of the seclusion room as a non-standard room for observation does not require observation protocols. Patients occasionally may be placed in a seclusion room for clinical reasons (i.e., video monitoring). Whenever the rationale for placement is clinical in nature, the clinical staff shall conduct an interdisciplinary assessment of the reasons for this placement. The assessment will reflect consideration of the patient's current clinical condition (psychological and physical), including measures to maintain safety. This assessment will be documented in the progress notes and the patient's treatment plan.

   Criteria for movement back into a standard patient room will be identified in the treatment plan and include the patient's signature upon review.

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Page 1

PROCEDURE

RESPONSIBILITY		ACTION
Team Member	1.	Makes an assessment that a patient is at risk, (e.g., suicide risk, elopement risk).
RN in Charge	1.	Obtains a physician's order from staff physician or OD. (In an emergency, institutes observation precautions then obtains phone/verbal order within one (1) hour.). This is to be followed by physician assessment and signing of phone/verbal order within twenty-four (24) hours.
	2.	Initiates Observation Precautions order.
	3.	Assigns staff member to observe patient. (Acute Suicide watch requires constant supervision by staff.)
	4.	Re-evaluate patients on observation levels each shift for need to continue observation precautions.
	5.	If clinical situation no longer requires patient to be on a watch, the nurse and other clinical staff will communicate this assessment to the attending physician or POD to request an assessment that the watch order be discontinued.
Physician	1.	Assesses patient and writes order for observation precautions for the appropriate watch: Acute Suicide Watch, Stepdown Suicide Watch, Self-harm Watch, Assault Watch, and Elopement Watch. (See Observation Precautions protocol, 26.01 Attachment A). Note: Any modification in observation precautions protocols or more specific limitations must be outlined in the order (e.g., gowning, strip search, cavity search, etc.) Increased limitations must be justified in the accompanying progress note.
	2.	If necessary, places patient on an emergency mental health hold per CRS 27-65.
	3.	Documents necessity for observation precautions, any restriction of rights, and that the patient has been informed of the rationale and implication of the observation precautions. Criteria for discontinuation should clearly be explained to patient and documented.
	4.	When a patient is assessed by staff and physician to no longer need observation precautions, the physician shall discontinue a previously ordered observation precaution, by either a written, verbal or phone order. • ODs are not permitted to discontinue observation precaution orders without a review with the POD for approval.
	5.	Evaluates the clinical situation of the patient at least every seventy-two (72) hours (per physician order) and documents assessment either in a progress note or in the body of the next required order.

Clinical Staff 1. Are responsible for monitoring the patient on observation precautions per attached observation precautions protocol and restrictions.

Use of the seclusion room as a non standard room for observation does not require Observation precautions. It does require an interdisciplinary assessment of the reasons for placement and the assessment will be documented in the progress notes and the patient's treatment plan. Criteria for movement back into a standard patient room will be identified in the treatment plan and include the patient's signature upon review.

SIGNED:_____DATE:_____
Shelley Moriston, R.N., M.S., Director of Nursing Services

