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Alaska Psychiatric Institute Consultation Report & Recommendations For Nursing Staff Effectiveness

May 2012

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EXECUTIVE SUMMARY

The Mental Health Program of the Western Interstate Commission for Higher Education (WICHE) has been providing consultation services to the Alaska Psychiatric Institute (API) / Department of Health and Social Services (DHSS) since FY 2011.

This particular report was commissioned through WICHE to examine issues relating to Nurse Staffing Effectiveness practices, patterns and premium pay usage at API and to offer recommendations to improve the overall efficiency in staffing and its relationship to patient safety.

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. The documentation review included staffing patterns, weekly staffing effectiveness grids, financial documents, performance improvement, risk management data, policies and other administrative documents. A tour of the new state-of-the-art hospital was also conducted. Several themes emerged throughout the process of conducting interviews with staff and document reviews. The themes include the need for:

- Role clarification amongst the Nursing Leadership Team
- Improved Collaboration and Transparency amongst Senior Management Team Members
- Building a Culture of Safety
- Cost-Effectiveness and Efficiency of Work Schedules
- Better Anticipated Discharge Planning
- Training specifically focused on alternatives to Restraint and Seclusion as well as alternatives to Special Precautions
- Accountability of Senior Nursing Leadership to initiate and follow the Performance Improvement (PI) process through to problem resolution as it relates to audit findings and medication management

Consultation Report

The Western Interstate Commission for Higher Education's Mental Health Program has been providing consultative services to the Alaska Department of Health and Social Services/ Alaska Psychiatric Institute since FY 2011.

The objective of this consultation was to look at Nurse Staffing Effectiveness and its relation to patient-safety, nurse-patient ratios, nursing leadership structure, varied nurse work shifts and compliance issues. WICHE consultative staff was specifically asked to develop recommendations for clinical nursing and nursing leadership. As of recent, nursing staff allocation has exceeded its budget and has used increasing premium pay for staffing due to high workers compensation and family medical leave volume, high acuity and special precautions and the facilities desired core staffing.

Consulting Participants:

Deb Kupfer, M.H.S. WICHE Lead Staff

Valerie Devereaux, DNP, MS Nurse Consultant

General Observations

The hospitals' unique contemporary design was obviously selected to promote efficiency and to provide an open line-of-sight in patient care areas. The facility is spacious and bright. Each unit has two large dayroom areas giving patients plenty of room without a sense of being crowded. There is a therapeutic ambiance throughout the building which is also tastefully decorated with beautiful art work. All units are carpeted, which no doubt adds to the quietness observed throughout the facility. A huge gym was located off the hallway to the patient care areas.

The five (5) units are designed with a central open nurses' station equipped with closed circuit televisions (CCTV) for viewing patient care hallways. There is a large room available for staff and is considered the central documentation/charting and patient record area. The front wall is glassed to promote visualization of the unit. The facility is equipped with an electronic medical record (EMR). A small but functional medication room connects with the large charting area and has a window that opens for medication administration yet provides a nice barrier for safety. Each unit is equipped with one Oak Room for time-out, seclusion and /or restraint, and the larger unit has two. There are three 10 bed units, and 24 and 26 bed admission units. All staff encountered were friendly and professional.

Administrative staff are located on a second floor level. The Director of Nursing, Assistant Director of Nursing and Nursing Supervisors offices are all located on this second level. The administrative assistant to the Nursing Department is responsible for creating monthly schedules, which are then adjusted for acuity by nursing supervisor staff. The nursing office has a system to identify any staff that are approaching premium pay status. The on-call staff submit their availability on a monthly basis. They are scheduled to work prior to API using premium pay staff as needs arise.

Alaska has unique staffing challenges, no doubt far above other rural communities. Staffing agencies are not readily available to provide experienced psychiatric nurses. API went through a period of using frequent mandatory overtime due to the severe staff shortages. The current nurse leader was able to turn that around having waged a campaign for recruitment, she developed a successful mentoring program and to date has retained that pool of nurses. Although not completely without ongoing nurse staffing challenges, API has done an excellent job in this area.

Patient Status (COSS 2) A Factor Tied To Staffing

While attempts are made to treat individuals in the least restrictive manner, it is necessary on occasion to protect an individual from behaviors that may be harmful to themselves or others. Close Observation Status Scale (COSS) 2 at API is one of the highest levels of staffing used to monitor patients' behavior. While this formal high level of observation consumes nursing resources, the efficacy of this practice to reduce patient risk and provide therapeutic benefit remains unclear. To date no randomized controlled studies could be identified. The existing qualitative research fails to demonstrate a direct correlation between close observation and prevention of adverse patient outcomes.

This precaution status is used somewhat frequently at API and recent data show 1:1s ranging up to three to four some days throughout the weeks. This level of precaution is essential for some but also quite costly and as such requires aggressive daily management. 1:1s are costly not just because of the dedicated staff but this can also create the need to use premium pay staff.

Patients under increased precautions or COSS 2 monitoring should be either very ill or whose presentation exhibits potential imminent danger to self or others. It therefore follows that the most acute patient who requires a 1:1 observation should be evaluated every day by a psychiatrist and / or an advanced nurse practitioner to determine any change in condition and whether the continued need for such an extreme patient-staff ratio is still required.

At API management of the COSS 2 should be more aggressive. Patients are placed on COSS 2 perhaps as an over-precaution in many cases. Even those with legitimate need may not come off as swiftly as possible. The perceived clinician orientation toward the use of COSS 2 needs to be sharpened. The facility would benefit from educating clinicians to be more fiscally minded in their approach to special precautions. Additionally, such close observation is very intrusive for the patients and for this reason should not be used unnecessarily.

Patients are placed on high levels of precaution often because of risk for suicide or aggression. Aggressive episodes frighten other patients and staff. Interventions used as an alternative to restraints and seclusions are most often applicable. Aggressive behavior on psychiatric units is common and does not always need to be reacted to with a change in level of precaution or a 1:1. The multidisciplinary team needs to address the behavior however beneficial for the patient and others.

Debriefings are helpful for staff and patients and are generally most effective when this occurs as immediately following the aggressive episode as possible. API is fortunate to have CCTV's and this tool is extremely beneficial in reviewing the aggressive episode and antecedents in preparation for discussion with patients and staff. Placing patients on COSS 2 for a history of aggressive episodes is not necessarily the most optimum intervention.

During the visit "staff fear" was raised and in a psychiatric hospital setting where staff are vocalizing fear and concerns around safety, it is not uncommon that staff request additional staff be added often through 1:1 coverage. Physician/ Provider staff need not so readily respond to this plea by granting the 1:1. A more beneficial approach would be for Risk Management and Nursing to team up and study the aggressive events within the context of the patient-safety culture. It is effective when leaders invite staff to review the information available and video available on the incident in a non-punitive manner, but as "lessons learned" quality management approach. The focus in the milieu must be on early identification of agitation accompanied by swift low-level interventions to avoid the frightening aggressive acting out by patients.

An Aggression Reduction Committee can be beneficial as a performance improvement initiative where staff are charged with drilling down on aggression and bringing newly learned information back to their respective units. As staff become more skilled and observe leaderships' focus on safety they manage their units with greater confidence and less need for over-staffing.

Level of observation of patients, although ordered by the physician, should be viewed and managed through a partnership between the multidisciplinary team and the patient. To assist in achieving this partnership, *the reasons for, and the process of* the increased need for observation should be transparent to all parties.

Discussing the continued need for high level observation amongst the team members, may highlight information to support decreasing the level of COSS or how to manage observation through other means, such as while in program activities. At API the PNAs are customarily the staff who observe the patients on COSS 2. If the PNAs on a COSS 2 assignment are not documenting 15 minute observations of patient behaviors on flow sheets and, the PNAs are not present in the morning team debriefing, valuable information regarding the patient's safety in support of stepping down the precaution can be lost.

Physicians should be encouraged through policy and medical staff rules to evaluate the patients on COSS 2 level of care every 24 hours. Along with the order renewal if applicable, the medical record should reflect the case severity and the rationale for continued use of this highest level of precaution. If a patient remains on 1:1 for 48 hours, an independent evaluation should be conducted by the Chief Nursing Officer (CNO) and the Chief Psychiatrist. This evaluation should be conducted to verify that staff have considered alternative resources for COSS 2 and that the documentation for use of COSS 2 reflects actual imminent potential for danger and not simply for anticipated problems. COSS 2 level of observation cases should be identified through an indicator for professional peer review, which will provide baseline data for the Joint Commission's Professional Practice Evaluation.

