COMPASS
CLINICAL CONSULTING℠

ASSESSMENT FOR CENTERS FOR MEDICARE AND MEDICAID SERVICES COMPLIANCE

Presented to:

Arkansas State Hospital
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TABLE OF CONTENTS

INTRODUCTION

To comply with its agreement with the Service Improvement Agreement (SIA), The Arkansas State Hospital (ASH) hired Compass Group, Inc., d.b.a. Compass Clinical Consulting (Compass), to conduct an assessment of the hospital's compliance with CMS Conditions of Participation (CoPs). Compass was directed to conduct an assessment and report findings and recommendations to ASH and to CMS.

In August 2011, the Compass consulting team—Cary Gutbezahl, MD (team leader and QAPI expert); David Seltzer, MD (psychiatrist); Kate Fenner, RN, PhD (psychiatric nurse and compliance specialist); Barbara Maher, RN (psychiatric nurse and compliance specialist), and Len Puthoff (Life Safety Code)—conducted the assessment as required by the SIA.

The assessment included the A-tags (standards for all hospitals), B-tags (special requirements for psychiatric hospitals) and the K-tags (Life Safety Code requirements), not just the areas which were cited previously.

This report is being submitted to CMS and to ASH simultaneously. CMS will review the report and provide feedback in accordance with the SIA.

SUMMARY OF FINDINGS

ASH has not been adequately managed for many years—a result of unqualified executives and poor governance practices. These conditions led to cultural and programmatic deficiencies that resulted in a failure to comply with the CoPs or with good hospital management and clinical practice. These conditions are described in greater detail in the Root Cause Analysis.

During the assessment, Compass identified numerous deficiencies relative to the A-, B-, and K-tags. Several of these deficiencies were at the Condition level.

At the time of the survey, this high number of deficiencies was not surprising to the new management of ASH or the Arkansas Department of Human Services. The CEO and the interim director of the Division of Behavioral Health Services (Governing Body chair) are new to their positions and are well-aware of the seriousness and breadth of the problem. It is our belief that their fresh approach will be an asset in implementing changes.

Additionally, the staff and current management are committed to bringing the hospital into compliance, with the recognition that this will involve making major changes both operationally and culturally.

While change is always difficult in organizations, we are confident that ASH is prepared for the change and will fully cooperate in implementing the corrective action plan.

REPORT STRUCTURE

This report is organized into the following six sections:

- **A list of deficiencies for the A-tags.** This list is organized by Condition. Brief recommendations are provided, which will be elaborated upon in the corrective action planning phase. With rare exceptions, only A-tags that were deficient are noted. If an A-tag is not listed, it was found to be compliant.
- **B-tags.** All B-tags are listed, including compliant ones.
- **K-tags.** Only deficient K-tags are noted, accompanied by recommendations for corrective action.
- **An assessment** of several key topics, including the QAPI program.
- **A Root Cause Analysis (RCA)**. The RCA was guided by the need to develop a corrective action plan so that changes are implemented successfully, rather than as an investigation for punitive action.
- **Recommendations.** These recommendations will be integrated into the action plan. This list does not include a repetition of the recommendations in the K-tag section because these recommendations refer to deficiencies found in the specific locations described in the findings.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0043	**§482.12** Condition of Participation: Governing Body	The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.	Compliant.	
0049	**§482.12(a)(5)**	Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.	No evidence in minutes that Governing Body (GB) monitors medical staff oversight of quality of care	Develop procedures for medical staff oversight, and report to GB regularly.
0083	**§482.12(e)** Standard: Contracted Services	Governing Body responsible for services furnished in the hospital, including contracted services.	No evidence that GB has active role in monitoring performance of contracted services.	Revise contracts, and develop contractor oversight functions so information can be presented to GB.
			Documented evidence of employee orientation was not consistently seen in personnel files. Documented evidence of initial and ongoing competency was not found in the personnel files.	Ensure that there is a record of orientation in all personnel files. Records must be maintained to substantiate competency of staff on hire and on an annual basis.
0084	**§482.12(e)(1)**	Governing body assures that contracted services are provided in a safe and effective manner.	Dietary and Environmental Services contractors participate in the QAPI program of the organization; others do not. Additionally, ASH does not evaluate each contracted service provider, and some contracts do not have adequate language to ensure that services are provided in a safe and effective manner.	Revise contracts so performance can be monitored and to ensure involvement in the QAPI program. Contract with Radiology provider.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
			Radiology provider does not have a contract.	
0085	**§482.12(e)(2)**	Hospital maintains list of contracted services, including scope and nature of services provided.	Although contracts are available, there is no list of contracted services.	Develop and maintain a list of contractors.
0115	**§482.13** Condition of Participation: Patient Rights	A hospital must protect and promote each patient's rights.	Non-compliant.	
0116	**§482.13(a)** Standard: Notice of Rights	Hospital must ensure the notice of risk requirements are met.	No Notice of Rights posted.	Post notice.
0117	**§482.13(a) (1)**	The hospital must inform each patient of their rights in advance of furnishing or discontinuing patient care whenever possible.	At admission, the Important Message from Medicare (IM) is provided but is not made available again within two calendar days of discharge.	Develop process to manage the IM and ensure that it is provided two days prior to discharge.
0118	**§482.13(a)(2)**	The hospital must establish a process for prompt resolution of patient grievances and must inform each patient who to contact to file a grievance.	In discussions, it was discovered that there had not been a differentiation between the handling of complaints and grievances. The timeframe for the resolution of grievances has not been defined. No grievance committee has been established to review and act on grievances.	Review of the practices and policies around handling of complaints and grievances to comply with CoPs. Monitor practice to assure compliance.
0119	**§482.13(a)(2)**	The Board of Trustees (BOT) is responsible for effective operation of the Grievance Process, unless it delegates the responsibility in writing to a grievance committee.	There is no evidence that the grievance process is overseen by the GB. There has not been a grievance committee established to review and act on grievances.	Establish periodic reporting to GB.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0120	**§482.13(a)(2)**	The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate QIO.	Because patient length of stay is long, execution of these procedures is not ensured. Compliance with IM pre-discharge notice not ensured.	Develop procedures to ensure compliance with patient's right to appeal premature discharge. See prior recommendation about IM.
0121	**§482.13(a)(2)(i)**	The hospital has a clearly explained procedure for submission of grievances (and the patient clearly understands the procedure).	In discussions, it was discovered that there had not been a differentiation between the handling of complaints and grievances.	Revise grievance policy to include timeframe for resolution.
0122	**§482.13(a)(2)(ii)**	The Grievance Process specifies time frames for review of the grievance and the provision of a written response.	The timeframe for the resolution of grievances has not been defined.	Revise grievance policy and procedures.
0123	**§482.13(a)(2)(iii)**	In its resolution of the grievance, the hospital provides the patient with a written notice that contains: hospital name, hospital contact person, and the steps taken on behalf of the patient to investigate the grievance, the results of the investigation and completion date.	Current process is fragmented and not consistent	Revise procedures to monitor patients' rights requirements.
0129	**§482.13(b)** Standard: Exercise of Rights	The hospital must ensure that the exercise of patients' rights requirements is met.	Non-compliant. Monitoring data are not collected and reviewed by management or GB.	Develop procedures to assure compliance with patient's right to appeal premature discharge.
0131	**§482.13(b)(2)**	The patient/representative has the right to make informed decisions regarding his or her care.	Partial Compliance. Patient or representative has rights to informed decisions, but patients are not aware when physician is not in-house.	Revise admission package to inform patients that an MD may not be on-site 24/7.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0132	**§482.13(b)(3)**	The patient has the right to formulate advance directives (AD) and to have hospital staff and practitioners who provide care in the hospital comply with these directives.	No evidence in charts or via QAPI monitor to assure that AD are consistently addressed.	Develop policy on AD, and monitor implementation.
0142	**§482.13(c)** Standard: Privacy and Safety	The hospital must ensure the privacy and safety requirements are met.	Non-compliant. Patient was showered by staff, visible through glass window in Unit B.	Review policy, improve staff education, and monitor compliance.
0143	**§482.13(c)(1)**	The patient has the right to personal privacy.	Non-compliant. Patient was showered by staff, visible through glass window in Unit B.	Review policy, improve staff education and monitor compliance.
0144	**§482.13(c)(2)**	The patient has the right to receive care in a safe setting.	Multiple K-tag deficiencies cited.	See K-tag report.
0146	**§482.13(d)** Standard: Confidentiality of Patient Records	The hospital must ensure the confidentiality of patient records requirements are met.	Non-compliant.	
0147	**§482.13(d)(1)**	The patient has the right to the confidentiality of his or her clinical record.	Records are secure when in Medical Records, but the security of records in units—especially after patient discharge—is uncertain.	Revise policy to ensure that records are returned to Medical Records within 24 hours of discharge.
0160	**§482.13(e)(1)**	A restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.	Compliant. Policy was modified to clarify that medication use is consistent with treatment and when it is used as a chemical restraint (with the appropriate safeguards).	

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0162	**§482.13(e)(1)(ii)**	Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Only used for the management of violent or self-destructive behavior.	Seclusion documentation does not uniformly reflect timely recording of information.	Develop, monitor, and integrate into QAPI program, and implement corrective action.
0166	**§482.13(e)(4)(i)**	The use of restraint or seclusion must be in accordance with a written modification to the patient's plan of care.	Plans of care are not consistently modified after use of restraint or seclusion.	Modify practice, monitor compliance, and integrate into QAPI.
0194	**§482.13(f)** Standard: Restraint or Seclusion	Staff training requirements.	Non-compliant.	
0194	**§482.13(f)(1)**	The patient has the right to safe implementation of restraint or seclusion by trained staff.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0196	**§482.13(f)(1)(i)** **§482.13(f)(1)(ii)** **§482.13(f)(1)(iii)**	Training Intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion: (i)Before performing any of the actions specified in this paragraph; (ii) as part of orientation; and (iii) subsequently on a periodic basis consistent with hospital policy.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0199	**§482.13(f)(2)(i)**	Training Content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: (i)Techniques to identify staff and	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.		
0200	**§482.13(f)(2)(ii)**	Education, training, and demonstrated knowledge includes at least the following: • The use of nonphysical skills.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0201	**§482.13(f)(2)(iii)**	• Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0202	**§482.13(f)(2)(iv)**	• The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0204	**§482.13(f)(2)(v)**	Education, training, and demonstrated knowledge include at least the following: Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0205	**§482.13(f)(2)(vi)**	Education includes: Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including by not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0206	**§482.13(f)(2)(vii)**	Education includes: The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.	The organization provides training, but personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0207	**§482.13(f)(3)**	Trainer Requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.	Personnel files lack adequate documentation.	Correct deficiencies in personnel records.
0208	**§482.13(f)(4)**	Training Documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.	While there is evidence of training during orientation and NAPPI training, documentation in personnel records does not exist.	Correct deficiencies in personnel records.
0263	**§482.21** Condition: Quality Assessment and Performance Improvement Program		Non-compliant. Nearly every standard is not met.	The entire QAPI program needs to be revised. Leadership needs to rejuvenate program, integrate QAPI program into routine management activities, and ensure results. See comments in separate section.
0264	**§482.21(a)** Standard: The hospital must ensure that the program scope requirements are met.		Non-compliant.	
0265	**§482.21(a)(1)**	The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators over time for which there is evidence that it will improve health outcomes.	Measures exist, but no changes in performance are identified. Outcome measures are not routinely defined.	