SIGNED:_____DATE:_____
Bruce Leonard, M.D., Medical Director

APPROVED:_____DATE:_____
Keith LaGrenade, M.D., Hospital Director

Observation Precautions – Colorado Mental Health Institute at Fort Logan

Acute Suicide Watch ‡ • Patient in staff sight at all times • Sleep in open seclusion or monitored in day room • Patient & Room searched each shift for contraband, no cords, shoelaces, etc. • Thick bedding – not covering patient's head & neck. Safety blanket, no sheets. • Assess need for safety smock, gowns or other hospital issued clothing, if not, limit to one set of street clothes per day, no shoes • Accompanied by 1 staff to essential appointment or off-unit emergency • Patient constantly observed in shower / bathroom • Check visitors for contraband, observe permitted visitors carefully. Staff must remain present during visit. Deny visits that have a contra-therapeutic effect on patient, documenting rationale • Patient restricted to unit	**Stepdown Suicide Watch ‡** Requires Psychiatrist order (in collaboration with staff) • Patient in observable area with 15 minute staff checks • Sleep in open seclusion or in day room or in "restricted area" or in own room if close to nursing station and a roommate is present • May retain one set of street clothes per day, no shoes • Accompanied by 1 staff to essential appointment or off-unit emergency • May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity – no razors till off suicide watch • Visitors – same as Acute Suicide Watch – or as modified by physician's order • Patient restricted to unit • Patient and Room search each day
Assault Watch ‡ • Patient on 15 minute checks • Consider single room, QA, Seclusion, 10 foot restriction, medication change • Assess safety of patient's belongings • Keep patient a reasonable distance from other peers • Accompanied by 2 staff (1 can be SSO) to essential appt or off-unit emergency • May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity – no razors till off assault watch • Visitors - Same as an Acute Suicide Watch – or as modified by physician's order • Restricted to unit, may participate in programming on unit, no passes • Patient & Room search each shift – unless increase is needed	**Elopement Watch ‡** • Patient on 15 minute checks • Assign patient room away from exits • Patient to sleep in room • Remove car keys and money • Assess need for gowns/ no shoes, or doctor may write order for one set of street clothes/ no shoes • Accompanied by 2 staff (1 can be SSO) to essential appt or off-unit emergency • May shower and use bathroom alone, after informing staff. May use hygiene items and return to staff upon completion of activity • Visitors - Same as an Acute Suicide Watch – or as modified by physician's order • Restricted to unit, may participate in programming on unit, no passes • Patient & Room search each shift
Self Harm Watch ‡ Same as Stepdown Suicide Watch except: may retain shoes, must constantly be observed in shower / bathroom, and patient & room searched each shift.	**Grave Disability / Medical Precautions: ‡** To be addressed with individual physician orders.

‡ For All Risk Watches Document 15-min. checks on flow sheet and enter progress note every shift with high risk assessment tool.

Observation Precautions – Colorado Mental Health Institute at Fort Logan

	Acute Suicide Watch	Stepdown Suicide Watch	Self Harm Watch	Assault Watch	Elopement Watch	Grave Disability / Medical Precautions
Observation	In staff sight at all times Sleep in QA or monitored in day room. Constantly observed in bathroom/shower.	In observable area with 15 minute checks. Sleep in QA or in day room or in own room if close to nursing station and a roommate is present. May shower & use bathroom alone, after informing staff.	In observable area with 15 minute checks. Sleep in QA or in day room or in own room if close to nursing station and a roommate is present. Constantly observed in bathroom/shower.	Pt. on 15 minute checks. Sleep in single room, QA, Seclusion. May shower and use bathroom alone, after informing staff.	Pt. on 15 minute checks Assign room away from exits. May shower and use bathroom alone after informing staff.	To be addressed with individual physician's order
Risk Items	Thick bedding – not covering head & neck. Safety blanket, no sheets. Pt. & room searched each shift for contraband, no cords, shoelaces, belts, scarves, ties, etc.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each day.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each shift.	May use hygiene items and return to staff upon completion of activity – no razors. Pt. & room searched each shift – or more if needed.	Remove car keys and money. May use hygiene items and return to staff after completion of activity. Pt. & room searched each shift.	To be addressed with individual physician's order
Visitors	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	Check visitors for contraband, observe permitted visitors carefully. Staff to remain present during visit. Deny visits with contra-therapeutic effect on pt., documenting rationale.	To be addressed with individual physician's order
Proximity & Passes	Restrict to unit, no passes. Accompanied by at least 1 staff to essential appointments or off unit emergency.	Restrict to unit, no passes. Accompanied by 1 staff to essential appointments or off unit emergency.	Restrict to unit, no passes. Accompanied by 1 staff to essential appointments or off unit emergency.	Keep a reasonable distance from peers. Consider 10' restriction. Restricted to unit, no passes. Accompanied by 2 staff (1 can be SSO) to essential appt. or off unit emergency	Restricted to unit, no passes. Accompanied by 2 staff (I can be SSO) to essential appt. or off unit emergency.	To be addressed with individual physician's order
Dress	Assess for safety smock, gowns or other hospital issued clothing, or one set of street clothes per day, no shoes.	May retain one set of street clothes per day, no shoes.	May retain one set of street clothes per day, with shoes.	Assess safety of patient's belongings.	Assess need for gowns/no shoes, or dr. may write order for one set of street clothing / no shoes.	To be addressed with individual physician's order

26.01A-GRID 12/10

Expectation of Staff Assigned to 1:1 Patient

Date: _____ Shift: ☐day ☐evening ☐night ☐other: _____

Staff Assigned: _____ from: _____ to: _____
Staff Assigned: _____ from: _____ to: _____
Staff Assigned: _____ from: _____ to: _____
Staff Assigned: _____ from: _____ to: _____
Staff Assigned: _____ from: _____ to: _____

Reason for 1:1: _____
☐Danger to self ☐Danger to others ☐Medical issues ☐Other_____

Staff assigned to 1:1 will not be given any other assignment during the time they are providing 1:1 coverage. Staff will do the paperwork assigned, i.e. observation sheet, shift charting, risk assessment for the patient you are assigned to 1:1.