Recommendations:

- **Implement daily evaluations for patients on COSS 2 as a high level priority**
- **Initiate Executive Leadership's presence and participation in review of on-going cases COSS 2 to communicate the priority.**
- **Ensure COSS 2 documentation is present and clearly defines the potential risk.**
- **Develop processes for the multidisciplinary team to have input on patients on COSS 2. Decisions should not be deferred to one or two team members.**
- **Use Behavioral Plans for complex patients who create on-going safety concerns.**
- **Develop Aggression Reduction activities to bring to light information missed, which can be used as a jumping off point for PI initiatives.**
- **Follow all episodes of aggression with multidisciplinary debriefings.**
- **Develop a comprehensive Safety Plan to guide all through the transition to an evidence-based safety culture. (safety plan attached)**

Fall Risk Precautions and COSS 2

Falls precautions are most effective as a part of an evidence-informed organizational safety culture. Many organizations treat adverse incidents as technical challenges, however, the larger challenge exists in transforming the patterns and behaviors of staff that have developed in the workplace. An organizational patient safety culture arises when the organizations' leaders view safety as the highest priority. Best practice strategies should be aimed at increasing awareness and making a business-case for safety.

One opportunity to further enhance API's culture of safety could be through the development of an ad-hoc falls committee that could begin by drilling down on all falls data. This could provide valuable insight into how, where and why people fall at API. Within this culture of safety, staff would view patients at risk for falls through a different lens. Patients do fall, and although all attempts are made to avoid this occurrence, a 1:1 COSS level 2 is not always the best and most efficacious intervention to be implemented. Understanding why people fall and

minimizing injury is central to a quality falls prevention program. Additionally, staff should have specific age appropriate training including but not limited to, understanding dementia: what works and what doesn't.

The Veterans Administration and the National Patient Safety Center as well as the Agency for Healthcare Research and Quality (AHRQ), Nurses Handbook, offer excellent evidence-based information and tool-kits for falls assessment and prevention programs. These organizations cite the Morse Falls Scale and the Hendrichs II assessment as the most sensitive, valid and reliable tools to use for fall assessment. These tools in combination with the get-up-and-go test are referenced as best-practice in the industry.

On occasion API assigns a precautions status of COSS 2 for those at "risk of falling". This precaution should only be used as a last resort measure. Staff monitoring patients on 1:1 for fall precautions are not always able to stop or break a fall and can be injured themselves. Using the patient safety culture paradigm, emphasis should be placed on minimizing the severity of injury. Hip pads, helmets, bed and chair alarms are examples of useful tools which are available and inexpensive.

Staff need to be constantly vigilant identifying contributing environmental factors as well as assuring that patient's have proper foot wear, glasses on when they are required for vision and other assistive aids which are often identified as the root cause of falls. For a successful falls prevention program, staff must be reminded daily during hand-off of all patients at risk of falling.

Psychotropic medication and benzodiazepines are frequently administered to individuals that fall. That being said, pharmacy staff should have a major role in falls prevention. All patient profiles, especially those at risk for falls, should be analyzed for potential drug-drug interactions that may hasten a fall and when identified, a risk-benefit discussion should be held between pharmacy and the prescribing providers. To date, pharmacy staff have never been contacted to report a fall. The evidence is strong supporting the fact that high numbers of falls relate back to medication so, it follows that pharmacy involvement should not only be required but highly desired.

Recommendations:

- **Develop a falls ad-hoc committee drilling down on all past falls 6 months – 1 year to identify root causes of falls.**
- **Use Falls Tool Kits mentioned above include posters and visual aids as staff reminders.**
- **Have available hip pads, bed/ chair alarms etc. aids to alert staff timely and minimize injury.**
- **Consider whether current fall assessment tool is best-practice.**
- **Institute follow-up by nursing leadership's on all falls to determine appropriateness of interventions.**
- **Implement staff training on age-specific issues including dementia: what works and what does not work.**
- **Partner Nursing and the falls reduction process with Pharmacy staff.**

Transportation of Discharges- Tied to Premium Pay or Unit Staff

An additional challenge for API nurse staffing revolves around discharge. This process was identified during several staff interviews and described as a "labor intensive" institutional stressor. Many patients who arrive at API are not easily discharged due to API's unique transport and geographical issues. In fact, approximately 15-20% *o*f the discharge population may require air transportation. Apparently, this is not routinely a scheduled service so staff are pulled without prior notice to provide escorts to airports, sometime waiting hours. API allegedly receives sudden alerts of aviation availability for a discharge to a particular location. A helpful exercise may include a performance improvement data drill down to determine if there are any patterns of transport hours that emerge for better planning.

Recommendations:

- **Improve reporting efforts of all anticipated potential discharges and assure information is entered into the EMR system daily report.**

- **Conduct focused discussions at all AM team multidisciplinary rounds for upcoming discharges, not just for the present day.**
- **Dedicate RN overlap time to Discharge Readiness activities.**
- **Conduct an in-house study looking for areas of improvement in the discharge process.**
- **Consider a float position with primary duty for transport if supported by analysis of discharge data. This may need to be re-evaluated following the development of the Admission's Office, as the new admissions process may allow for better scheduling of both admission and discharge transports.**

General Safety Considerations

Staff at API have expressed concerns over safety. An all out effort to address these concerns is critical. Safety committee meetings should include all levels of staff, especially those providing direct care. Focused safety seminars with small groups of staff are valuable sessions to elicit concerns across all shifts. Plans for corrective action following such meetings should be developed and acted upon immediately. Often, concerns can be ameliorated with simple low dollar solutions. The importance of staff competence in the areas of low-level verbal interventions cannot be under-stated, and can have a very positive impact on unit safety for both the patients and staff.

The evidence-based Team Stepps Program that incorporates unit-based safety coaches is a powerful program designed for healthcare professionals to enhance patient safety. It is sponsored through AHRQ and the Department of Defense (DoD). Training is free of charge to eligible individual institutions. They use the train-the-trainer method so over time a good proportion of staff are well versed in their methodology for safety. Information can be found at the AHRQ home page.

Recommendations:

- **Develop a comprehensive risk management / safety program (sample attached).**
- **Obtain membership in the American Society for Healthcare Risk managers (ASHRM). They provide excellent resources.**
- **Review information on ASHRM Pearls for Psychiatric Hospitals @ ASHRM bookstore.**

Hand-Off Communication and Patient Observation

According to the Joint Commission (2010), an estimated eighty percent (80%) of serious medical errors involve miscommunication or communication failures between caregivers when transfer of patient responsibility (hand-off) occurs. This hand-off process is necessary and designed as an opportunity to provide a report of critical information about the patients' current status, history or other note-worthy findings. Hand-off provides an opportunity for questions and clarification between providers.

Healthcare organizations have struggled with the process of passing critical information about patients along at the change-of-shift or when they transfer patients within their system of care. The evidence demonstrates communication failures in healthcare are one of the greatest sources of medical errors. The consequences for miscommunication during hand-off can be critical and include delays in treatment, adverse events, patient harm, omissions in care and, in psychiatric hospitals, communication failures often result in employee injuries.

API has its own challenges when it comes to hand-off. Psychiatric Nurse Assistants (PNAs) work 8.0 hour shifts with a 30 minute break. (This issue is spelled out clearly in a previous WICHE report to API, Nov. 2011). PNAs work 37.5 hours per week, which does not allow for shift overlap or meaningful time for hand-off report. Nursing staff work 10 hour shifts and have a two (2) hour overlap, per nurse per shift. Hand-off report for the PNAs has been delegated to the more senior PNA IV.

The PNA IV arrives one-half hour before the other PNAs on the unit's team. The PNA IV receives hand-off from a nurse currently on duty. Shortly thereafter the PNA IV provides hand-off to PNA colleagues coming on duty. This hand-off was observed on one of the two acute admission units. It is assumed that this was a typical PNA hand-off practice. During this process, the PNA IV stood before his PNA colleagues in front of a board with pictures that identify patients. The report was extremely brief and predominantly touched on discharges planned. There was a newly admitted patient on the unit for which little meaningful information was exchanged. All PNAs stood through this few minute report and no questions were asked. This important process took place in the busy charting area where other staff were talking and at work. This hand-off was less than ideal and direct care staff could not have been prepared with necessary knowledge about the patients they were to supervise and treat.