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0266	**§482.21(a)(2)**	The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators over time for which there is evidence that it will reduce medical errors.	No evidence of reduction in medical errors.	
0273	**§482.21(b)(1)** Standard: The hospital must ensure that the program data requirements are met		Non-compliant.	
0275	**§482.21(b)(2)(i)**	The hospital must use data collected to monitor the effectiveness and safety of services and quality of care.	Occasionally, data are monitored over time to identify trends, but this monitoring does not occur consistently.	
0276	**§482.21(b)(2)(ii)**	The hospital must use the data collected to identify improvements and changes that will lead to improvement.	Data are rarely used to develop action items to improve outcomes.	
0283	**§482.21(c)** Standard: The hospital must ensure that the program activities are met.		Non-compliant.	
0285	**§482.21(c)(1)(i)**	The hospital must set priorities for its performance improvement activities that: • Focus on high volume, high, risk and problem prone areas.	The basis for setting priorities is not defined except for sentinel events. The goal is stated as avoiding adverse outcomes.	
0285 cont.	**§482.21(c)(1)(ii)**	• Consider the incidence, prevalence, and severity of problems in those areas,	Priorities do not reflect past data, regional trends, etc.	
0286	**§482.21(c)(2)**	Performance Improvement Activities must: • Track medical errors and adverse patient events	Reporting of adverse patient events is incomplete (inconsistent use of reporting methods).	
0288	**§482.21(c)(2)**	• Implement preventative actions	Although there is an	

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		and mechanisms that include feedback and learning through out the hospital.	established method for investigating sentinel events and near-misses and conducting a root cause analysis, there appears to be a lack of accountability for the monitoring, follow-up, and ongoing reporting of progress related to the preventative actions.	
0289	**§482.21(c)(3)**	The hospital must: • take actions aimed at performance improvement	There is inadequate evidence that corrective action from the QAPI program has resulted in sustained change.	
0290	**§482.21(c)(3)**	• after implementing those actions , the hospital must measure its success	Continual measurement is evident, but the results rarely show improvement, thus indicating ineffective change management.	
0291	**§482.21(c)(3)**	• and track performance to ensure that improvements are sustained.	Ongoing measurement of problematic items is noted, but improvement is not sustained.	
0297	**§482.21(d)** Standard: PI Projects		Non-compliant.	
0300	**§482.21(d)(3)**	The hospital must document: • The Quality Improvement projects being conducted.	No list of QI projects is available.	
0301	**§482.21(d)(3)**	• The reasons for conducting the projects.	Reasons for selection are not indicated.	
0302	**§482.21(d)(3)**	• Measurable progress achieved on the projects.	Progress on the project is not documented.	
0309	**§482.21(e)** Standard: Executive Responsibilities		Non-compliant.	

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0310	**§482.21(e)(1)**	That an ongoing program for quality improvement is defined, implemented and maintained.	Non-compliant. The lack of response following poor results suggests inadequate executive involvement or commitment.	
0311	**§482.21(e)(1)**	That an ongoing program for patient safety, including the reduction of medical errors is defined implemented and maintained.	Non-compliant. The lack of response following poor results suggests inadequate executive involvement or commitment.	
0312	**§482.21(e)(2)**	That the hospital-wide quality assessment and performance efforts address priorities for improved quality of care ….and that all improvement actions are evaluated	Non-compliant. Insufficient evidence that monitoring of improvement actions demonstrate improvement. No scheme for prioritizing work.	
0313	**§482.21(e)(2)**	That the hospital wide quality assessment and performance efforts address priorities for patient safety…and that all improvement actions are evaluated.	Insufficient evidence that monitoring of improvement actions demonstrate improvement. No scheme for prioritizing work.	
0314	**§482.21(e)(3)**	That clear expectations for patient safety are established	Non-compliant.	
0315	**§482.21(e)(4)**	That adequate resources are allocated for: • Measuring, assessing, improving and sustaining the hospital's performance.	Compliant.	Resources are distributed in one department only.
0316	**§482.21(e)(4)**	• reducing risk to the patient	Compliant.	Resources are distributed in one department only.
0317	**§482.21(e)(5)**	That the determination for the number of distinct improvement projects is conducted annually.	Non-compliant. No evidence that there is a coordinated approach to determining the number of projects	
0338	**§482.22** Condition of Participation: Medical Staff	The hospital must have an organized medical staff that operates under	Compliant.	

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.		
0340	**§482.22(a)(1)**	The medical staff must periodically conduct appraisals of its members.	Non-compliant. There is no systematic objective method for integrating quality of work and patient outcomes into the evaluation of physician clinical performance. Physicians and patient care areas are not informed after privileges are granted.	Develop a systematic monitoring program for all physicians with clinical privileges. Develop methods for notifying physicians when privileges are granted, as well as for notifying patient care areas.
0385	**§482.23** Condition of Participation: Nursing Services	The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	Compliant.	
0386	**§482.23(a)** Standard: Organization	The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.	Most policies have not been reviewed since before the two-year tenure of the DON. Nursing QAPI is not integrated into the organization's QAPI program.	Update nursing policies.
0392	**§482.23(b)** Standard: Staffing and Delivery of Care		Non-compliant.	
0393	**§482.23(b)**	The hospital must provide 24-hour	Staffing plans do not reflect	Develop a structured staffing

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under §488.54*(c)*of this chapter.	needs of patients. (Core staffing plan and "add staff when needed.")	plan that can adapt to patient needs.
0396	**§482.23(b)(4)**	The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.	The care plan is not revised to reflect course of care and changes to patient condition.	Revise treatment planning process to ensure revisions are made so that the treatment plan reflects patient condition and care plan at all times during hospitalization.
0404	**§482.23(c)** Standard: Preparation and Administration of Drugs		Non-compliant.	
0405	**§482.23(c)(1)**	All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.	Drugs are rarely administered within 30 minutes of scheduled time. Monitoring of medication errors is incorporated into the QAPI program, but QAPI is limited to self-reported medication errors and does not include observation of medication administration. Timeliness and other problems are not monitored. Although a well-defined process is in place, staff does not consistently follow the required steps in administering the medications.	Revise medication administration process. Develop program to improve medication error identification. Because it is unclear whether the double-check process to be carried out by two licensed personnel (checking the dose for accuracy against the physician's order, patient identification, and double signature on the MAR) is actually being followed, managers should periodically address this practice in staff meetings and observe the practice being performed correctly.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0406	482.23(c)(2)	With the exception of influenza and pneumoccocal vaccines, which may be administered per physician approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and State law and who is responsible for the care of the patient (see 482.12(c)).	Closed-chart review identified orders that listed route as "po or IM" without additional specification.	Revise practice to ensure that no order is accepted if noted as "po or IM" without additional clarifying instructions.
0407	§482.23(c)(2)(i)	If verbal orders are used they must be used infrequently.	Policy does not delineate when and how VO are used (limitations as to type or drug)..	Revise policy to comply.
0431	**§482.24 Condition of Participation: Medical Record Services**	The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.	Compliant.	
0441		The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only by authorized individuals.	Non-compliant. Security of records within the hospital is inadequate. Records are not sent to Medical Records within 24 hours of discharge and can disappear. As a result, records have been lost.	Require that records be sent to Medical Records within 24 hours of discharge.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
0458	482.24(c)(2)	All records must document the following, as appropriate: (i) Evidence of-- (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.	In the review of open medical records, it was noted that patient history and physical examinations are not consistently documented within 24 hours of the patient's admission. This disparity was seen in records in which there were no notes to indicate that the information could not be obtained due to the patient's inability to undergo the assessment.	Implement monitoring of timeliness and content-quality of patient history and physicals. Ensure that there are adequate resources available to meet the required timeframe.
0469		All records contain a final diagnosis within 30 days following discharge.	Some records are not completed within the timeframe.	Review practices to ensure records are completed within timeframe, and develop a records tracking system to prevent loss of information.
0490	**§482.25** Condition of Participation: Pharmaceutical Services		Compliant.	
0500	§482.25(b) Standard: Delivery of Services	In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.	Non-compliant. After hours, medication orders are not reviewed for appropriateness by a pharmacist before the first dose is dispensed. Currently, a policy in place that addresses the use of medications brought into the hospital.	Develop process to have new orders reviewed by a pharmacist in all circumstances. Integrate reconciliation into QAPI program to achieve 100% understanding of the reasons why medications were not used.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
			A system in place to reconcile medications that are not administered when the pharmacy inventories patient medications or restocks patient medications. Most of the time, the pharmacy is able to determine the reason the medications were not used.	
0508	§482.25(b)(6)	Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending MD and, if appropriate, to the hospital PI program.	Program does not include observation of medications passes; concurrent and retrospective review of patient's clinical records; ADR surveillance team; implementation of medication usage evaluations for high-alert drugs; and identification of indicator drugs. Many ADRs are not reported (e.g., patients with EPS).	Develop processes for review to improve medication administration practices.
0509	§482.25(b)(7)	Abuses and losses of controlled substances must be reported in accordance with applicable Federal and State laws to: -Individual responsible for pharmacy -CEO	Wastage is monitored, but documentation errors have not been reported to QAPI.	Integrate documentation problems into QAPI process.
0528	**§482.26** Condition of Participation: Radiologic Services		Non-compliant. Diagnostic radiology services are offered by an outside provider, but there is no specified contract or requirements for the vendor.	Develop contract for provider. Include requirements for participation in QAPI program and for physician credentialing.
0529	§482.26(a) Standard: Radiologic Services	The hospital must maintain, or have	Provider does not participate	Develop scope and complexity

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		available, radiologic services according to the needs of the patients.	in the QAPI program. The scope and complexity of radiological services offered are not specified in writing or approved by the medical staff and governing body.	statement for approval by medical staff and governing body.
0576	Condition of Participation: Laboratory Services	The hospital must maintain or have available, adequate lab services to meet the needs of its patients. The hospital must ensure that all lab services performed to its patients are performed in a facility certified in accordance with Part 493 of Chapter 42.	Compliant. Services are available through a contractual agreement, which requires that quality data be submitted to ASH.	Include requirements for accreditation of laboratory by College of American Pathologists or The Joint Commission. Monitor turnaround times and lost specimens.
0618	**§482.28** Condition of Participation: Food and Dietetic Services	The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietician who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.	Compliant.	
0631	§482.28(b)(3)	A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and	Diet manual was not approved by medical staff.	Submit diet manual to medical staff for approval.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		food service personnel.		
0652	Condition of Participation: Utilization Review	The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.	Compliant.	
0656	Standard: Determination Regarding Admissions or Continued Stays	Required procedures for addressing determinations that an admission or continued stay is not medically necessary.	Process is in place but is not described in policy.	Update policy to include required process.
0658	Standard: Review of Professional Services	The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.	Although mentioned in UR plan, the evaluation has not been conducted in more than one year.	Conduct an evaluation study.
0747	Condition of Participation: Infection Control	The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.	Non-compliant. Unsanitary conditions were found in some locations. Overall, the disease prevention and control program is not implemented or well-designed. Examples of substandard program design include the following: • Room used for storage of food items for patients was not clean, and the dirty refrigerator contained both staff and patient food items. • The ice chest-style machine used to provide ice for patients did not appear to have a regular cleaning schedule.	Entire Infection Control program needs an overhaul. Cleanliness should be addressed throughout the hospital, especially in areas where food is stored. Patient and staff food items cannot be stored in the same refrigerator. Because the style of the ice chest requires a person to use his/her hands to handle the ice scoop, a cleaning schedule must be established and followed. To avoid sharps injuries the