Staff will check the QA room at the beginning of each shift for contraband or dangerous items. Document on observation sheet.

Staff are to observe and interact with the patient.

Staff should limit interactions with patient due to:_____

_____

Assist with ADLs as needed.

Engage patients in activities, reality orientation exercises assist them with participating in group activities.

Staff assigned to 1:1 are to be observing patient, not reading or wearing headphones.

Staff assigned to provide 1:1 coverage will provide information to the charge nurse about the patient's condition, risk factors, I & O if indicated, etc.

When patient is awake in the QA:
☐Staff assigned to 1:1 must remain at the doorway of the QA.
☐May observe the patient from the monitor in the nurses' station.
☐N/A
☐Other: _____

When the patient is awake in the milieu:
☐Staff will remain within arm's length of patient.
☐Staff is to observe patient at all times and remain in the same room.
☐N/A
☐Other: _____

When the patient is sleeping in QA:
☐Staff assigned to 1:1 must remain at the doorway of the QA.
☐May observe the patient from the monitor in the nurses' station.
☐N/A
☐Other: _____

When the patient is sleeping in dayroom:
☐Staff is to observe patient at all times and remain in the same room.
☐N/A
☐Other: _____

When the patient uses the restroom, showers, performs ADLs independently:
☐Staff will remain within arm's length of patient.
☐Staff will maintain visual contact with patient.
☐Staff assigned to 1:1 must remain at the doorway of the restroom.
☐Other: _____
☐N/A

When patient has an order that allows use of courtyard:
☐There must be 2 staff available to escort the patient.
☐Other: _____
☐N/A

Meals:
☐Remove plastic from food items.
☐Use only plastic utensils.
☐Use only plastic spoon.
☐Finger food only, no plastic utensils.

Clothing
☐Patient may wear own street clothes.
☐Patient may wear clothes with no strings, pockets.
☐Gowns only.
☐Paper gowns only.

Belongings in Room
☐No belongings in room.
☐Blanket only in room.
☐May have paperback book without staples, crayons, and paper.
☐May have walkman/radio.
☐May have _____

PATIENT SAFETY CHECKS INSTRUCTION

1. Start Date: Place the date in this space.
2. Stop Date: Place the date on which the checks end in this space.
3. AM/PM: Mark whether it is AM or PM.
4. Patient Name: Write each patient's first and last name in the spaces.
5. Actual Time: Document the actual time you begin to do the patient safety checks.
6. Room: Document each patient's room number in the space.
7. Status/Level: Document each patient's status/level in the space.
8. Half Hour Boxes: Document the actual location of each patient where you observe them. If the patient is not on the unit, document with the appropriate code where they are at that time.
9. Exit Doors Secured: Document whether all doors are locked and secured.
10. Staff Initials: Place your initials in the box indicating that you performed the patient safety checks for the half hour period.
11. Administrative Assistant Review: Signature or initials of the person entering the information into Avatar
12. Nurse Manager Review: Signature of the Nurse Manager indicating that the form has been reviewed for completeness.

- Completed forms are reviewed by the Administrative Assistant and then reviewed by the Nurse Manager
- The Administrative Assistants will review the Patient Safety Check form each business day to see if a patient has gone to a medical appointment off grounds (MAO). If a patient has gone to medical appointment off grounds, the Administrative Assistant will input the appropriate code into Avatar to document that the patient has left the hospital to go to the medical appointment.
- Nurse Managers are required to keep the forms for a 3-year period.