Recommendations:

- **Develop a process for adequate shift hand-off communication.**
    - **The previous WICHE report (Nov. 2011) detailed the cost associated with the increase of PNA hours from 8 to 8.5 allowing for a 30 minute shift change. It would not be ethical or safe given all the evidence-based information available on the importance of hand-off to allow PNAs to report for duty without adequate prepping of needs and risks.**
    - **The 30 minute overlap allows for hand-off while patients remain under supervision. One suggestion is while registered nurses are on 10 hour shifts, they most certainly could relieve the PNA's on the unit and one nurse at a time gives the PNAs a proper report.**
- **Conduct effective hand-offs in a quiet area where staff can listen and ask questions. A three-ring binders or Kardex could contain necessary information like precautions and patient safety plans for PNA and other staff reference.**

Unit Safety Enhancements

A structural / functional observation was made in regards to the charting area. This is a busy station where computer terminals are set up for electronic medical record (EMR) entry. Each one of the charting areas are structurally similar however, in some units the glass is covered up eliminating the opportunity to observe patient activity at the desk, hallways and dayroom area. Additionally, computer terminals are set up along the back and side walls positioning staff with their backs to the glass and completely inhibiting the opportunity to observe patient activity. A recommendation would be to maximize the opportunity to visualize the unit and patient activity. Opening this view would lend support to the PNAs who are on the units most with the patients and would allow nurses additional observation time. The assumption taken is that the glass may have gotten covered up because patients were congregating outside the glass windows, which may indicate that staff should be more available in the milieu. The second assumption is that the designer considered the view important in this specialty environment or there would have been a wall. HIPPA issues did not appear relevant. Covering this window creates an unnecessary barrier and essentially segregates nursing staff for a good amount of time away from the milieu.

Each morning the units' multidisciplinary team (RN, Psychiatrist, Social Worker, Psychologist or Intern and medical students) meet briefly for rounds to review issues pertaining to patients and discuss the past 24 hours of care. PNAs were not represented in this meeting. An additional beneficial focus for this debriefing time could be placed on anticipated discharges and COSS 2 patients.

Recommendations:

- **Install a roll-top enclosure at the open nursing unit desk to close in cameras so staff can move about the unit away from the desk. An additional set of monitors could be added in the charting room so nurses can share the oversight responsibility freeing up the PNAs.**

- **Assure a clear view is available from all nursing station charting room window areas.**
- **Maximize patient observation by repositioning back wall terminals to front glass wall area.**

Nursing Leadership Team and Staffing

During the visit to API separate interviews were held with the DON, ADON, Nurse Manager and two Nursing Supervisors. All unit nurses currently work four 10-hour days. The DON recently returned to five day per week while Nurse Managers and Supervisors remain on 10 or 12 hour days.

While speaking to a Nurse Manager it was learned that this role, their duties and authority have changed considerably over time. Although Nurse Manager roles will always require flexibility, managing a unit with 24 hour accountability is challenging enough but made more difficult with a schedule for duty four of seven days. According to the Nurse Manager, duties such as interviewing staff, hiring and managing disciplinary actions have been transferred to other nurse leadership positions diluting the managers' role.

It is assumed that API's goal is to identify competent nursing leaders to manage each unit with a scope of duty similar to but, not limited to the following:

Clinical Leadership	**Clinical Governance**	**Education and Research**
Clinical coordinator	Change management	Mentor
Patient flow/ Discharge planning	Coordination of PI activities	Orientation of staff , medical and
Driving Model of Care	Oversee audits and identifies trends	nursing students
Unit rounds	Monitors infection control	Informing staff of new policies
Case conferencing	Accreditation coordinator	Own professional development
Crisis management	P&P coordinator	Attends workshops/ conferences
Works clinically if needed	Incident reporting	
Supports heavy workloads	Complaints management	
Skill mix issues	Work place health and safety	
Driving Evidence-based clinical care	coordinator	
Monitors clinical Indicators		

Leading and Managing People	Business Management	Materials Management
Rostering –input, planning	Workforce Planning	Equipment needs and (quotes)
Leave management	Service planning	identification
Position occupancy status	Budget build-up contribution	Meetings with sales reps
Supervision/Performance appraisals	Performance Indicator reporting	IT needs coordinator
Grievances, debriefings, staff support	Daily Data Management/ FTEs	**Extras**
Interviews	Patient acuity monitor	Patient - Counselor
Maintains skill mix for safe care	Filing/emails/correspondence	Family Meetings
Coordinates and chairs meetings		Coordinate multidisciplinary teams

Due to the size of API with roughly 80 beds and with unit census fluctuations, there are models of leadership structures to consider as potentials to achieve the desired outcomes. Rather than thinking of API as a conglomerate of units, it would best be thought of as a system, a combination of processes, people and resources that, working together achieves an end. Joint Commission looks to see how the team of leaders work together to provide high-quality safe patient care. This point is raised to highlight critical factors. (1) API has levels of nurse leaders. Clinical coordinators and nurse managers during the day and a house supervision model evenings, nights and weekends. API has not had all Nurse Manager positions consistently filled and there is such variation in unit size.

In addition to duties highlighted above audit data collected by RNs and Managers pertaining to but not limited to; medication error variances, issues pertaining to medication management and controlled substances and restraint seclusion data must be incorporated into the performance improvement process and at all phases of this process all findings must be transparent to the executive leadership group.

Below are two examples of how unit oversight could be structured.

Model 1

Nurse Manager 1	Nurse Manager 2	Nurse Manager 3
26 Bed –Susitna	24 Bed- Katmai	3 (10) Bed Specialty

OR

Model 2

Nurse Manager 1	Nurse Manager 2	Nurse Manager 3	Nurse Manager 4
26 Bed –Susitna	24 Bed- Katmai	Chilkat- 10	Denali & Taku

Under Model 1 the difference at full census is 4 patients. One nurse manager over three (10) bed units would allow for keen insight into opportunities to gain more efficiency. The Clinical Coordinator could provide support and backup. Of note, private sector nurse managers carry much higher responsibilities such as for 50 bed units. Also for comparison with the private sector, an 80 bed hospital would not typically employ a Clinical Coordinator. Those duties would be assumed by the ADON. API's goal is to have accountability for unit function, finance and the delivery of sound clinical programs and care. With scarce resources it is difficult to support a model with five (5) unit based leaders plus a Clinical Coordinator. Senior Nurse Leaders should consider unit managers, as part of leadership, to be available during major programming and business hours 5 days per week. Effective nursing leadership teams lead by coaching and modeling and become expert delegators of tasks and authority and are guided by the principle of *trust but verify.* In a facility with scarce resources thought must be given to one nurse FTE dedicated to metabolic syndrome data collection. In institutions state psychiatric institutions with as many as 350 patients there are not dedicated nurses assigned to this now considered "routine practice" The initial data is part of the nurses admission assessment and incorporated into the monthly assessment process following each patients' scheduled need.

Currently the units have charge nurses who work 10 hour shifts. The charge nurses could be developed further and have more accountability for their staff. This is possible because the current schedule of 10-hour shifts includes a two-hour overlap time of shifts. Three traditional shifts generally cover 24-hours. In this case the three shifts total 30 hours of nurse time.

RN Shifts
6am-4pm
2pm-12am
10pm-8am

An RN post is 1 RN position spanning over three shifts and equaling 24 hours. At API, using the current core staffing there are 7 RN posts or 21 RNs scheduled in the 24 hour period excluding managers and supervisors.

On 10 hour shifts, these 21 nurses are scheduled for 40 hours per week but, compressed into 10 hour shifts in a 24 hour period; this creates an overlap of 6 hours each 24 hours. For each 7 RN posts there are 42 hours of overlap per day. Over the course of 365 days an extra 15,330 hours are used in over-lap or, an additional approximate 7.3 FTEs in over-lap time. Do breaks need to be mentioned or stated that they are not included in the calculations?

Twenty-one (21) RN's (I- III's) with an average salary of $30.41per hour multiplied by 2080 hours annually worked equals $1,328,308.30 (without benefits).

Assuming this average salary of $30.41 per hour multiplied by the 15,330 over-lap hours, you estimate an approximate $466,185.30. These are salary dollars only and the benefit package of approximately 40 % is not calculated in this number.

Of importance to note, typical 40 hour nurses cover 5 days so replacement is for two days off, vacation / time off. When 40 hour nurse positions are compressed into a four day work-week an institution needs to replace nurses for 3 days plus vacation and time off. The typical replacement factor for 40 hour FTEs is now insufficient and the institution requires more staff to cover the 7 day posts.

Ten-hour shifts are extremely popular; after all, they provide more days off per year and are a lot more tolerable than 12-hour shift.