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
			• In several locations, there were unsecured sharps containers with large openings in the top. Contents would not be secure if the containers were knocked over.	sharps containers must be secured in some form of holder wherever they are being used in the hospital.
0749		The IC officer develops a system for identifying, reporting, investigating, and controlling infectious and communicable diseases of patients and personnel.	Identification process is subject to failures because it is dependent upon reporting behaviors rather than computer-supported reporting.	Integrate lab reporting into identification process.
0750		The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases.	Sheets are kept in a binder but there is no log.	Develop a log—preferably an electronic log so data can be sorted for analysis.
0756	Standard: Responsibilities of Chief Executive Officer, Medical Staff, and Director of Nursing Services	The CEO, DON, and Medical Staff must: • Ensure that the hospital wide QAPI program and training programs address problems identified by the IC officer. • Be responsible for the implementation of successful corrective action plans in affected problem areas.	While IC reports findings, no action is taken on infection events, e.g., high number of skin infections. Under-reporting of infections by nursing staff is likely, as evidenced by low number of URIs.	Act on data, and investigate consistently high wound-infection reports.
		The methodology to collect an analyze data is defined.	No written methodology.	Develop written methodology.
		Policies for cleaning patient care areas and equipment.	Non-compliant.	Develop policy.
		Policies for cleaning non-patient care areas	Non-compliant. Develop policy.	Develop policy.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		Exposure control plan	Non-compliant.	Develop exposure control plan.
		Policies are reviewed every 3 years.	Many policies have not been reviewed in over 3 years.	Review all outdated policies, and set schedule for policy review.
		The facility provides the following: • Decontamination and sterilization of equipment and supplies • Monitoring of sterilizing equipment on a routine schedule • Policies on use of disposables • Policies addressing shelf life of sterile items • 24/7 availability of clean linen • Policy for removal of soiled linen that reduces the spread of infection	Policies addressing the use of disposable items and the shelf life of sterile items were not found.	Develop policies.
0799	Condition of Participation: Discharge Planning	The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.	Compliant.	
1123	Condition of Participation: Rehabilitation Services	If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.	Non-compliant. Care is provided by contractor for adolescents and OT for adults units. No PT or speech therapy services are available for forensic patients.	Define service needs, and develop operating plans for rehabilitation services that meet the needs of potential patients.

A-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
1124	Standard: Organization and Staffing	The organization of the service must be appropriate to the scope of services offered.	Scope of services not defined and not approved by the Medical Staff.	Have medical staff recommend a scope of service to Governing Body.
1125		The director of the service must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.	No director is on staff.	Manage rehabilitation contractors.
1132	Standard: Delivery of Services	Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and their orders must be incorporated in the patient record.	Compliant. Orders for therapy are present. Services are timely and appropriate for the needs of the patients.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B98	**§482.60** Condition of Participation: Special Provisions Applying to Psychiatric Hospitals	Psychiatric hospitals must— (a, b, c, d)	Compliant.	
B99	**§482.60(a)** Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.	The hospital will be deemed to meet standard (a) if it meets standards (c) and (d).	Compliant.	
B100	**§482.60(b)** Meet the Conditions of Participation specified in §§482.1 through 482.23, and §§482.25 through 482.57;	The hospital is either accredited by JCAHO or AOA; or meets the Condition of Participation for Hospitals, §§482.1 through 482.23, and §§482.25 through 482.57.	Compliant. Triennial Survey 1/12-2/12	
B101	**§482.60(c)** Maintain clinical records on all patients…sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries as specified in §482.61; and…(d)		Compliant. Medical Records Review	
B102	**§482.60(d)** Meet the staffing requirements specified in §482.62.		Compliant.	
B103	**§482.61** Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals	The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.	Compliant	
	§482.61(a) Standard: Development of Assessment/Diagnostic Data			
B104	**§482.61(a)** Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.		Compliant.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B105	**§482.61(a)(1)** The identification data must include the patient's legal status.	"Legal status" is defined in the state statutes and dictates the circumstances under which the patient was admitted and/or is being treated— e.g. voluntary, involuntary, committed by court, evaluation, and recertification are in accordance with state requirements.	Compliant. As determined by state statute.	
B106	**§482.61(a)(2)** A provisional or admitting diagnosis must be made on every patient at the time of admission and must include the diagnosis of intercurrent diseases as well as the psychiatric diagnosis.		Compliant.	
B107	**§482.61(a)(3)** The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.	The purpose of this regulation is to provide an understanding of what caused the patient to come to the hospital, as well as the patient's response to admission. Records should not contain vague, ill-defined reports from unknown sources. Records should record "who," "what," "where," "when," and "why."	Compliant. 12 of 12 records appropriate for reasons of admission.	
B108	**§482.61(a)(4)** The social service records— including reports of interviews with patients, family members, and others—must provide an assessment of home plans and family attitudes, community resource contacts, and a social history.	Patient length of stay is a key factor influencing hospital documentation policy, i.e. establishing timeframes for completion, documentation, and filing of the psychosocial assessment, and treatment planning in the medical record. A psychosocial history/assessment must be completed on all patients, addressing three key components: factual and historical information; social evaluation; and conclusions	Compliant. Detailed social history and ongoing social worker notes (included in progress notes) and social worker-coordinated discharge planning.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		and recommendations.		
B109	**§482.61(a)(5)** When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.		Compliant.	
B110	**§482.61(b)** Standard: Psychiatric Evaluation	Each patient must receive a psychiatric evaluation that must—(1, 2, 3, 4, 5, 6, 7)	Compliant.	
B111	**§482.61(b)(1)** Be completed within 60 hours of admission;		Compliant.	
B112	**§482.61(b)(2)** Include a medical history;	The psychiatric evaluation must include the non-psychiatric medical history including physical disabilities, mental retardation, and treatment.	Compliant. 9 of 9 Open charts: 3 of 3 closed	
B113	**§482.61(b)(3)** Contain a record of mental status;	The mental status must describe the appearance and behavior, emotional response, verbalization, thought content, and cognition of the patient as reported by the patient and observed by the examiner.	Compliant. 9 of 9 open charts: 3 of 3 closed	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B114	**§482.61(b)(4)** Note the onset of illness and the circumstances leading to admission;	In a hospitalized patient, the identified problem should be related to the patient's need for hospital admission. The psychiatric evaluation includes a history of present illness, including onset, precipitating factors and reason for the current admission, signs and symptoms, course, and the results of any treatment received.	Compliant. 9 of 9 open charts; 3 of 3 closed	
B115	**§482.61(b)(5)** Describe attitudes and behavior;	The problem statement should describe behavior(s) which require change in order for the patient to function in a less restrictive setting. The identified problems may also include behavioral or relationship difficulties with significant others which require active treatment in order to facilitate a successful discharge.	Compliant.	
B116	**§482.61(b)(6)** Estimate intellectual functioning, memory functioning and orientation;	…and (b)(7)	Compliant.	
B117	**§482.61(b)(7)** Include an inventory of the patient's assets in descriptive (not interpretive) fashion.	Although the term "strength" is often used interchangeably with "assets," only the assets that describe personal factors on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents, and employment status, which may be useful in developing a meaningful treatment plan.	Non-compliant. 3 of 3 closed records and 3 open records—little to no evidence of assets inventory.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
	§482.61(c) Standard: Treatment Plan			
B118	**§482.61 (c)(1)** Each patient must have an individual comprehensive treatment plan.	The patient and treatment team collaboratively develop the patient's treatment plan—the outline of what the hospital has committed to do for the patient, based on an assessment of the patient's needs. The facility selects its format for treatment plans and treatment plan updates.	Compliant.	
B119	**§482.61(c)(1)** The plan must be based on an inventory of the patient's strengths and disabilities.	The written plan must include—(i, ii, iii, iv, v)	Compliant.	
B120	**§482.61(c)(1)(i)** A substantiated diagnosis;		Compliant.	
B121	**§482.61(c)(1)(ii)** Short-term and long-range goals;		Compliant.	
B122	**§482.61(c)(1)(iii)** The specific treatment modalities utilized;		Compliant.	
B123	**§482.61(c)(1)(iv)** The responsibilities of each member of the treatment team;		Compliant.	
B124	**§482.61(c)(1)(v)** Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.	When the progress and treatment notes are reviewed, the content of the notes must relate to the treatment plan. The notes must indicate what the hospital staff is doing to carry out the treatment plan, as well as the patient's response to the interventions.	Compliant.	
B125	**§482.61(c)(2)** The treatment received by the patient must be documented in such a way to ensure that all active therapeutic efforts are included.		Partial Compliance. Physical therapy, Speech therapy not included in treatment planning.	Include all rehabilitation needs in treatment planning.
B126	**§482.61(d)** Standard: Recording Progress	Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as specified in	Compliant.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		§482.12(c),		
B127	**§482.61(d)** Nurse		Compliant.	
B128	**§482.61(d)** Social Worker		Compliant.	
B 129	**§482.61(d)** When appropriate, others significantly involved in active treatment modalities.		Non-compliance. No evidence that rehabilitation is recorded and integrated into treatment planning.	Assure that documentation is recorded into record and included in treatment planning.
B130	**§482.61(d)** The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first two months and at least once a month thereafter,		Compliant.	
B131	**§482.61(d)** Recommendations for revisions in the treatment plan as indicated as well as…	(See B132)	Non-compliant. Closed- and open-chart review revealed static treatment plan without revisions even after significant patient events.	Revise treatment planning process to encourage modification in response to clinical changes.
B132	**§482.61(d)** A precise assessment of the patient's progress in accordance with the original or revised treatment plan.		Partial Compliance. Updates on treatment plans evident in 2 of 3 closed medical records. None in 3 of 3 open record.	Integrate monitoring of treatment planning process, including modifications, attendance and participation in group therapy, and recording of progress, into QAPI.
	§482.61(e) Standard: Discharge Planning and Discharge Summary			
B133	**§482.61(e)** The record of each discharged patient must have a discharge summary that includes a recapitulation of the patient's hospitalization and…		Compliant. 12 of 12 closed records appropriately document discharge planning.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B134	**§482.61(e)** Recommendations from appropriate services concerning follow-up or aftercare, … and		Compliant. 12 of 12 closed records appropriately document discharge planning.	
B135	**§482.61(e)** A brief summary of the patient's condition on discharge.		Compliant.	
B136	**§482.62** Condition of Participation: Special Staff Requirements for Psychiatric Hospitals	The hospital must have adequate numbers of qualified professional and supportive staff members to evaluate patients; formulate written, individualized, comprehensive treatment plans; provide active treatment measures; and engage in discharge planning.	Compliant. More than adequate professional staff.	
	§482.62(a) Standard: Personnel			
	§482.62(a) The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to…		Non-compliant. There are areas where staffing could be improved, especially in rehabilitation services.	
B137	**§482.62(a)(1)** Evaluate patients;		Compliant.	
B138	**§482.62(a)(2)** Formulate written individualized, comprehensive treatment plans;	Staffing must be sufficient so that members of the patient's treatment team and others responsible for evaluation and assessment can contribute their respective data for consideration in the formulation of the treatment plan.	Compliant.	
B139	**§482.62(a)(3)** Provide active treatment measures;		Non-compliant. While there are enough staff, staff are not consistently engaging with patients.	Re-direct staff attention to patient therapy.