Appendix IV -Other State Hospital Staffing Information

Idaho – State Hospital South – 60 beds: 6:1 hospital-wide standard ratio, with occasional fluctuations due to acuities

Idaho	Days	Evenings	Nights
Unit 3– 23-25 Census	2 RNs, 4 Techs	2 RNs, 4 Techs	1 RN, 3 Techs
Unit 4– 15-22 Census	2 RNs, 2 Techs	2 RNs, 2 Techs	1 RN, 2 Techs

Total direct care staffing:
14 full-time RN/LPNs, 2 part-time RN/LPNs
22 full-time techs, 2 part-time techs
36 FTEs for routine direct care staffing for 60 beds

PRN staff: 3 RNs, 2 techs who can work anytime, 3 other techs who are available to work some weekends

Austin State Hospital Direct Care Staffing and Ratios:

Austin State Hospital	Days	Evenings	Nights
APS East: Adult Acute – 4 Units 86-88 Census	6 RNs, 4 LVNs, 12 PNAs	6 RNs, 4 LVNs, 12 PNAs	4 RNs, 2 LVNs, 12 PNAs
APS West: Adult Acute 4 Units 88-90 Census	6 RNs, 4 LVNs, 12 PNAs	6 RNs, 4 LVNs, 12 PNAs	4 RNs, 2 LVNs, 12 PNAs
Specialty Units: LT Adults, Geri/IDD/Deaf 3 Units 95-98 Census	6 RNs, 5 LVNs, 22 PNAs	6 RNs, 5 LVNs, 22 PNAs	5 RNs, 2 LVNs, 22 PNAs
CAPS Adolescent & Latency 3 Units 30-36 Census	2 RNs, 1 LVN, 11 PNAs	2 RNs, 1 LVN, 11 PNAs	RN, 1 LVN, 7 PNAs

Staffing may be increased if indicated for 1:1 orders.

Utah State Hospital

Utah		NIGHTS		DAYS			EVENINGS		
	# Beds	RN	P Tech	RN	LPN	P Tech	RN	LPN	P Tech
Child	15	1	3	1	1	6	1	1	6
Girls	21	1	2	1	1	4	1	1	4
ARTC	5		2			2			2
Boys	17	1	4	1	1	6	1	1	6
Foren -1	22	1	4	1	1	6	1	1	6
Foren -2	26	1	2	1	1	4	1	1	4
Foren -3	25	1	2	1	1	4	1	1	4
Foren -4	25	1	2	1	1	4	1	1	4
NW	28	1	2	1	1	4	1	1	4
NE	28	1	2	1	1	4	1	1	4
SE	25	1	2	1	1	4	1	1	4
Legacy	27	1	2	1	1	4	1	1	4
Mtn. View	27	1	2	1	1	4	1	1	4

Staffing is occasionally increased when 1:1 MD orders are written.

Colorado Mental Health Institute at Fort Logan

Typical CMHIFL Staffing Pattern – 25 Bed Adult Admission Units:

Colorado	Days	Evenings	Nights
Unit 3– 23-25 Census	2 RNs, 3 MH Clinicians	2 RNs, 3 MH Clinicians	1 RN, 1-2 MH Clinicians

Non-admission units typically have 1 RN and an additional MHC

Staffing is adjusted based on census fluctuations and in extreme situations – sometimes briefly – for an hour or two, other times per shift – with a general maximum of staffing of 6/6/4.

Acuities are tracked for trend information, but not for routine staffing adjustments.

CMHIFL – Unit: April 2010	Unit Staff	Internal Pool	External Pool	Total FTE	Avg. Daily Attendance	Ratio
ADULT TEAM 1- ADM./Acute	26.1	1.5	0.5	28.1	21.8	1.29
ADULT TEAM 2	24.0	5.1	1.5	30.7	23.1	1.33
ADULT TEAM 3- ADM./Acute	27.5	4.1	1.9	33.5	22.3	1.50
ADULT TEAM 5	24.9	2.0	1.5	28.4	18.1	1.57
Total-Inpatient Psychiatric-94 beds	102.5	12.8	5.5	120.7	85.3	1.42

Note in the table below that CMHIFL is counting all non-administrative staff assigned to the treatment teams in their ratio. The non-nursing staff are italicized and highlighted in yellow.

1) Reflects direct care FTE allocated to the units and Average Daily Attendance (ADA) of patients as of 4/30/10
2) Internal pool is calculated using the Pool $s per Unit for March 2010 and the utilized Pool FTE as of 3/31/10. The percentage of the total dollar amount for each unit is multiplied by the utilized FTE for the same unit.
3) External pool is calculated by dividing the total hours per team by the number of work hours in March 2010.
4) Job classes included in direct care FTE category:
CLINICAL THERAPIST I, II (OT/RT)
HCS TRAINEE III
MENTAL HLTH CLINICIAN I, II, III
MID-LEVEL PROVIDER
NURSE I, II, III
PSYCHOLOGIST I
SOCIAL WORK/COUNSELOR II, III, IV

The following 2 pages are example of the 'staffing bands' used at the Colorado Mental Health Institute at Fort Logan. The two units shown are admission units. They have developed bands for both 'planned' and 'emergency' staffing. An example of emergency staffing would be when there is a blizzard and limited transportation options for staff to get to work.