Reasons For and Against 10 Hour Shifts

Ten-hour shifts are fine in office setting or in 24/7 operations which have more variable workloads with predictable “rush hours”. Ten-hour shifts are not a good choice if the workload stays relatively constant throughout the day. Ten-hour shift schedules require more employees because they are based on 30 hour work days (three 10-hour shifts). If replacing 8 hour shifts with 10 hour shifts without making any other changes, 25% more people are needed to maintain the same coverage. If the choice does not include hiring more people, when this change is made, coverage levels are reduced by 25%.

In the case of API, if not clear to current leadership, it must be determined if additional nurses were allocated prior to the conversion to (4) 10-hour shifts. If no additional base positions were allocated then ongoing unbudgeted nursing hours are accrued to fill the 7 RN posts per day. This would be managed through on-call or premium pay. If the 25 % deficit in staff needed to fulfill required posts is not managed prior to the transition, the financial strain can be severe. While supervisory nursing staff continue to call staff in for coverage, additional unauthorized FTEs begin to swell over and above the 7 FTEs sitting in the overlap coverage.

As the 10-hour shifts overlap, you actually have employees from two (2) shifts working at the same time. If you try to align the overlapping shifts with peak work-flow hours, you generally have some unusual start times, which are difficult to manage in a hospital environment.

That being said, since the conversion in 2008, 10-hour shifts have been considered one of the successful strategies put in place for recruitment and retention, which may be the case. Until API can conduct an analysis and a reconciliation of positions, costly overlap time should be managed carefully. One comment made during the visit at API related to challenges with discharges. API may consider dedicating overlap hours to focus and organize discharges, conduct performance improvement activity and provide additional unit program groups. Without structuring this time, routine everyday matters will consume it.

Throughout the nation hospitals are struggling with this issue. Many hospitals have 12-hour shifts. In rural areas it is more difficult to maintain because you actually need more staff. Because API actually has about 7 FTEs built into overlap and possibly additional in unauthorized hours (if this is the case), 12 hour shifts may be a consideration. Hospitals that have been attempting to move staff from 10-hour shifts to 8-hours shifts are meeting with resistance and an increased loss of retention. It is high risk in rural settings. Changes that may come about need to be planned well, particularly where resources are limited. There may be an opportunity to gradually move into 8 hours shifts if consideration can be given to alternating work periods with two weeks of 8 hours shifts and two weeks of 10-hours shifts. This may or may not be possible depending on API's time and attendance process. At the very least this would eliminate approximately half of the overlap hours and add the burden of additional shift changes.

Census-Based Staffing Bands

The census at API experiences significant fluctuations and in recent months has been frequently been between 60-75 per-cent of capacity. The greatest variances occur on the two large admissions units. It has been noted that even when census is running at reduced capacity for an extended period, staffing remains constant and at times, over the 'core' unit staffing allocations. This is not an efficient use of resources and could be better managed by the use of census-based staffing bands such as the proposed example below. WICHE's November 2011 report suggested similar staffing adjustments (see bullets below). However, at that time the census was running closer to capacity. In light of recent census fluctuations coupled with the premium pay issues, implementing census-based staffing bands (with periodic adjustments due to extreme patient acuity or other issues) would be beneficial. Recommendations from the November 2011 WICHE Report included:

- 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.

Census-Based Nursing Department Staffing Plan

UNIT		CENSUS	DAYS	EVENING	NIGHT
Chilkat (10) Adolescent Unit	Planned Minimum	1-5	1 RN/ 1 PNA	1 RN/ 1 PNA	1 RN/ 1 PNA
	Planned Minimum	6-10	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA
Denali (10) Neuropsychiatric Intensive Care Setting	Planned Minimum	1-5	1 RN/ 1 PNA	1 RN/ 1 PNA	1 RN/ 1 PNA
	Planned Minimum	6-10	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA
Katmai (24) Adult Acute Care Unit	Planned Minimum	1-12	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA
	Emergency Minimum	1-12	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 1 PNA
	Planned Minimum	13-19	2 RN/ 3 PNA	2 RN/ 3 PNA	1 RN/ 2 PNA
	Emergency Minimum	13-19	1 RN/ 3 PNA	1 RN/ 3 PNA	1 RN/ 2 PNA
	Planned Minimum	20-24	2 RN/ 4 PNA	2 RN/ 4 PNA	1 RN/ 2 PNA
	Emergency Minimum	20-24	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA
Susitna (26) Adult Acute Care Unit	Planned Minimum	1-12	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA
	Emergency Minimum	1-12	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 1 PNA
	Planned Minimum	13-20	2 RN/ 3 PNA	2 RN/ 3 PNA	1 RN/ 2 PNA
	Emergency Minimum	13-20	1 RN/ 3 PNA	1 RN/ 3 PNA	1 RN / 2 PNA
	Planned Minimum	21-26	2 RN/ 4 PNA	2 RN/ 4 PNA	1 RN/ 2 PNA
	Emergency Minimum	21-26	1 RN/ 3 PNA	1 RN/ 3 PNA	1 RN/ 2 PNA
Taku (10) Forensic Unit	Planned Minimum	1-5	1 RN/ 1 PNA	1 RN/ 1 PNA	1 RN/ 1 PNA
	Planned Minimum	6-10	1 RN/ 2 PNA	1 RN/ 2 PNA	1 RN/ 2 PNA

Patient Acuity and Staffing

Nursing supervisors typically make rounds to units once per shift, and on occasion depending on need, perhaps more. Nursing supervisors are making the decisions if changes in staffing are needed. More frequent supervisor rounds, at least twice per shift could benefit the supervisors' decision-making to support right-size staffing.

The acuity system used by API is discussed in detail in a previous September 2011 WICHE report to API. The source of the acuity system cannot be identified therefore; its validity and reliability cannot be verified.

API nursing leadership stated that the system is not used for core staffing purposes however, while on site nursing supervisor staff did demonstrate how they find it useful. As an example, if the census drops and a nurse or PNA could be cancelled, the supervisor staff may rely on the acuity numbers to support a higher number thus retaining the staff. Its use has been to support the "what if" scenarios. Supervisors have to make hard calls at times and this has provided them additional back up or rationale for their decisions. Without knowing that it is a valid and reliable measure, it cannot be supported. If the hospital would desire a formal acuity system then one that is tested could be sought.

Staffing a hospital or shift is not an exact science nor always predictable. Nurses tend to use caution and in some cases may keep scheduled staff in place that could have been cancelled. Consideration should be given to a paid on-call program. Knowing that back-up staff are available could easily change the manner in which nurses' staff shifts. An analysis of cost in this case could be helpful. The number of on-call staff does not have to be excessive. The goal is to meet the hospital patients' needs and although staffing plans in acute care require flexibility, staffing personnel should not bolster staff based on multiple potential "what if" scenarios. Nursing supervisor staff should have senior staff available for review of additional staffing needs and to discuss opportunities for staff savings.

Recommendations:

- **Reallocate Nurse Manager assignments and downsize to 3 to 4 Nurse Managers only, 5 cannot be supported with 10-– bed units.**
- **Shift nurse leadership positions to a five-day work week to increase continuity across the week and support greater engagement in management activities with other hospital leadership staff.**
- **Conduct a comprehensive work-flow study to determine if there is predictable need for overlap time above the traditional 30 minutes for hand-off.**
- **Conduct a look-back to 2008 to determine if additional FTEs were reallocated to meet additional FTE needs, unless leadership is assure of this previous change.**
- **Conduct an analysis of shift workflow loads as a basis for factoring business-case for 10-hour shifts.**
- **Conduct side-by-side staffing position reconciliation.**
- **Conduct nurse tolerance survey for shift modification.**
- **Consider moving direct care staff to eight-hour shifts, while looking into the feasibility of shifting to 8.5 hour work days, as this precedent has already been set in the State.**
- **Give strong consideration to structured use of nurses' time if 10-hour shifts are to continue for any period of time. There is a tendency for staff to just pace over 10 hours with a risk that nothing additional gets accomplished.**
- **Implement census-based staffing bands based on the higher bands for the three 10-bed units and the middle bands for the two larger admission units instead of using the current acuity-based model. Adjust policies as needed.**
- **Assess the value of assigning much needed RN resources to such tasks as collecting metabolic syndrome data when today these data are considered data within a nursing assessment. Additionally, all nursing FTEs assigned outside of direct care nursing should be reviewed to determine true value and need when this institution is struggling to maintain minimum staffing without having premium pay issues.**
- **Consider an Informatics Team versus one Informatics nurse due to the high need to manage EMR changes at this phase of implementation.**

- **Assure (nurse leadership) that deficits noted through audit cycles, medication error variances and survey findings are managed through the performance improvement process. All findings, improvements and progress must be transparent to all senior team members as nursing moves from its silo into a fully embraced collaborative supporting team leadership.**
- **Empower HR to become more actively involved with monitoring the status of a worker's compensation / Family Medical Leave Status Act case and provide to Nursing continual feedback. API to consider discussion with external Claims Company over-seeing cases to determine if management could be tightened.**
- **Consider a study to explore how Alaska's Nursing compensation compares nationally. If 10-hour shifts are the main recruitment tool for API, an evaluation cost-benefit analysis may be helpful in determining the direction API wishes to take.**

Conclusion

Although this report centers around Nursing Staffing Effectiveness issues it cannot be completed without also stating that API is fortunate to have a remarkable workforce. It is obvious that staff are dedicated to the institution and the patients under their care. Nursing Leadership must be commended for their initiatives and successes. It is noteworthy to mention that while many institutions struggle to maintain upper nursing leadership; this has not been the case at API. In addition this leadership team set their sights on succession and has developed new nurses through an effective mentoring program to the point where a few have recently been promoted into their own leadership structure.