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B140	**§482.62(a)(4)** Engage in discharge planning;	The patient, together with all relevant professionals caring for the patient, should be expected to participate in the discharge planning process. Staffing should be sufficient to facilitate this outcome, to the maximum extent possible.	Compliant. Staff (primarily LISW) and patient participate with staff in discharge planning as indicated by signature.	
B141	**§482.62(b)** Standard: Director of Inpatient Psychiatric Services; Medical Staff	Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent qualified to provide the leadership required for an intensive treatment program.	Compliant. CMO is a board-certified psychiatrist.	
B142		The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.	Compliant.	
B143	**§482.62(b)(1)** The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry.	A physician is qualified to take the examinations for board certification upon successful completion of a psychiatric residency program approved by the American Board of Psychiatry and Neurology and/or the American Osteopathic Board of Psychiatry and Neurology.	Compliant. CMO is a board-certified psychiatrist.	
B144	**§482.62(b)(2)** The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	Services and treatment prescribed to patients must be in accordance with appropriate and acceptable standards of practice. In states that allow psychologists to have admitting privileges, it is still the responsibility of the clinical director to oversee the quality of the patient's treatment.	Non-compliant. No documentation of a system for CMO's oversight or evaluation.	Develop monitoring program and integrate into professional assessment and privileging process.

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B145	**§482.62(c)** Standard Availability of Medical Personnel	Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic services and treatment are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available, or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.	Compliant. *Availability of UAMS for emergency and referral as appropriate; *24/7 MD on call for ASH	
B146	**§482.62(d)** Standard: Nursing Services	The hospital or unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.	Compliant.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B147	**§482.62(d)(1)** The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill.	During the interview with the DON, assess his/her educational background and psychiatric nursing and leadership skills. If the DON has less than a master's degree in psychiatric nursing, expect to see evidence of experience and on-going training in psychiatric nursing. Documented consultation from a nurse with a master's in psychiatric nursing constitutes on-going training.	Partial Compliance. DON has extensive psychology experience, but does not have master's in psychology—documentation consultation from master's-prepared (psych) nurse is ongoing.	Contract with a qualified nurse to consult with DON to provide on-going training.
B148	**§482.62(d)(1)** The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.	Through structured observations of the patients in the sample and other patients in the hospital, patient and staff interviews, and medical record review, ascertain that nursing services are provided in accordance with safe, acceptable standards of nursing practice.	Compliant. Some concern focused on antiquated medication management practices in nursing.	Revise medication administration process.
B149	**§482.62(d)(2)** The staffing pattern must ensure the availability of a registered nurse 24 hours each day.		Compliant. Documented in staffing assignments.	
B150	**§482.62(d)(2)** There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.		Partial Compliance. Staffing system developed, but not uniformly utilized.	Assure consistent use of staffing system.

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B151	**§482.62(e)** Standard Psychological Services	The hospital must provide or have available psychological services to meet the needs of the patients. Psychology services may include the following: diagnostic testing and diagnostic formulations on request from physicians; provision of individual, group and family therapies; participation in multi-disciplinary treatment conferences; and program development and evaluation. The number of full-time, part-time, and consulting psychologists must be adequate to provide necessary services to patients. Arrangements with outside resources must ensure that necessary patient services will be provided.	Partial Compliance. Emphasis on multidisciplinary team treatment in planning conferences. Closed-record review yields ample documentation of diagnostic testing but no evidence of family therapy.	Integrate family therapy into treatment when appropriate.
B152	**§482.62(f)** Standard: Social Services	There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished.	Compliant.	
B153		The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Accepted standards of practice are based on policy statements adopted by the National Association of Social Workers and a definition of social work practice in healthcare adapted by the Consortium of Health Care Social Work Organizations. Staff should adhere	Compliant.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
		to the facility's personnel requirements.		
B154	**§482.62(f)(1)** The director of the social work department or service must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a master's degree in social work (MSW), at least one staff member must have this qualification.	The duties, functions, and responsibilities of the director of social services/social work should be clearly delineated and documented in the facility's policies and procedures. If the director is not MSW qualified and at least one staff member is MSW qualified, verify the duties, functions, and responsibilities of the MSW.	Compliant.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B155	**§482.62(f)(2)** Social service staff responsibilities must include, but are not limited to, participating in discharge, planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.	Social work contact with the patient, family, and significant others should occur during, or as soon as possible after the admission. High-risk case finding should result in significant data being available for early integration into the treatment plan and subsequent social work action as indicated. The treatment team should consider for possible inclusion into the patient's treatment plan the anticipated social work role and expected interventions as recommended in the psychosocial assessment. Treatment and discharge planning activities and liaison/follow-up efforts should be based upon the goals, including discharge goals, and staff responsibilities specified in the treatment plan.	Compliant. Social workers heavily involved in admissions assessment.	

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B156	**§482.62(g)** Standard: Therapeutic Activities	The hospital must provide a therapeutic activities program. A variety of therapeutic and rehabilitative activities are selectively used as therapeutic tools in providing active treatment to the psychiatric patients. Therapeutic activities focus upon the development and maintenance of adaptive skills that will improve the patient's functioning. In contrast, leisure activities provide the patient with individualized opportunities to acquire knowledge, skills, and attitudes about meaningful leisure involvement and experiences. A patient may need treatment and/or remediation of functional behavior(s) prior to leisure involvement. However, for some psychiatric patients, the highest-priority need may be for leisure education and activities.	Partial Compliance. Heavy reliance on LISW led groups—little 1:1 treatment planning evidenced. Some recreational therapy treatment; no speech or physical therapy evident for adults.	Implement more 1:1 treatment. See prior recommendations about rehabilitation services.

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B157	**§482.62(g)(1)** The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.	The hospital is responsible for ensuring consistent availability and provision of individualized therapeutic activities and rehabilitative services based on patient needs. The selection of individualized therapeutic and rehabilitative staff modalities should be based on patient need and goals set in the patient's treatment plan. Rehabilitative services may include educational, occupational, recreational, physical, art, dance, music, and speech therapies and vocational rehabilitation evaluation and counseling. There are other disciplines that also serve patients. Consultants include but are not limited to the following: educational instructors, registered occupational therapist/certified occupational therapy assistant, certified therapeutic recreation specialist, certified therapeutic recreation assistant, speech-language pathologist (with certificate of clinical competence), registered and certified music therapist, registered art therapist, and registered physical therapist. The qualified vocational specialist may perform duties of a rehabilitation counselor, vocational evaluator, or the work adjustment specialist.	Non-compliant. Little evidence of individualized treatment—predominant modality is group. Closed and Open Medical Records Review	Implement more individual treatment sessions.