CMHI-Ft Logan FY 2010-2011
STAFFING PLAN
Hospital-Wide Nursing Services

Adult Team 1

	Day		Evening		Night	
	RN	HSW	RN	HSW	RN	HSW
Planned Minimum with census of 25	2	3	2	3	1	2
Emergency Staffing with census of 25	1	3	1	3	1	1
Planned Minimum with census of 23-24	2	2.5	2	2.5	1	2
Emergency Staffing with census of 23-24	1	3	1	3	1	1
Planned Minimum with census of 19-22	2	2	2	2	1	1
Emergency Staffing with census of 19-22	1	3	1	3	1	1
Planned Minimum with census of 13-18	2	1	2	1	1	1
Emergency Staffing with census of 13-18	1	2	1	2	1	1
Planned Minimum with census of 7-12	1	1	1	1	1	1
Emergency Staffing with census of 7-12	1	1	1	1	1	1
Planned Minimum with census of 1-6	1	1	1	1	1	1
Emergency Staffing with census of 1-6	1	1	1	1	1	1
Allocated FTEs	22.1					

Revised 06/12/10

CMHI-Ft Logan FY 2010-2011
STAFFING PLAN
Hospital-Wide Nursing Services

Adult Team 3

	Day		Evening		Night	
	RN	HSW	RN	HSW	RN	HSW
Planned Minimum with census of 25	2	3	2	3	1	2
Emergency Staffing with census of 25	1	3	1	3	1	1
Planned Minimum with census of 23-24	2	2.5	2	2.5	1	2
Emergency Staffing with census of 23-24	1	3	1	3	1	1
Planned Minimum with census of 19-22	2	2	2	2	1	1
Emergency Staffing with census of 19-22	1	3	1	3	1	1
Planned Minimum with census of 13-18	2	1	2	1	1	1
Emergency Staffing with census of 13-18	1	2	1	2	1	1
Planned Minimum with census of 7-12	1	1	1	1	1	1
Emergency Staffing with census of 7-12	1	1	1	1	1	1
Planned Minimum with census of 1-6	1	1	1	1	1	1
Emergency Staffing with census of 1-6	1	1	1	1	1	1
Allocated FTEs	22.1					

Revised 06/12/10

Appendix V- Trauma Informed Care Resources

Resources for Trauma-informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.samhsa.gov/nctic/trauma.asp) states that most individuals seeking public behavioral health have histories of physical and sexual abuse and other types of trauma-inducing experiences. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

SAMHSA's National Center for Trauma Informed Care identifies (although does not specifically endorse) the following well-known trauma-specific interventions based upon psychosocial educational empowerment principles that have been used extensively in public system settings.

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

Sanctuary Model of Organizational Change is one in particular that may benefit ASN/ACPTC because it not only addresses trauma-informed care, but also emphasizes the organization change that needs to occur to truly adopt this model.

Our social safety net has been seriously corroded in the past decade and social service, health care, and mental health care systems are suffering greatly under the burden of many stressors including decreased funding, managed care restrictions on care, compromised training and supervision

programs, legal mandates and restrictions, and excessive paperwork. This system deterioration is further complicated by the fact that currently, in most social service and mental health settings there is a lack of a clear, consistent, comprehensive and coherent model for delivering care that takes into account the impact of exposure to violence, abuse, and other forms of traumatic experience on individuals, families, staff, and organizations. Complex, parallel process interactions occur between traumatized clients, stressed staff, pressured organizations, and hostile economic and social forces in the larger environment. As a result, our systems can inadvertently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to help. Not only does this have a detrimental effect on clients, but it also frustrates and demoralizes staff and administrators, a situation that can lead to worker burnout or secondary trauma with all its attendant problems. Ultimately, the inefficient or inadequate delivery of service and the toll this takes on workers, wastes money and resources. This vicious cycle also lends itself to a world view that the people receiving the services are the cause of the problem and that their situations are hopeless and they cannot really be helped.

The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children. The Model has since been adapted by residential treatment settings for children, domestic violence shelters, group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in other settings as a method of organizational change. (http://www.sanctuaryweb.com/organizational-change.php)