API, its leadership and staff continue to make strides forward in many areas such as in programs, admissions and the EMR implementation, all of which are not simple tasks, specifically with one informatics nurse is dedicated. It is evident however that this team has their feet firmly placed on the road to excellence in the delivery of mental health services.

COMPLIANCE AND PERFORMANCE IMPROVEMENT PLAN- Sample

2012

PURPOSE

The leadership of XXX State Hospital has established the mission and vision for the hospital and annually, through the strategic planning process, sets the organization values and establishes the strategic goals, objectives and priorities for improvement for the coming year. The purpose of the Performance Improvement (PI) Plan is to outline the PI Program, which describes the methodology that XXX STATE HOSPITAL utilizes to achieve continuous improvement of processes, outcomes and systems in order to achieve the hospital's mission, vision and strategic objectives and to outline the organization's comprehensive and coordinated approach to achieving and maintaining continuous compliance with contract regulatory and accreditation requirements.

The overall goal of the Performance Improvement Program is to ensure that processes are designed well and that we systematically monitor, analyze and improve performance with the ultimate goal of improving outcomes for persons served. The program is comprehensive, encompassing all aspects of direct care and support services provided by XXX STATE HOSPITAL and include both the quality of clinical care and the quality of service provided. It is a management-led effort and involves all levels of the organization. The success of the program depends on the integration of information from all key functions within the organization, as well as input from a variety of outside sources. XXX STATE HOSPITAL will apply the principles and concepts of Continuous Quality Improvement (CQI) and performance measurement in all areas in an effort to involve and empower the entire work force, as well as family members and persons served. Many of the activities of the Performance Improvement Program will be established through the development of interdisciplinary committees and improvement teams that provide problem identification, analysis, improvement efforts and evaluation of outcomes.

SCOPE

Strategic Plan

The strategic plan outlines the hospital's mission, vision and values and identifies the strategic objectives and priorities for the year. At the Strategic Plan Retreat several goals were chosen through a SWOT and Prioritization analysis. Also the strategies to be employed to achieve them and performance measures for assessing progress were chosen.

Performance Improvement Plan

The Performance Improvement Plan outlines the philosophy, organizational structures, practices and operational processes that constitute the hospital's Performance Improvement Program, which is the vehicle for facilitating the highest quality, customer safety and continuous improvement of care, services, and outcomes for persons served. The Plan:

- Describes the role of the Executive Management Group in providing leadership for the PI program.
- Defines the role of the performance improvement subcommittees and departments in the PI Program
- Describes the structure of the PI Program
- Promotes a consistent and systematic methodology for performance improvement
- Establishes mechanisms for reporting performance improvement activities
- Provides for evaluation, review and revision of the PI Program.
- Promotes improved intercommunication between units and administration for better performance improvement processes.

Operating Procedures

Written operating procedures provide specific guidance for the day-to-day implementation of the essential processes of the PI program.

ORGANIZATIONAL STRUCTURE

Governing Board

The Governing Board has ultimate responsibility for the quality of care and services provided at the hospital, and have delegated to hospital management the responsibility for developing and implementing the performance improvement program. Quality Management reports quarterly to the Governing Board on the implementation and effectiveness of the PI Program.

Hospital Management

Leadership for the PI Program is coordinated through the Executive Management Group (EMG), the Organized Medical Staff (OMS), and subordinate interdepartmental management groups. The Executive Management Group provides overall oversight of the performance improvement program, including, but not limited to:

- Screen, select and prioritize areas for improvement
- Re-prioritize issues in response to unusual or urgent events
- Assign or approve collaborative performance improvement teams based on high risk, high frequency or problem prone areas
- Establish time frames for progress reports on performance improvement activities

- Approve formats for the documentation of team activities and results
- Review reports of subcommittees, departments and performance improvement teams
- Evaluate the effectiveness of the Performance Improvement Program annually and determine performance improvement priorities for the coming year.

Quality Management Department

The Quality Management (QM) Department coordinates the development and implementation of the continuous quality improvement system and provides support for the day-to-day operation of the PI Program, including, but not limited to:

- Ensures proper and effective use of problem-solving methods and statistical tools
- Provides needed training regarding the tools and approaches to the performance improvement process to all staff involved
- Facilitates the development and implementation of corrective action plans when deficiencies or deviations from acceptable standards are recognized for a particular program or process involving one or more programs
- Develops operating procedures for specific aspects of the PI program
- Monitors the implementation and assess the effectiveness of changes made
- Ensures compliance with regulatory agencies
- Ensures compliance with National Patient Safety Goals
- Provides support with Policies & Procedure revision
- Ensures revised standards education is provided to all staff
- Assures compliance with the National Patient Safety Goals
- Administrative Rounds Follow up
- Staffing Effectiveness

Performance Improvement Standing Committees

Interdepartmental and interdisciplinary collaboration and cooperation are facilitated through the following standing committees, which have been assigned responsibility for specific functions and operate according to a charter. A committee reporting structure is established whereby committees report regularly to the Organized Medical Staff and/or Executive Management Group. Each committee is required to evaluate its performance yearly.

Quality Council
Environment of Care
Ethics Committee
Group
Infection Control
Information Management
Senior Management Group
Medical Record Committee
Administrative Committee
Executive Management
Forensic Review Committee
Medical Staff Organization
Peer Review Committee

Customer Safety Specialized Behavioral
Program
Pharmacy and Therapeutics
Utilization Review committee

These committees provide avenues for internal (staff) and external customer participation in decision making for performance improvement.

Customers participate through the Family Advisory Group, the Consumer Affairs Committee, XX/ Drop-in Center Advisory Committee, Customer Safety Committee, and the Customer Satisfaction Committee.

Performance Improvement Teams

The Executive Management Group and Standing Committees establish multidisciplinary performance improvement teams to work on specific projects that have been identified as priorities for improvement, based on performance results and factors such as whether the issue is high risk, problem prone, occurs frequently, and affects or involves several processes and/or departments.

Departmental Groups

Hospital departments participate in performance improvement activities specific to services provided. Each department identifies performance improvement priorities and selects performance indicators to monitor improvement efforts. Representatives of these departments are also included as members of subcommittees and participate in performance improvement teams.

CQI CONCEPTS, METHODS AND TOOLS

The performance improvement process is built around the key concepts of dedication to quality and customer value, a scientific approach to continuous improvement and fostering an environment of teamwork and cooperation. Quality is the central focus of the program. Quality is defined in terms of the needs of our primary customers as expressed in the mission statement. Customers are broadly defined to include internal customers (primarily persons served, families, Department of XXX, XXX employees, and other customers (vendors, community mental health providers, individuals with the court systems, etc).

The hospital has selected specific performance improvement approaches, methods and tools to be used by management and staff in order to ensure a systematic approach. Performance improvement activities center on process planning and design, process management and process improvement.

P-D-C-A (Plan, Do, Check, Act) is a cycle based upon the premise that to always meet customer needs, you must continuously improve. You must plan it, do (or implement) it, check the results of your actions and act upon the findings,

applying lessons learned to future activities. This model is utilized by all levels of staff when designing, managing and improving processes.

The Failure Mode Effect Analysis process is used as a yearly proactive analysis. The team members receive training in this method as part of the team process.

It is the goal of the Performance Improvement department to introduce the Lean Six Sigma DMAIC. D-M-A-I-C (Define, Measure Analyze, Implement, and Control) is a tool of Lean Six Sigma utilized to enhance continual process improvement. This model will be utilized to monitor the effectiveness of the goals and objectives outlined in the Strategic Plan.