B-TAG	STANDARD	DESCRIPTION	FINDING	RECOMMENDATION
B158	**§482.62(g)(2)** The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.	Qualified staff should complete their respective discipline assessments for use in multidisciplinary treatment planning. Specific role(s) and modalities to be implemented by rehabilitative staff must be determined by goals set in the patient's treatment plan. Qualified therapists who provide clinical services and administrative staff should utilize established monitoring and evaluation mechanisms to conduct consistent timely review of the quality and appropriateness of therapeutic and rehabilitative services delivered to patients.	Non-compliant. Little evidence of individualized treatment—predominant modality is group. Closed and Open Medical Records Review	Implement more individual treatment sessions.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K18	Corridor Walls and Doors	Roller latches were found on several doors in patient care areas. The Facilities Team has a listing of the locations in which these latches were found.	Perform an in-depth tour of all door latches, and remove **all** roller latches.
K22/ K44/ K47	Exit Signs	As a result of a patient-caused flood, the illuminated exit signs on Nursing Unit C are not functioning.	Repair the electrical circuit powering the lights.
K21	Door Hold-Open Devices	Many doors throughout the facility are propped open by wedges, kick-down devices, boxes, chairs, and even a rock. These devices could potentially allow smoke and fire to spread in the event of an emergency. Locations include Ambulatory Area, Medical Records, Nursing Unit Medication Rooms, Pharmacy, Supply Building, Maintenance Building, and Dock Area.	Remove all door hold-open devices unless they are linked to the fire alarm system in order to allow closure. In addition, instruct staff that doors on required closures cannot be blocked open, and make frequent rounds to reinforce this finding.
K44	Horizontal Exits	The main building service areas #851 and #852 do not have full two-hour protection or separation from the rest of the building or exit corridor. The wall is not fully built out with appropriate drywall. Sections of wall are not completed. In addition, there is no separation between a two-hour and one-hour rated area. This lack of separation reduces the level of protection to only one hour while the signage indicates a two-hour rated wall. Several electrical switch rooms are not protected from the exit corridors. Drywall is missing in several rooms. In Nursing Units B and C, penetrations exist in the Isolation Room ceilings.	Install rated drywall on the service- area side of the wall as needed to ensure that a two-hour wall is present. Install proper separation between the service area and electronic equipment room. Install rated drywall on the switch side of the walls as needed to ensure that a two-hour wall is present. Insure that walls are properly identified and marked.
K104	Smoke Compartmentalization and Control	Duct penetrations through fire barriers are not clearly identified, and inspection documentation is not complete.	Improve the identification and inspection documentation of duct penetration inspections.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K32	Remote Exits in Fire Section	In the activity center building, the far corner exit is locked. According to staff, the key is not readily available.	Understanding that this is a high-security area, either the key must be constantly available while the center is occupied, or the door and exit discharge area needs to be reworked to address the security concern as well as the fire-exit availability.
K34	Stairway Usage	In Building 3, the fire exit stairway is being used as an equipment and supply storage area. Housekeeping is also storing an open trash container in the stairway.	Remove all equipment, supply storage, and lockers from this area.
K37/ K47	Dead-End Corridor	In Building 3, at the top of the stairway, a conference room has been installed directly off the stairway. The doors are currently on an approved hold-open device, but were blocked from closing.	Investigate the practice of keeping the doors to this meeting room closed and labeled, "Not A Fire Exit."
K35/ K38/ K72	Readily Accessible, Clear Exits	In office area 252-259, broken furniture is being stored that obstructs the exit path. The area was identified on 8-8-11, and the items were still present on 8-12-11.	Remove the furniture from the area.
K48	Fire Plan	Although a fire plan exists, there were three different areas in which staff could not implement the plan because they were unsure of the location of the pull-boxes, did not have keys to activate the alarm, or did not know the proper operation of fire extinguishers.	Investigate the Fire Drill method to involve all staff in the activation of the drill.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K50	Fire Drills	Although fire drills are being conducted and recorded, these drills can be conducted in a more effective and efficient manner.	Instead of activating the alarm from the Security Office, go out to the units and present the employees with a verbal situation and have them actually activate the fire plan— a learning experience for the staff. Have the Security Department document the drill and alarm system operation on a formal Security Report. This documentation should include the notification of the Central Alarm Station of the drill, reception of the alarm, and a return to normal status. This documentation will assist in meeting additional sections of The Life Safety Code requirements. Consider having an identified evaluation team actually round the buildings to document the dill activity, as the return of fire drill evaluation forms appears to be incomplete. Immediately after the drill, conduct a short meeting to discuss and document observations and findings.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K51/ K52/ K54	Fire Alarm System Records	The fire alarm system test and maintenance records do not meet the requirements of NFPA 72 and were not readily available during the survey. The fire alarm system inspection, testing, and maintenance documentation by the Triple S alarm company available at this survey consisted of a single page item appearing to be more of a bill than report. There was no documentation of the required central station signal testing. There is a question of whether the Supply Building fire detection system is fully functional. The Simplex report indicates that the old kitchen area detection devices were not tested. It was reported that three smoke detectors were removed by patients in their rooms. This action should have signaled a fire alarm system trouble alarm. According to the documentation, it was not clear whether the fire alarm system identified a problem and reported a trouble alarm to the monitoring station.	Require that the reports submitted by the company meets the requirements of the NFPA 72. As a comparison, the Simplex maintenance report format performed on the out buildings is more acceptable. Ensure that the devices function, and improve the documentation of the testing of these devices. Have the alarm system tested to ensure that removal of a device will produce a trouble alarm to the monitoring station. In addition, when a trouble alarm is received have a procedure in place on what steps to take to correct the problem and insure that the trouble is cleared. Document this activity.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K154/ K155	Fire Alarm and Sprinkler System Repair	The fire alarm and sprinkler system was out of service for over four hours, and the fire department had not been notified nor had additional fire watch procedures been put in place or documented. Based on observation and documentation, it has been the practice when the fire system is out of service to call the central station monitoring company and give them a range of hours that the system has been down. However, if the system were back in service earlier, no notification took place. In addition, when the system was placed back in service, no follow-up call was made to notify the central station that the system was live; instead, the facility relied on the initial call and time frame reported.	Additional fire watch procedures should include placing additional firefighting equipment in the affected area, additional rounds in the work area, and advising affected staff of the temporary measure in place. Any time the fire or sprinkler system is out of service longer than four hours, call the fire department's non-emergency line and advise them of the situation. When the system is back online, call again to notify the fire department of the online status. Document the calls. Develop and implement what are commonly called "Interim Life Safety Measures," or ILSM procedures, any time the integrity of the facility's fire protection system is affected.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K147	Electrical	In several electrical service switch rooms throughout the buildings, electrical panel boxes and junction boxes are not covered—specifically in the outbuilding areas including the maintenance building, supply building, and basement maintenance areas. In many of the outbuildings, the boxes containing the circuit breakers are blocked. On the sidewalk areas outside of the building in between the main building and maintenance building, wire is exposed on the light pole. In most of the main building medication rooms' sink areas, a small electrical fan is placed on the edge of the sink. In general, your generator system is unique and effective. The operating agreement with the University is a forward-thinking project and should serve you well. However, the testing records of the system do not meet the requirements of healthcare standards. Battery-powered lights are present in the new stairway elevator building, but no testing records were provided during the survey.	Install the covers on all electrical panels and junction boxes. Clear out the area of all unneeded items and ensure that the path is clear. Properly insert the wires and cover the junction boxes on the light poles. Remove or relocate the fans so that it is not located near a water source. It is recommended that modifications be made to the testing reports to indicate that the testing passed the goals. The reports should be signed by the person who conducted the test. In discussion with the Power Plant Operations Director he has agreed to make the changes to the generator report to reflect the needed areas. Inventory all battery-powered lights. Perform and document testing as required by NFPA standards.

K-TAG	SUBJECT/ STANDARD	FINDINGS	RECOMMENDED ACTIONS
K211	Alcohol-Based Hand Rub Dispensers	While properly installed, several of the dispensing units have been broken off the wall, leaving a sharp, jagged edge.	Immediately replace or remove the units when they are damaged.

ASSESSMENT OF AREAS OF CONCERN

LEADERSHIP AND ACCOUNTABILITY

As will be discussed in the Root Cause Analysis, the principal causes of failure at ASH are attributable to failures in leadership, both at the hospital executive- and Governing Body levels. The Governing Body failed to monitor compliance and hospital operations adequately, even when it was aware of scrutiny and concerns by external agencies. We believe that this failure was due to the Governing Body's lack of understanding about its role in oversight activities, as well as its unwillingness to challenge management's inability to deliver results that indicate improvement.

Similarly, senior executives of both past and present were unprepared for their roles, with the exception of the current interim CEO. Interviews with current leaders revealed that they did not participate in a formal or informal process of sequential developmental opportunities prior to assuming their current roles. In addition, they have been provided little assistance in developing their capabilities while in the role. Career development paths and leadership succession do not appear to be part of organizational planning—a disappointing discovery, as it seems that members of management are often recruited from within the state system.

The Medical Director and Director of Nursing are typical examples of promotion from within but with inadequate preparedness for their executive level positions. Both are caring clinicians who are dedicated to good patient care, but whose professional careers have been at UAMS and ASH. They are very comfortable when interacting with staff and patients on the units. They are liked by the staff and are positive influences on the staff. And although deeply committed to the hospital and its mission, neither was prepared by prior experiences for their roles as clinical executives. They are hands-on "do-ers" but lack the leadership cultivation to engage others in change initiatives, and they lack the managerial experience to handle the complex and diverse demands associated with their roles. When good clinicians are not mentored to make the transition from clinician to clinician executive, they take on too much work upon themselves, which leave others disengaged from the change initiative. As a result, many change initiatives have failed to be sustained.

Nevertheless, we believe that both have potential to successfully perform their jobs with coaching and cultivation. The consultants will provide coaching and assist in engaging both executives in ongoing development programs that will continue after completion of the SIA.

The "nepotistic" characteristic of state employment also leads to another unusual observation: when senior leaders who do not meet performance expectations are replaced, they are reassigned to another position within the system. As a result, past Directors of Nursing and CEOs still work at ASH. While this practice may seem humane, the fact that termination means only relocation can result in unanticipated outcomes, such as a less-than-motivated, demoted employee, as well as lingering efforts to preserve the past when new leaders are trying to generate change. Their presence may also reinforce a sense of safety or immunity, so that the perception of the urgency for change is not pressing.

Recommendations

It is beyond the scope of this work to create a management development program. However, the consulting staff will work with the interim CEO to provide training and coaching assistance to managers within ASH. We will teach management what to monitor, how to assess measurements, and strategies for interventions and corrective action.

Relative to the Governing Body, the project plan will include developing well-defined reporting requirements, including formats and key questions to be answered, agendas for the important programs, and projects that should report to the Governing Body. In addition, the Governing Body will be coached to take an activist role in assessing CEO and organizational performance and intervening constructively to promote desired outcomes. Overall, the Governing Body needs to participate in addressing resistant problems and cannot merely express concern. We also believe that the Governing Body or its executive committee should meet to monitor performance more frequently than quarterly, at least until stable, acceptable results are achieved.

TREATMENT PLANNING AND PROVISION

There is a widespread acknowledgment among the clinical staff that treatment planning is weak. Like other identified problems, this issue of insufficient planning has been permitted to persist. Some interview participants stated that the documentation was not important, and therefore, fixing the problem was not a priority. This comment suggests two attitudes of concern. Aside from the widespread willingness to let problems persist, it also suggests a belief against organizing and standardizing processes to ensure consistency in clinical practice. We will monitor acceptance of change to determine whether this suspicion is valid.

Current treatment planning is essentially perfunctory and does not have a consistent linkage to the actual treatment that is delivered. The system for treatment planning seems flawed in timeliness, flexibility, and individualization, and no mechanism exists for adjusting or revising a treatment plan except within the prescribed two-week or one-month timeframe (the timeframe being longer for long-stay patients). Indeed, the Master Treatment Plan (MTP) form is difficult to use and making changes requires rewriting the entire document. As a result, medication changes and changes in response to behavioral events are often not reflected in the MTP. The time-consuming act of making changes currently impedes changes from being recorded, a problem which could be remedied by the installation of an electronic medical record.

Whereas the treatment plans are seen as "paperwork" rather than as the basis for coordinating care, the value of documentation, in general, is not appreciated. Some interview respondents stated that forms are often not completed and non-day shift documentation may be incomplete or absent. Aside from the serious implications related to the quality and appropriateness of patient care, this inadequate documentation is a factor contributing to long lengths of stay. Also of note is that management's awareness of these concerns has not resulted in effective efforts to fix the deficiencies.

In addition to medication, treatment is organized around group therapy, with little one-on-one therapy. Patient participation in groups varies greatly due to variations in their clinical conditions—some patients are unable to participate in group. With groups as the primary vehicle for non-pharmacologic treatment, it does not appear that treatment is customized to patient needs.

Furthermore, there is no evidence that nurses provide therapy, as it seems that most interactions with patients are with non-clinical staff (e.g., behavioral health technicians). Additionally, opportunities to have constructive interactions with patients are not consistently utilized. We observed recreational activities where there was no staff involvement unless there were behavioral problems. In a therapeutic environment, we expect a greater staff effort to interact with patients and demonstrate positive social experiences.

Physicians are involved in treatment planning and are seen as the team leaders. However, several interview respondents believe that some physicians need to show more leadership and be more

assertive in the treatment planning process. While medical records demonstrate physician involvement in diagnosis, there is often little evidence of physician involvement in treatment, other than adjustment of medication.

The various disciplines appear distinctly separated by departmental boundaries. Collaboration and coordination of care are inadequate due to a very serious lack of communications. Namely, several years ago, the nursing staff separated from the rest of the treatment professionals, and their role as part of the treatment team is poorly defined. The role of social workers is similarly poorly defined and appears to be different depending on who is describing it. There appears to be agreement that social workers are too confined to discharge-planning activities, which detracts from their ability to contribute to treatment in a more meaningful way.

Recommendations

1. Change the attitude that treatment planning is about documentation; it should be seen as organizing care to meet the patient's needs.
2. Physicians need to show more consistent leadership in treatment planning.
3. Customize treatment plans to patient needs and update as necessary.
4. Redesign treatment plan forms if the process is an impediment to optimizing treatment planning.
5. Nurses should be involved in providing treatment.
6. Explicit expectations need to be defined in terms of how staff work together and how staff treats patients. These expectations should be built into staff education and competencies.