PERFORMANCE MEASUREMENT AND REPORTING

To measure, assess and continuously improve performance, departments, hospital committees and performance improvement teams develop observable, measurable performance indicators. The Executive Management Group has prioritized these indicators and established standards for data collection, analysis and reporting.

Direct service indicators have been selected to ensure that all dimensions of performance are measured. That allows the hospital to determine whether it is "doing the right thing" and "doing the right thing well." Performance on indicators is monitored by departments, committees and the Executive Management Group.

There are four categories of performance improvement indicators that a department and/or committee select via a priority grid or as mandated with the ORYX Indicators that coincide with the XXX Hospital's Strategic Plan for 2009. The performance improvement indicators are divided into four categories:

Dashboard Indicators

The EMG has selected Dashboard Indicators to provide intense monitoring of results that are considered high priority for meeting the hospital's long-term goals and short-term business objectives. These indicators measure and assess processes and outcomes related to direct care and treatment of patients served and key hospital operations. The Dashboard Indicators are reported monthly to the designated subcommittees, Quality Council and the Executive Management Group.

Committee Indicators

The Committee Indicators have been selected by the various subcommittees in order to provide close monitoring, analysis and improvement opportunities for

processes that have been identified as priorities for improvement. These indicators also provide valuable customer input into the performance improvement process. The Committee Indicators are reported monthly to the designated subcommittee and quarterly to the Quality Council and Executive Management Group.

Departmental Indicators

The Departmental Indicators have been selected by the departments in order to monitor improvement efforts specific to services provided by each of these groups. The departments have identified these processes as priorities with the goal of improving outcomes for their specific customers. The Departmental Indicators are reported monthly in department meetings. Selected departmental indicators may be reported quarterly to the Executive Management Group and Quality Council.

ORYX Indicators

The ORYX Indicators provide the facility with comparative data related to processes and outcomes that we have identified as priorities. The hospital participates in the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) Performance Measurement System. We are currently participating in the Hospital – Based Inpatient Psychiatric Services (HBIPS) Core Measures which include:

- Assessment of violence risk, substance use disorder, trauma and patient strengths completed.
- Hours of restraint use
- Hours of seclusion use
- Patients discharged on multiple antipsychotic medications
- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- Post Discharge Continuing Care Plan Created
- Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider upon Discharge

XXX STATE HOSPITAL performance on each of these indicators is compared with a national average based on data from all the other state hospitals that have selected these indicators. The comparative data is utilized to identify improvement opportunities. The Quality Management Department presents comparative data to the Quality Council and Executive Management Group as updates are received from NRI.

ORGANIZATIONAL COMMUNICATION

Several avenues have been created for management to communicate with staff, and for receiving and utilizing staff feedback for identifying opportunities for improvement.

Senior Management Group

The Senior Management Group (SMG) is established to facilitate two-way communication between the EMG, management, supervisory staff, and line staff. The SMG consists of managers and supervisors designated by the EMG. SMG meetings are held once per month and serve as a conduit for information from EMG and feedback from line staff to EMG. SMG members are responsible for receiving and transmitting information through SMG, departmental/unit meetings and other appropriate forms of communication.

Department/unit meetings

Department heads and unit supervisors/managers are required to conduct meetings with their staff on a regular basis, in order to share information from leadership and committee meetings and provide staff with the opportunity to participate as a team in performance improvement at the department level.

General staff meetings

The Executive Management Group conducts general staff meetings as necessary to communicate with staff about major decisions, policy changes, upcoming activities, improvement opportunities and projects, and to give staff the opportunity to ask questions and give feedback.

Bi-monthly Newsletter

The Harper Gazette is published to facilitate communication between the hospital leadership and staff and for information sharing among staff. Publication will be managed by an editorial committee appointed by the EMG to ensure appropriate and relevant content, professional presentation and timely production and distribution.

Staff satisfaction survey

At least every other year staff has the opportunity to complete a satisfaction survey. The results are analyzed and presented to staff, along with a report on the actions that are being implemented and others that are being considered to address the priority issues identified through the survey responses. Employees are also given the opportunity to provide input on other issues through a variety of other surveys administered at general staff meetings or otherwise.

Feedback from customers

Feedback from internal and external customers is actively solicited and utilized to identify opportunities for improvement. Feedback on person served needs and perceptions is provided through the Department's Resident (Person Served) Satisfaction Questionnaire, which each person served, has the opportunity to complete at least once per year and upon discharge. Families and community agencies provide feedback through the Department's Mental Health Community Partners Survey, which the hospital administers twice per year. The results of these surveys are analyzed and, when appropriate, actions are designed, implemented and assessed to address areas identified for improvement. Management provides a response to the persons completing the survey on the results and actions implemented or proposed to address concerns.

PERFORMANCE IMPROVEMENT TRAINING

Performance improvement orientation is provided for all new employees. Department heads or their designees provide on-going performance improvement training. A competent and skilled workforce is essential for providing quality care and services that meet or exceed contract, accreditation and regulatory standards. XXX assesses the competence of each employee to perform assigned duties prior to employment and continuously throughout their tenure with the facility. Required competences for each position are identified and used as a basis for hiring employees. Each employee receives a general pre-service orientation, which includes patient safety information. Employees also receive unit specific orientation and annual updates on topics related to performance of their assigned duties. A program of ongoing training is also provided for leadership. Specific training (Quality Educational Program) in the team process and performance improvement methods and tools is provided to team leaders and members as new performance improvement teams are launched. Also, leadership and staff will be educated regarding contract requirements, Joint Commission accreditation standards and applicable state and local laws, rules and regulations. A Quality Week is conducted as a tool to educate and communicate Performance Improvement information and to reward effective outcomes as a result of team work through the Quality Expo.

EVALUATION OF THE PERFORMANCE IMPROVEMENT PROGRAM

The Executive Management Group evaluates the effectiveness of the performance improvement program on an ongoing basis and provides quarterly reports and a complete annual evaluation report to the Governing Board. The evaluation measures how the hospital performs relative to the specific processes that are outlined in the Performance Improvement Plan and the effectiveness of the performance improvement process as reflected in processes and outcomes related to care and services hospital-wide.

The Quality & PI Manager reports regularly to the Executive Management Group on the overall implementation of the substantive components of the program. Effectiveness of the program is assessed through review of data relating to performance and outcome of processes and services.

Performance improvement priorities are determined from internal data analysis, comparative data and customer input. This information is incorporated into a SWOT analysis, which is performed as part of the strategic planning process.

RELATIONSHIP WITH REGULATORY AGENCIES

Reporting

XXX will submit accurate and complete reports within the time frames stipulated by DMH. Timely response will be provided for additional reports or requests for information.

Monitoring

XXX will adequately prepare for and fully cooperate with scheduled and unscheduled monitoring activities to determine compliance or investigate complaints. Corrective action plans will be developed, submitted and implemented, with ongoing monitoring and measurement to verify that the desired improvements have been achieved and are being sustained

COMPLIANCE OFFICER

PI Manager/Risk Manager shared responsibility

XXX Hospital has designated the PI Manager and Risk Manager as the compliance officers to coordinate compliance activities and facilitate compliance in the facility. The compliance officer/PI manager is accountable to facility leadership to ensure that the facility creates the structures and processes to achieve and maintain continuous compliance with requirements, accreditation and regulatory standards. The compliance officer/PI manager officer:

- Provides education and interpretation of standards and communicates with leadership and staff regarding changes in requirements, TJC or regulatory standards.
- Facilitates self-assessment processes and coordinates/conducts internal monitoring for standards compliance.
- Collects, reviews and submits action plan reports to DMH and other agencies.
- Coordinates on-site surveys and other contract, accreditation, and regulatory monitoring and investigation activities. Disseminates findings from monitoring activities, coordinates development, submission, and implementation of action plans, including Root Cause Analysis (RCA) Action Plans.

- Coordinates response to requests from DMH, TJC and regulatory agencies.

The Compliance Officer/Risk Manager is accountable to facility leadership and DMH to ensure that the facility creates the structures and processes to achieve and encompass a broad range of duties including but not limited to the investigation of alleged misconduct, the development of policies and rules, training and staff, maintain and oversee day-to-day Medicare compliance. The Compliance Officer/Risk Manger:

- Coordinates incident report monitoring system and conducts internal monitoring for standards and contracted requirements
- Prepares and submits required reports, i.e., Critical Event, Notification of Death, Code XX Reports, to DMH, and regulatory agencies as required
- Initiates and Develops Root Cause Analysis (RCA) for events as applicable.
- Facilitates DMH Office of Professional Responsibility (OPR) referrals and follow up investigations as assigned.
- Conducts Medicare billing compliance audits on a monthly basis and report findings to Executive Management Group/Quality Council

- ## MANAGEMENT OF SUBCONTRACTS

XXX subcontracts for some of services required and Subcontractor agreements will be in writing and will be approved in advance by DMH, when required. Agreements will include a detailed scope of work, rate and method of payment, and other applicable provisions and will be signed by both parties. A member of the facility leadership team will be responsible for oversight of each contracted service and will monitor the quality of services provided and verify satisfactory provision on services prior to approval of invoices for payment. Accurate and timely payments will be made to contractors upon submission of complete and accurate invoices indicating that the services have been provided as agreed.