PHARMACOTHERAPY AND MEDICATION ADMINISTRATION

The CMS survey cited excessive use of psychotropic drugs. In the sample of charts reviewed, medication ordering practices seemed appropriate. However, medications are occasionally given in inadequate doses and for insufficient periods of time. Furthermore, medication practices among psychiatrists are highly variable.

No evidence was found that the prior practice of authorizing "PRN" medications for behavior management has been continued.

Problems were found with the medication administration process. Medications are often provided outside of the regulatory timeframe. This problem is due, in part, to the process used, which requires all patients to line up for medications before any are passed. The process is inefficient and delays treatment. In addition, medications are not adequately labeled after leaving medication storage, and errors can occur. Finally, patient identification is not consistently performed.

Historically, pharmacy and nursing have not collaborated on ensuring safe medication practices. Pharmacy has been monitoring process performance, and the data suggest that medication variances are under-reported. Documentation by the nursing staff is inconsistent. Additionally, medication side effects are severely underreported, especially extra-pyramidal symptoms of first-generation anti-psychotics.

We reviewed the medication error data and reports to the Pharmacy and Therapeutics Committee. Because Medication Administration Records (MAR) are manually produced, many errors are a result of transcription errors. At least one-third of medication errors would be eliminated by automated MAR generation; however, prior efforts to obtain funding for a Pyxis system were denied.

Recommendations

1. Develop treatment guidelines and protocols to foster greater consistency and efficiencies that would likely lead to better patient care and shorter lengths of stay. A specific example is medication guidelines, which would ensure sufficient dosing and time for the development of effects. Potential references include American Psychiatric Society treatment guidelines and the NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE).
2. Redesign medication administration so patients get medications on time when the patient, not the whole unit, is ready.
3. While pharmacy "owns" monitoring and compliance, nursing "owns" administration after medications are provided by the pharmacy. These groups need to collaborate on ensuring safe medication practices. As such, nursing must assume greater responsibility for supervising and ensuring safe practices.
4. Pyxis, Omnicell, or comparable equipment should be installed to better control medication distribution and to implement an electronic Medication Administration Records (eMAR).

RESTRAINTS AND SECLUSION

We reviewed documentation on 24 episodes of restraint or seclusion, in open and closed charts. Documentation included the indication for restraint or seclusions and indicated that the prescribed procedural safeguards—including consideration of alternatives, termination when appropriate, physician involvement, and monitoring of patients—were performed in compliance with the Conditions of Participation and the hospital policy.

We did not see, in observation or in medical records, any evidence that restraint or seclusion episodes were not recognized as such. The previously reported problems of "prn" medications for behavioral control and Intensive Treatment Protocol have been discontinued.

There were deficiencies related to the management oversight of restraints and seclusion. Notably, incomplete restraint information is collected by the organization in the QAPI program. For example, there is no monitoring conducted that would facilitate a reduction in the use of restraints or seclusion. Additionally, we were unable to verify that all staff members were appropriately trained in restraint and seclusion procedures because personnel records did not include documentation of an employee's or contractor's participation in such training. Training documents indicated that the curriculum was inclusive of the required elements as defined in the hospital policy.

As noted in a prior CMS report, we did not observe changes in treatment plans as a result of restraint or seclusion episodes, although we did observe restraint and seclusions discussed in team meetings. As mentioned elsewhere in this report, treatment plans are rarely changed in response to positive or negative events, a deficiency that needs to be corrected.

Recommendations

1. Improve the comprehensiveness and goals for reviewing restraints and seclusion episodes within the QAPI program. In addition to assuring compliance, look for opportunities to reduce the use of restraints and seclusion.
2. Integrate review of the video into staff self-evaluation of restraint and seclusion episodes.

3. Ensure that all employees and contract staff have been trained and are competent in the Restraint and Seclusion policy and procedures. Ensure that documentation is in each person's personnel folder.
4. Modify treatment plans after restraint and seclusion episodes to reflect the need to alter treatment to reduce future episodes.

STAFFING RESOURCES AND TRAINING

The hospital has an adequate number of psychiatric staff members, including subspecialties. The facility, however, maintains limited medical capabilities and therefore has limited medical staffing. As a result, they rely upon the 911 system, and their ability to support patients is limited until an ambulance arrives. This situation may be acceptable if the frequency and results of serious medical events were low and well-managed; however, serious medical events are not tracked in the QAPI program.

The hospital has a sufficient number of nurses. However, there is no staffing adjustment based on acuity, and many nurses are participating in non-patient care activities. We believe that we can shift resources to provide more hours of patient care by shifting assignments within the existing resources.

The hospital also has an adequate number of non-professional clinical staff position. However, there is high turnover rate in certain positions, and agency staff is used to fill vacancies. This rate of turnover requires that a significant amount of resources be directed to orientation. The turnover rate also means that as behavioral health technicians (BHTs) develop experience, they subsequently leave, often to other parts of the state system.

Part of the value of a good training program is to enable people to integrate their experience with explicit knowledge, thereby generating new learning and insights. The new learning enables better performance. This positive outcome, however, is hindered by turnover, leading to training problems and a reduction in staff experience.

Management presented to us their plan for redesigning the roles of non-professional clinical staff that are part of the care team. The plan involves creating career ladders and better integration of different roles into a unified unit structure. We support their plan and will assist them in making the outlined changes.

Rehabilitation services are provided by contractors, but ASH does not monitor contractor performance and compliance. For adolescent patients, the contractor provides speech, occupational, and physical therapy. Another contractor provides occupational therapy for adults; however, there is no contractor for speech and physical therapy for adults. Additionally, there is no monitoring of rehabilitation therapy for timeliness, effectiveness, or other care-related process or outcome measures.

The campus of the facility is large, occupied by a patient population that is rough on both the facilities and equipment. According to staff, the Plant Operations staff comprises approximately ten FTEs. We recommend that an additional five FTEs be assigned to this department to ensure the monitoring of Life Safety Code compliance. This number was calculated using a 1 FTE:20,000 sq. ft. ratio. Although this ratio may be lower than the ratio at some other facilities, it seems appropriate given the facility age of the older buildings and the risks and behaviors of the patient population.

Recommendations

1. Adjust nursing staffing for acuity and census.
2. Integrate into QAPI program a review of medical emergencies to determine whether addition medical physicians are needed.
3. Modify nursing practice to provide more therapy, and monitor nursing therapy time.

4. Develop contract for adult rehabilitation services.
5. Integrate rehabilitation services into the QAPI program.
6. Add an additional five FTEs in Plant Operations to meet the facility's maintenance and Life Safety Code compliance needs.

MANAGEMENT OF TRAINING AND COMPETENCY

During our assessment, we found evidence that ASH provides many types training to staff. However, management of training and staff competency seemed inadequate. We were told that there were no consequences to not having completed the required training or current competencies. Of greater significance is that the personnel records did not contain information about training and competencies. We could not find evidence that competencies were managed to ensure that all requirements were met. This absence of training and competency records included employees, contractors, and agency staff.

Recommendations

1. Design process to monitor personnel training. Ensure that "refresher" training is scheduled and occurs on the set schedule. Develop capability to prevent employees from working if their competency requirements lapse.
2. Implement reorganization plans for non-professional clinical staff, and monitor effect on staff retention. Efforts need to be undertaken to eliminate use of agency staff and entice BHTs to extend their service at ASH.
3. Evaluate alternative nursing staffing models to accommodate acuity levels and volumes.
4. Contract for adult speech and physical rehabilitation services.
5. Monitor rehabilitation services to ensure quality, including timeliness, effectiveness, and that all patient needs are being met.

ATTITUDE TO PATIENT CARE

Staff members express a genuine interest in providing better patient care. However, this attitude does not consistently result in therapeutically oriented behaviors. We were told that staff members often perform tasks that patients should do for themselves because it is "easier." Similarly, we developed some concern that staff is often more focused on behavioral control than providing therapy. We believe this focus is not intentional but a by-product of an unmanaged culture.

Similarly, we believe that there are blind spots about unacceptable behaviors. For example, we observed a patient being washed in a non-private location (blinds were open until the staff saw observers). While we believe that these behaviors represent "blind spots" rather than deliberate attempts to ignore patient rights, the behaviors are unacceptable. As will be discussed in the Root Cause Analysis, we believe these behaviors arise from a cultural norm that views intervention, whether by team member or manager, as conflict and undesirable, rather than necessary to promote optimal performance and organizational integrity.

Recommendation

1. Develop planned cultural change to promote better alignment of behaviors with values.

THE QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT PROGRAM

In assessing the impact of the QAPI program on hospital operations, it is clear that the program contributes little, if anything, to the organization. The QAPI program, as it currently operates, does not provide a framework for managing process and team performance. The structure of the QAPI program is rudimentary, providing little guidance as to how measures are selected, how projects are prioritized, and how to design and implement projects. Measures are specified, although the rationale for selecting the measures is not documented. While all parts of the hospital are included in the program, hospital-wide indicators are more prevalent than monitors specific to varying patient populations. Our team was surprised that certain indicators that we considered important to ensuring compliance—such as in the areas of restraint documentation—were not measured. Data are presented in a manner that enables trend identification over time or by location. However, there was no system for gathering data that could be used to assess performance of members of the medical staff.

ASH has a policy on reporting occurrences and sentinel events, but it is widely accepted that significant underreporting occurs. We reviewed some well-investigated events but found that there was no mechanism to ensure that the recommendations were implemented.

The principal problem with the QAPI program lies in its ineffective operation. This opinion is grounded in the number of examples we found of data not being acted upon, even though the results were not acceptable and show opportunity for improvement. Commitment and capabilities are more important than structure in promoting operational success.

The failure of the program is a consequence of the many factors that generate organizational culture. At ASH, the culture is a result of a failure of leadership to engage and lead the QAPI program, as well as executives not knowing how to bring about change within the organization. Although there is a chain of accountability to the Governing Body, reporting responsibility is not sufficient to ensure responsible monitoring of accountability. The Governing Body failed to intervene when data demonstrated persistent problems that management seemed unable to correct.

It is difficult to gauge the number of resources needed to operate the QAPI program, given the observation that actionable data has not heretofore been acted upon. We believe that there are adequate numbers of personnel in QAPI. However, this opinion is hindered by an absence of computerization that impedes efficiency. The Division of Behavioral Health Services is aware of this problem and has begun exploring potential solutions. Another impediment to QAPI is the paper-based medical record that requires manual data collection. Although manual data collection is relatively inefficient, the bigger problem is the degree of randomness in the program's design and operation, especially the persistence of problems that have already been identified. Confusion creates more inefficiencies than a paper-based medical record.

Recommendations

1. A consultant who has developed and operated QAPI programs in psychiatric hospitals will assist in improving the design of the program. These changes will result in further measurement and inclusion of more aspects of care including the performance of contractors. In addition, priority-setting criteria will be developed to guide QAPI organizing activities.
2. Mechanisms need to be developed to monitor the implementation and effectiveness of Root Cause Analyses and other occurrence investigations.
3. The QAPI program should be automated with the assistance of the division, as planned.
4. After the program is redesigned, reevaluate the resources needed to operate the expanded program.

5. Develop training programs to prepare staff and management to organize projects, conduct problem-solving activities, implement changes, and monitor effectiveness.

INFECTION CONTROL AND PREVENTION

The infection control and prevention program needs to be completely recreated. Infection Control is managed by an individual who has never performed infection control prior to her the start of employment at ASH, approximately two years ago. Although she did receive ACIP training, there is no evidence that any aspects of the program were implemented.

Past evidence indicated that the program was in better condition when the last infection control practitioner (ICP) was in the role. Since this ICP left, few—if any—policies have been updated. Additionally, a number of highly important policies, such as the exposure control policy, could not be located. The current ICP does not conduct rounds to observe infection prevention behaviors, and there is no system with the lab to identify positive infection tests. Instead, the ICP relies on the family medicine staff to report positive findings. This system seems unreliable; for example, infection reporting data reveal that in a five-month period, there were no upper respiratory infections. We also observed that there were six skin infections during that time period—the highest number of any type of infection—yet there was no investigation into this data.

Recommendations

1. A consultant who is certified in infection control will direct the redesign of the infection control and prevention program.
2. The ICP needs to be capable of operating the infection control program. If the current staff member cannot be trained to operate the program, ASH will need to hire someone who can.

THE IMPACT OF PATIENT POPULATION CHANGES

In recent years, the patient population admitted to ASH has changed to include more forensic and developmentally disable patients. These changes create the need for different types of treatment and have resulted in difficulties in discharge planning which lead to longer hospitalizations.

Changes in the patient population have been driven by the courts and other non-clinical factors. The forensic population has increased, and their length of stay is determined by the courts, rather than clinicians. Court orders for evaluation can last for 10 months, and there is a large backlog of requests for forensic evaluation. Some forensic patients may not have treatable psychiatric diagnoses (e.g., personality disorders) but remain at ASH against the wishes of the clinical staff. Thus, patients who have no acute psychiatric diagnosis requiring acute hospitalization may be placed in the hospital for prolonged durations. The presence of these numerous forensic patients who do not have treatable psychiatric disorders creates behavioral problems as well as problems for developing treatment programs for the acutely ill patients.

When forensic patients are not competent to stand trial, disposition is an issue due to lack of external resources that are willing to accept violent patients. Consequently, these patients remain at ASH for years. These patients have very different needs than do patients with treatable psychiatric disorders.

Similarly, there has been an increase in admissions for developmentally disabled adolescent patients under court direction due to insufficient community resources. The presence of these patients, who lack a treatable psychiatric problem, also creates issues in an acute psychiatric facility.

While the source of this problem is outside the control of ASH, senior management is expected to identify trends as soon as possible in order to help the organization adapt. However, at ASH, senior management did not recognize the changing population and therefore did not address the problem before it was brought to their attention by outside sources.

Recommendation

1. Although a complete remedy to this problem is outside the control of ASH and within the purview of policy-makers in other governmental agencies, senior management needs to build an internal monitoring program to detect changes that affect patient safety and the quality of care provided at ASH.

ROOT CAUSE ANALYSIS

As indicated in the A-, B-, and K-tag reports, there are many standards of care that are not currently being met, along with widespread non-compliance with the Conditions of Participation (CoPs). These deficiencies involve multiple processes and programs, including QAPI, grievances, staff competencies, treatment planning, and infection control.

At the heart of the situation at Arkansas State Hospital, we believe there are two principal deficiencies. First, ASH's management structure is comprised of individuals who have been poorly prepared for their management and leadership roles. In addition, the Governing Body has failed to provide adequate oversight of management. The combination of these two critical deficiencies has led to inadequate management systems and ineffective leadership. As a consequence, inadequate management systems have led to poor identification of problems, inadequate corrective actions, and a lack of managerial accountability. Furthermore, Ineffective leadership has failed to establish an effective culture and guide the organization successfully through a challenging environment.

Figure 1 in **Appendix A** presents a diagram of the conceptual framework developed to illustrate the root causes of the problems at ASH.

FAILURE AT THE SENIOR LEADER LEVEL

All organizations, including ASH, are affected by their environment. Accordingly, the key role of executive leadership is to provide the resources, skills, guidance, and structured activities needed to ensure that the organization is able to recognize and adapt to the internal and external dynamics.

It should be evident that, in the past, the executive leadership fulfilled these important responsibilities. To a large extent, we believe that this deficiency is due to the combination of a failure to select competent executives—as determined by their prior experience—and a failure to provide adequate supervision and coaching to enable these executive to successfully develop into their roles after selection.

Senior executives (and most managers)—with the exception of the interim CEO—have had little to no experience in their respective roles prior to promotion at ASH; they also received little preparation for these roles prior to or upon assuming management roles. In addition, no coaching or systematic development programs have been provided to assist new senior executives in developing the ability to address the challenges of organizational leadership and management. The absence of prior preparedness, along with a lack of coaching, has resulted in widespread deficiencies in knowledge and skills. A critical example of these deficiencies is that, until recently, senior management did not pay attention to, or even have an awareness of, the CoPs.

The lack of managerial development coupled, with a culture of insularity (discussed below), has impeded the senior team's effectiveness in leading the organization through a changing environment. The Chief Medical Officer and Chief Nursing Officer are smart, dedicated, and highly motivated individuals, but a failure to offer developmental support has limited their effectiveness in their roles. Similarly, members of the medical staff have not been cultivated to provide leadership in clinical care, either individually or collectively. As an example, we observed no physician leadership, despite having several physicians in attendance, in a Pharmacy and Therapeutics meeting in which data was presented (as it had been in prior meetings) showing unacceptable results and a lack of improvement over several months.

To remedy these problems, the consultants will work with the senior leadership:

1. To develop the skills necessary to transform the cultural impediments (described below);

2. To design and implement the required processes and programs that comply with regulatory requirements and best practices;
3. To design and implement management systems that will monitor processes and programs;
4. To improve long-term management by ensuring that senior management reinforce the appropriate behaviors necessary to identify and address problems; and
5. To create management training and leadership development programs within ASH to ensure management development within the organization, including appropriate assessment and accountability systems.

FAILURE AT THE GOVERNING BODY LEVEL

The Governing Body is principally responsible for overseeing the Chief Executive Officer and the leadership of the hospital. As observed during our assessment, they have failed to provide that supervision. While we did not investigate the causes for this lack of supervision, we believe that the Governing Body did not understand its responsibilities for overseeing programs such as QAPI and grievances. Faced with the scrutiny that the hospital received from multiple agencies, the Governing Body was slow to intervene with tighter oversight of management.

These statements do not imply that these issues cannot be fixed. Management systems can be developed, and the current management at ASH is fully capable of developing the skills and knowledge required to fulfill these managerial and leadership responsibilities. The interim CEO, unlike his predecessors, is well-prepared to lead the organization. With his leadership, a well-designed corrective action plan, and informed consultants, we are confident that ASH will be able to adapt to comply with the Conditions of Participation.

To remedy these problems with the Governing Body, several changes need to be implemented (although this is not an exhaustive list):

1. The Governing Body needs to be educated about its responsibilities.
2. An annual agenda, with all reporting requirements, needs to developed and adhered to.
3. The Governing Body needs to be trained to better evaluate data that is presented and to be more assertive in intervening when results show unsatisfactory levels of compliance and management has failed to achieve acceptable improvements.
4. The Governing Body needs to oversee the development of a new cultural milieu that will be a principal responsibility of senior leaders.
5. When replacing the interim CEO, the Governing Body needs to develop and adhere to a profile for the CEO that ensures that the qualifications for the job are met.
6. The Governing Body needs to define how it will monitor CEO performance and how it will respond to deficiencies in performance.
7. The Governing Body needs to ensure that top management is reaching outside the local community for information about best practices and standards of care.

The purpose of this improvement project is not to assign blame for past failures but rather to identify factors that continue to influence the organization and must be considered in the development of the corrective action plan. We have chosen to divide these factors into two major categories: internal and external. The internal factors are considered to be within the control of the organization, while external factors are beyond the control of the organization and require adaptation, rather than correction. The

internal factors are primarily cultural elements. We believe that a cultural transformation, as introduced earlier in this report, is the most critical and challenging aspect of the remedial plan.

It is our intention to remedy the internal deficiencies by managing the culture, providing learning (knowledge) and skills training, and redesigning work to promote the desired, and compliant, behaviors and attitudes.

INTERNAL FACTORS

The organized medical staff function does not exist.
Most effective clinical organizations have a medical staff that is actively engaged in establishing standards for clinical care. Whether achieved through the medical staff organization or by a group of a few highly influential physician leaders, physician leaders act collectively to encourage improved performance and high standards.

ASH does not have a history of collective medical staff leadership and action. Individuals do contribute, but there is no cooperative action or shared vision and values. In addition, the medical staff has played a limited role in the QAPI program to promote improvements in clinical performance.

Leadership lacks of awareness of external standards and practices.
The culture at ASH is characterized by a high level of insularity. Most individuals occupying leadership positions have come from inside the organization or from within affiliated governmental organizations in Arkansas. As a result, leaders in the organization do not have connections to external organizations, thus limiting their opportunities to learn from similar facilities in other states.

Although the leadership at ASH is not resistant to learning, seeking insight from a professional network outside of Arkansas is not part of the culture. When asked during interviews how they learn about practices occurring elsewhere, most respondents stumbled to find an answer. This setting of insularity breeds an internal focus, which impedes constructive comparisons with external standards and best practices.

Strong internal boundaries prevent teamwork.
In the past, senior leaders have supported the development of silos within the organization, which resulted in little to no communication across organizational boundaries, as well as limited or absent interdisciplinary planning and communication. Therefore, the organization lacks understanding of how to reach across disciplines to address problems or new situations.

Poor communication was also observed in the interactions with senior and mid-level managers. Individuals in these positions should be able to influence others to adopt new behaviors but instead demonstrate a sense of helplessness. A pervasive attitudes exists about "this is how things are…" with little willingness or courage to challenge the status quo even in the face of glaring evidence that change is needed.

Under a prior Director of Nursing, the nursing staff, in particular, separated itself from other caregivers and rarely interacted with other disciplines or departments. As a result, the nurses have adopted an insular clinical role. They do not participate in group therapy, and they maintain progress notes that are separate from the other clinicians. Furthermore, during our assessment, we were informed that many clinicians do not regularly review nursing documentation because it is additional work. Though there are significant resources devoted to nursing—particularly plentiful nursing management—there is little benefit in patient-care outcomes realized from this investment.

Care should be provided, especially in a psychiatric setting, by an interdisciplinary team with overlapping and complementary skills. Boundaries adversely affect patient care and administrative effectiveness.

Therefore, leaders need to provide the direction and structure necessary to promote collaboration across disciplines as the organization works toward common goals.

Leadership did not reinforce constructive behaviors.
Two observations indicated a historic lack of supportive leadership supportive behaviors. First, we observed several instances in which individuals tried to address problems but were not supported by leadership. Because the effort to bring about change was not supported, relationship conflict emerged between parties that had different positions rather than a constructive, task-related conflict. The academic literature argues that relationship conflict often overrides constructive, task-related conflict when the conflict is not managed. Accordingly, it was made clear that past leaders did not intervene to redirect conflict toward the collaborative correction of problems and instead promoted behaviors that led to destructive relationships.