Subcontractors will be required to provide appropriate on-site leadership and supervision for their staff and will be required to provide documented proof that staff are qualified to work in the facility and competent to perform assigned duties. Contract employees will contribute fully to the XXX performance improvement program, including data collection and analysis, and active involvement in standing committees and performance improvement teams.

Sample Risk Management Plan

PURPOSE:

The purpose of the Risk Management Plan is to document an organized, coordinated and clear manner of identifying risk factors to the facility, to promote and support development of practices aimed at minimizing the adverse effects of loss, and to reduce, modify, eliminate and control conditions that may cause loss. All risk management activities can be clearly tracked to provide trending data, accountability, and program evaluation and establish limits to standards. The Risk Management Plan also establishes the level of authority and responsibility for decision making processes and interaction through facility wide communication.

PROCEDURE:

A. This Risk Management Plan of the XXX Facility is an integrated comprehensive proactive program designed to oversee all aspects of risk identification, risk evaluation and coordination of corrective action implementation. The Governing Body supports the development of the risk management process and has delegated risk management functions to the facility's Risk Manager. All healthcare providers, in partnership with the medical staff, are responsible for the safety, health and well being of all residents, visitors and facility staff. Thus, it is the responsibility of all providers to work together continuously to promote safe work practices and improve quality of care.

B. The program provides for the coordination of collecting internal and external data on potential facility risk and reports the analysis and investigated findings of the facility's actual and potential risk to the Governing Body, medical staff, administration and the respective department, programs and committees. The reporting mechanism is such that communication is reviewed by all key members of the organization in a timely manner. The process establishes and monitors methods to avoid, eliminate or reduce risks in resident care. The process incorporates the resources of the internal organization, insurance claims management, legal counsel, corporate authorities, external agencies and databases.

C. Immunity:

1. No individual or institution reporting, providing information, opinion, counsel or services to a medical staff committee, or any medical staff, administration or Governing Body Committee that evaluates quality of care issues or part of the internal Risk Management Program shall be liable in a suit for damages based on such reporting, providing information, opinion, counsel or services provided that such individual or institution acted in good faith and with reasonable belief that said actions were warranted in connection with or in furtherance of the functions of the internal Risk Management Program.

D. Confidentiality:

1. Any and all documents and records that are part of the internal Risk Management Program as well as the proceedings, reports and records from any of the above committees shall be confidential and not subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except for proceedings by the department responsible for disciplinary and/or review action of any professional.

E. Objectives:

1. Identify factors that present the potential for injury to residents, visitors or personnel, other risk of facility liability or damage to facility property
2. Reduce the risk of sentinel event occurrence
3. Minimize the occurrence of situations that can lead to injuries and liability claims
4. Reduce risk through proactive loss control programs
5. Control the severity of loss or potential liability when loss occurs
6. The risk management process is part of the XXX Facility's goal for providing the best possible care to its residents and a safe workplace for personnel. Because factors that may present potential liability problems may be present in any component of the facility, the Risk Manager maintains communication with all departments within the facility, including general and fiscal services, clinical departments and medical staff.

F. Data resources:

1. Incident Report (risk identification report mechanism)
2. Performance Improvement activities
3. Resident Safety Committee Reports
4. Environment of Care Committee Reports
5. Utilization Management referrals
6. External review agencies and databases
7. Claim notification from Health Information Management or Business Office Departments
8. Infection Control Reports
9. Administration referral
10. Medical Staff request
11. Resident/family complaints
12. Resident Satisfaction Questionnaires
13. Root Cause Analysis of Sentinel Events
14. Sentinel Event Action Plans

G. Components:

1. Identifying the potential and actual risk in resident care and safety. The incident report (risk identification) process is designed to identify, evaluate, trend and report analysis of findings to assist in reducing the frequency of preventable adverse occurrences that may lead to liability claims.
2. Practical application and implementation of the Sentinel Event Policy and Procedure and Root Cause Analysis/Action Plan Policy and Procedure, which requires immediate team analysis of all root causes of any defined sentinel event. A thorough root cause analysis leading to a determined problem resolution action plan will assist in reducing further sentinel events throughout the facility.
3. Through prompt identification and follow-up of these adverse events, risk management is an effort to control costs of individual claims. Assuring complete documentation for legal defense and early intervention with the resident and family are keys to averting payments for frivolous claims and to controlling the costs of claims where the facility or physicians bear some legal responsibility.

    a. Incident Follow-up:

        i. Reported via written report, oral notification, occurrence screening or resident complaint

    b. Four (4) Step Approach to Incident Follow-up:

        i. Immediate response

        ii. Further investigation

        iii. Loss control and loss prevention

        iv. Evaluation of defensibility prior to settlement or litigation

            (a) Step 1: Immediate Response:

- Verify that the resident is now receiving appropriate medical management.
- Review the documentation for completeness, contradictions and clues to the cause. Copy the chart to prevent alterations. Interview those involved.
- Involvement of medical staff department directors/committee chairperson as appropriate.
- Notification of the resident and family by the physician of an untoward event.
- Preserve any equipment or other evidence.
- Notify administration, facility insurance carrier and the Billing Department.

(b) Step 2: Further Investigation:

- Gather all pertinent facts about the incidents:
  - Scene - where, when, equipment involved, resident and circumstances at the time
  - Parties - names and addresses of all those involved
  - Description - include quotes of described events
  - Damages - extent of injury, extended length of stay, estimated additional medical expenses, loss of earnings, number of dependents, pain and suffering, permanent disability
  - Assess degree of facility responsibility
  - Continue to communicate with the resident and family through the physician

(c) Step 3: Loss Control and Loss Prevention:

- Loss Control:
  - Keep open communication with the resident and family.
  - If appropriate, "write off" a portion of the resident's bill.
  - Develop a risk management case file, with complete, secure documentation.
- Loss Prevention:
  - Enter incident report into database for trend analysis.
  - Determine, possibly through Performance Improvement Committee/Risk Management analysis/CQI evaluation, if changes in processes, in-service education or other steps as necessary.

(d) Step 4: Evaluation of Defensibility Prior to Settlement or Litigation:

- Communicate with appropriate parties and evaluate how defensible the case would be in court (standard of care met, document substantiates care, estimate cost of settlement).

- Contact administrative authorities, claims management representative and/or legal counsel; initiate discussions with the resident and family to reach a settlement.

4. Facility wide review of incidents, injuries to residents, actual or potential sentinel events and safety hazards shall be reported as evidence of the risk management function. Risk management reporting system:

   i. Governing Body - monthly Performance Improvement Report, Sentinel Event Report, quarterly pending liability suit listing, Risk Management and Safety Report

   ii. Performance Improvement Committee - PI/Risk Identification Report and Analysis (including any sentinel event and root cause analysis/action plan), PI/Risk Management Interventions Summary Report, Infection Control Monitoring, Medication Error Report Analysis

   iii. Resident Safety Committee/Environment of Care Committee - Safety Analysis Report (including Sentinel Event Report, as appropriate to occurrence), monthly

   iv. Infection Control Committee - infection monitoring

   v. Medical Staff Committees - Risk Management/Performance Improvement Activities Report (including sentinel event, root cause analysis and action plan)

   vi. Nursing Performance Improvement - Risk Management/Performance Improvement Report (including sentinel event, root cause analysis and action plan) Resident Questionnaire, Infection Control Monitoring

   vii. Performance Improvement Department - concurrent update on risk management cases

   viii. Business Office - concurrent risk management case update and pending liability suit

   ix. Resident Satisfaction Surveys - monthly monitoring and reporting facility wide

   x. Pharmacy and Therapeutics Committee - Medication Error Report, Food Drug Interaction Report

   xi. Infection Control/Transfusion Committee - Transfusion Reaction Report

   xii. Infection Control Committee - Report of Surveillance Activities and Trends

5. Operational linkage between performance improvement and risk management functions to facilitate identification, follow-up, and corrective action or prevention of actual or potential problems/needs in resident care and safety, visitor untoward events and personnel illness and injury prevention. Both functions and goals are under the umbrella of the Performance Improvement Department and utilize the same data sources, such as occurrence screening and occurrence reporting, as well as the same peer review processes to assess individual occurrences, problems and trends.

H. Integration of Risk Management and performance improvement:

RISK MANAGEMENT	PERFORMANCE IMPROVEMENT
• Identifies risk and adverse and sentinel events through occurrence reporting, resident complaints and other data sources.	• Identifies problems through continuous monitoring of priority focus indicators of the quality and appropriateness of resident care.
• Assesses and analyzes (root cause) incidents, adverse and sentinel events and trends through the Performance Improvement Committee Risk and Management Analysis.	• Assess performance improvement data through the peer review process.
• Recommends and monitors corrective actions designed to reduce resident risks.	• Monitor effectiveness of corrective actions.

1. Through the performance improvement process, identified problems/needs of facility staff, programs and medical staff can be resolved with implementation, interventions and evaluation. The risk management and performance improvement functions have accessibility to all necessary, relevant facility and medical staff data.
2. Biomedical, Safety and Security: Assuring the safe and effective use of medical equipment depends on the professional responsibility for purchasing equipment, checking prior to use, operating equipment properly, assuring correct settings, reporting problems to the Biomedical Engineer and documented maintenance.

I. Integration of Risk Management and Security/Safety Engineering:

1. The risk management aspects of a safety engineering program include incident reporting and follow-up for equipment related occurrences and/or medical device failures.

2. The safety engineering aspects of the program include pre-purchase review, pre-operation testing, staff training, preventive maintenance and documentation. In the event of an equipment related occurrence and/or medical device failure, the Safety Officer is responsible, in coordination with the Risk Manager, for implementing testing of the equipment/device by the facility Biomedical Engineering Department or by a qualified independent biomedical engineering company.

3. The Safety Officer is responsible for securely storing the identified and tagged piece of equipment/device and determining if other similar equipment/devices in the facility should receive a preventive examination. The Safety Officer is responsible for following the Safe Medical Devices Act and notifying the FDA and the manufacturer of the malfunction and if a resident's injury occurred which may result in a claim. In coordination with the Risk Manager, the Safety Officer will determine whether the equipment/device should be repaired and returned to service, held for evidentiary purposes or returned to the manufacturer.

a. Integration of Risk Management and Education:

i. Accountability and corrective measures for incidents most often involve educational functions. Once the exposure to loss has been identified and priorities set or new policies developed, the Risk Manager may request that an effective educational program with training and retraining will be implemented.

ii. The Risk Manager will coordinate, plan and implement educational programs to minimize the risk of harm to residents and others through the general orientation handbook, Risk Management educational sessions as indicated, and coordinate an annual presentation facility wide by the Risk Manager, insurance carrier and/or legal counsel.

b. Integration of Risk Management and Resident Relations:

i. The Resident Relations Plan functions to evaluate resident feedback identify individual problems and to take appropriate measures through a reporting system to improve resident satisfaction, enhance the facility's image and reduce liability losses where resident dissatisfaction is involved. The Performance Improvement Department addresses resident relations and systematically responds to resident complaints about non-medical problems, staff attitude or delayed medications and identifies medical problems, such as lack of information and informed consent concerns and refers these matters to the appropriate medical staff member/committee.

ii. The systematic reporting of resident concerns, frustrations, anger or communication breakdowns and the collective response of corrective action will result in both greater resident satisfaction and reduced risk of claims. The role of the Performance Improvement Department, in coordination with the Risk Manager, is to determine an appropriate course of action to ensure that optimum care is provided while working with the department or departments involved in the problem, including the negotiation on behalf of the individuals, providing input toward changes in facility or department policy and procedure and providing follow-up to ensure that satisfactory resolution has been reached for each individual. Through risk management participation, identified need for in-service education can be arranged and reported and related visitor and resident care activities submitted to facility Performance Improvement Committee.

c. Business Office: To assist in prompt resolution of financial problems with residents and families, the Risk Manager has the authority to work closely with the Business Office Manager to resolve discrepancies in resident billing. The authority to "write-off" certain portions of the resident's bill will be recommended by the Risk Manager to the Business Office Manager after administrative approval.

d. Legal Counsel: The facility's legal counsel and administrative personnel work closely in coordinating and resolving associated problems as a result of an incident prior to it becoming a significant claim. The facility's legal counsel

and administrative personnel also coordinate a defensible representation through staff interview, documentation review, preservation of evidence, estimating probable damages and expenses, assessing the degree of facility responsibility and developing a case file for settlement and/or litigation purposes.

e. Claims Management: The facility's insurance carrier provides claims management services to the Risk Manager to provide consultation, direction and proactive investigation and interventions in the coordination of controlling medical liability loss and in reducing potential loss claims. The Claims Manager provides quarterly reporting to the administration on claims management activities. The Risk Manager provides, as indicated, reports on incident occurrences, investigation activities and results and corrective action when appropriate.

f. Medical Records: The facility's Health Information Management Department provides for security of medical records involved in a potential or actual claim and notifies the Risk Manager of the receipt of a request for a copy of a resident's medical record due to potential litigation. The Risk Manager and/or administrative personnel work closely with the Health Information Management Director in informing of any potential or actual claims and assists in providing secure and confidential storage of the medical record.

g. Integration of Risk Management and Medical Staff:

i. The Risk Manager and/or the Performance Improvement Coordinator provides risk-related and potential corrective action reports with follow-up documentation as indicated to selective medical staff committees through the performance improvement process reporting system.

ii. Prompt reporting of medically related adverse events allows the Risk Manager/Performance Improvement Coordinator to advise the physician about proper documentation procedures and how to approach the resident and family of an untoward event. The Risk Manager and/or administrative personnel will also assure that all documentation is in order and that an investigation case file is prepared in the event litigation does ensue.

iii. The identification and follow-up of medically related incidents will be integrated in to the facility's risk management and performance improvement programs. The medical staff committees will review adverse occurrences involving medical care and management, and report their findings through the performance improvement process. Through this review process, possible quality and appropriateness of care issues will be managed and opportunities to improve care identified. The medical staff will participate in risk management activities related to the clinical aspects of resident care and safety as follows:

(a) The identification of general areas of potential risk and sentinel events in the clinical aspects of resident care and safety.

(b) The development of criteria for identifying specific cases with potential risk and/or sentinel events in the clinical aspects of resident care and safety and evaluation of these cases.

(c) The root cause analysis with resultant correction of problems in the clinical aspects of resident care and safety identified by risk management activities.

(d) The design of programs to reduce risk in the clinical aspects of resident care and safety.

ix. Another area of risk management involvement is assuring the implementation of informed consent. Informing the resident of the risk of medical and/or surgical procedures is part of good medical management, physician's practice and a legal requirement. The physician is responsible for the process of informing the resident about risks and hazards of medical and/or surgical procedures. The facility staff may assist the physician in the process by obtaining the resident's, or the individual legally empowered to act for the resident, signature on model consent forms after the communication process between physician and resident has been completed and documented. The risk management process will review written policy and procedures annually relative to the informed consent process. Policy and procedures shall address the medical and/or surgical procedures and treatments for which informed consent of the resident, manner of documentation of consent and appropriate persons other than the resident, from whom consent may be obtained.

J. Credentialing process, physician performance profile:

1. The Risk Management Plan creates a comprehensive physician reappraisal/reappointment system utilizing both risk management and performance improvement activities as the database. Through identified areas of risk management that can be used in the medical staff reappraisal/reappointment process, an effective presentation of the physician's performance can more accurately be assessed.

2. The risk management and performance improvement functions will provide reporting of all involvement in any professional liability actions, previously or currently pending challenges to any licensure or registration, the reduction or loss of clinical privileges and final judgments or settlements involving the physician. This profile of the physician's performance will assist in the decision making process for conditions and status of privileges, determination and delineation of privilege additions and deletions in the reappraisal/reappointment process.

a. State, Federal and TJC: The Risk Manager will assist the facility administration and staff interpreting regulatory standards and assisting with performance compliance standards, including reporting of sentinel events pursuant to organizational Sentinel Event Policy and Procedure.

b. Risk Manager Committee Involvement:

(This responsibility is shared with the Performance Improvement Coordinator)

i. Governing Body, quarterly report/presentation
ii. Facility/Medical Staff Performance Improvement Committee
iii. Resident Safety Committee/Environment of Care Committee
iv. Infection Control Committee
v. Nursing Performance Improvement Committee
vi. Pharmacy and Therapeutics Committee
vii. Other Medical Staff Committee