Similarly, we observed a historic lack of concern related to staff injuries caused by patients. We inquired about how events are handled following an incident that results in injury to a staff member. We learned that the response was exclusively focused on the patient, with no attention to staff (other than the injured person) after incidents of patient violence. No attempt is made to debrief and provide supportive services to staff members who may be traumatized by witnessing an attack on a colleague.

The lack of leadership support demonstrates a lack of concern for coworkers and is an abdication of providing direction in the face of a disruptive event. This absence of leadership support creates a lacking sense of control—the control needed to work in a dangerous psychiatric setting. It also precludes the opportunity to learn from the experience and thereby prevent or deescalate future incidents.

Leaders must provide constant direction to prevent individual responses that might have adverse consequences—especially during a time of crisis.

Data and results are ignored.
The Quality Improvement (QI) effort cannot function without the support of senior leadership. The absence of support for a comprehensive, goal-driven QI plan, coupled with a style of decision-making that does not rely upon data, results in an ineffective QAPI program that repeatedly reports subpar results with little initiative to correct the deficiencies. The issue is a failure of leadership—QI becomes important when senior leaders model the value of continuous improvement. Though many motivated and smart staff members and managers have a desire to remedy the substandard results, the framework and energy needed to propel improvement have been largely absent. Additionally, there has been a paucity of education and development for staff in improvement methodologies and approaches, further compounding the challenge.

The culture's lack of focus on measurement is evident when examining patient length-of-stay and discharge initiatives. Because little value is placed on measureable results, there is also little impetus to efficiently or effectively move patients through care and toward a discharge disposition. Significant attention is placed on managing patients for their safety and generally hoping for good outcomes, without a deliberate process of seeking to move patients toward the goal of treatment. This behavior is not due to a lack of concern or commitment on the part of clinical staff; rather, it is an artifact of a culture of complacency and little accountability for attaining measureable outcomes.

The staff lacks a commitment to results.
As previously mentioned, the staff is committed to patients and to the institution; however, this dedication does not express itself in a commitment to results or success in any definable way. Instead, there is complacency with the status quo. This complacency is the behavioral manifestation of a lack of commitment to results. Familiar patterns are continued, disconfirming information is overlooked, and collaboration manifests itself as the avoidance of conflict.

This cultural element may be one of the most challenging to overcome, but it is critical for establishing a culture of Performance Improvement.

Treatment planning lacks vision and leadership.
The medical staff is assigned responsibility for overseeing the quality of care provided by the Governing Body, to whom they report. This function has not been fulfilled, as there exists a lack of design, measurement, and assessment of treatment effectiveness. Although teams meet to discuss patients, the collaboration seems limited, and the treatment teams seem to follow familiar pathways rather than addressing unique aspects appropriate to specific patients and their needs.

Our evaluation of treatment modalities reveals a significant reliance on medication therapy and group therapy. Groups are facilitated by licensed social workers, and registered nurses do not co-facilitate. Groups are assigned in initial treatment planning, and while group assignment is based on patient need, little attention is given to leveling the group for comparable ability to participate. As a result, the group sessions vary greatly in both quality and the degree of patient participation. We observed group that included patients who were fully unable to participate placed alongside attentive and participatory patients. The therapeutic impact of group participation is likely to be compromised by such a composition of such divergent abilities and levels. The effectiveness of group sessions must be evaluated so that improvements can be made.

Additionally, we were surprised by the apparent absence of one-on-one therapy. Chart reviews provided little evidence that one-on-one therapy sessions occurred, meaning that either such therapy does not occur or that it occurs but is not documented, and is therefore not integrated into the total patient-care management.

Though there is extensive use of psychotherapeutic medications, our consulting psychiatrist had concern that there was variation among practitioners. This variation could be reduced to result in better patient outcomes, if clinical guidelines, built on evidence and professional society recommendations, were developed and adopted.

We also noted that the hospital's data reveal that first-generation psychotherapeutic agents are used more frequently at ASH than at peer hospitals. While this may seem acceptable because the older drugs are comparably effective, it was noted that EPS side effects are underreported. This situation may serve as an additional example of the organization not actively seeking improvement opportunities. Familiar treatment patterns are maintained without regard for side effects that impact patient comfort.

Physician concern for adequacy of patient supervision results in a high frequency of Line-of-Sight assignments and one-on-one staffing, sometimes reportedly for weeks and or months at a time. These repetitive, high-attention assignments increase the risk that staff become inured to patient needs. This staffing pattern also results in greatly increased numbers of staff, usually nonprofessional, as staffing demands increase the use of agency staff—the least oriented or trained to the ASH milieu. As a result, the expense has the potential to lack good value, particularly when contracting for nonprofessional, agency staff. In addition, high-attention staffing may be perceived as providing treatment, while it in actuality provides safety. Patients may benefit from more interaction with clinical professionals.

Although there appears to be ample staff to attend to patient care, few clinicians seem to see caregiving as their primary responsibility. The majority of patient "care" is provided by behavioral health technicians and other nonprofessional staff. Moreover, there is little educational attention paid to entry-level staff once orientation is completed; continuing education is not embraced as an investment for staff development or retention. Registered nurses and licensed social workers appear to spend a significant portion of their day on paperwork, team meetings, and related administrative duties. As a result, patients experience little to no individual therapy. Group therapy and medication management are the treatment modalities of choice, despite a concentrated presence of highly trained clinicians.

As part of the corrective action plan, the medical staff will take ownership of designing, monitoring, and reporting on quality. The use of explicit clinical guidelines will be developed to shape care design. We should note that clinical guidelines inform decision making but do not serve as a substitute for the

clinical judgment necessary to address the unique conditions of individual patients. In fact, we believe that psychiatric care especially requires clinical judgment to address specific patient needs that might not be addressed or met by the guidelines.

EXTERNAL FACTORS

As mentioned previously, ASH's situation has been influenced by uncontrollable changes from external sources. However, the ASH executive team did not assist the organization in adapting to these external drivers of change. As a result, the organization lacked an effective response. When leaders fail to provide effective explanation and direction, individuals are left to develop their responses. Poor coordination and lack of direction resulted in a failure to address and adapt to external challenges.

Adequate financial resources do not exist to provide the standard of care.
Within the legislative process, ASH's needs compete with other state priorities. Many times, requests from ASH for resources were denied. Repeated denial of support is a potential cause of adopting an inward focus (Levy, Paul F. "The Nut Island Effect: When Good Teams Go Wrong". *Harvard Business Review.* March 1, 2001). No example better demonstrates capital constraints than the medication administration process.

The medication administration process is antiquated by modern standards, enabling medication diversion and putting patients at risk of error. The absence of computerized equipment—coupled with a mechanical, non-patient-centered process—exposes patients to untimely receipt of medication, confusion in patient identification, and failures in following high-risk medication procedures. We were told that although funds initially approved for a Pyxis system, which would automate many components of the administration process, the approval was withdrawn.

This denial of funding is a microcosm of the limited support that ASH has experienced. We believe that denying equipment necessary to meet modern standards of care has an adverse psychological effect upon individuals and organizational culture. Individually, one's motivation to identify and fight for causes is diminished whenever one experiences defeat. The loss of motivation is stronger when the pattern of denial is consistent. The mindset becomes, "Why fight for things when you know you are going to be denied?" In addition, one's commitment to discovering and trying to meet evolving standards is diminished if the governing body is not committed to ensuring the standard of care. Collectively, the same message is conveyed to all members of the organization. The feeling of "we can't" becomes more dominant than the desire to make improvements.

It should be noted that we did not find widespread short-staffing. Instead, we believe that a better alignment of staff with necessary functions should prevail. However, certain staffing additions will be needed, especially in rehabilitation services for adult patients. We also believe that ASH can achieve a better allocation of existing resources towards patient care versus administrative positions.

The organization has experienced a slow, unplanned, change in mission.
Without planning or coordinated action, the mission of the hospital changed due to an external party altering the patient population. This action was not performed as part of the state legislative process but instead arose as a consequence of court actions regarding individuals. The court system, for various reasons, has increased the number of forensic patients sent to the ASH for evaluation; many of these patients did not have acute psychiatric illnesses. Unfortunately, the ASH executive team did not recognize the impact of this change, including non-clinically driven length-of-hospitalization and treatment requirements for patients who do not have acute psychiatric disorders. The addition of longer-stay, non-psychotic patients resulted in different dynamics in the forensic units, which required different treatment and behavior-management challenges relative to acutely ill patients.

In the fall of 2010, another change occurred as severely developmentally disabled adolescents were admitted to ASH. This population requires a very different treatment plan than the existing adolescent population. Unprepared for this population, ASH experienced failures in treatment planning.

To address the problem of unidentified and unplanned changes, senior management will need to develop a regularly occurring discipline of "internal surveillance." In the course of routine operations, it is easy to "lose the forest for the trees"—it takes special effort to take a step back and try to develop new patterns. This discipline requires setting aside time to reflect on data, not from a perspective of problem-solving, but from a perspective of evaluating what is new or different.

LIST OF RECOMMENDATIONS[1]

OPERATIONAL CHANGES

1. Change the attitude that treatment planning is about documentation; it should be seen as organizing care to meet a patient's needs. Make treatment plans an integral part of treatment.
2. Physicians need to show more consistent leadership in treatment planning.
3. Customize treatment plans to patient needs and update when the patient situation requires changes, such as following restraint or seclusion episodes. Include family therapy when appropriate.
4. Redesign treatment plan forms if the process is an impediment to optimizing treatment planning.
5. Nurses should be involved in providing treatment.
6. Define explicit expectations in terms of how staff work together and how staff treats patients. These expectations should be built into staff education and competencies.
7. Develop treatment guidelines and protocols to foster greater consistency and efficiencies that would likely lead to better patient care and shorter lengths of stay. A specific example is medication guidelines, which would ensure sufficient dosing and time for the development of effects. Potential references include American Psychiatric Society treatment guidelines, and the NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE).
8. Redesign medication administration process so patients get medications on time when the patient, not the whole, unit is ready.
9. While pharmacy "owns" monitoring and compliance, nursing "owns" administration after medications are provided by the pharmacy. These groups need to collaborate on ensuring safe medication practices. As such, nursing must assume greater responsibility for supervising and ensuring safe practices.
10. Install Pyxis, Omnicell, or comparable equipment to better control medication distribution and to implement an electronic Medication Administration Records (eMAR).
11. Adjust nursing staffing for acuity and census. Monitor to ensure that staffing model is used consistently.
12. Modify nursing practice to provide more therapy and monitor nursing therapy time.
13. Develop contract for radiology services that includes credentials and quality monitoring requirements.
14. Develop contract for adult rehabilitation services.
15. Hire five additional FTEs in Plant Operations staff, based on space and patient population considerations.
16. Revise policy to ensure that medical records are returned within 24 hours of discharge.
17. Update nursing policies, and maintain timeliness requirement for review.
18. Revise policy to prevent accepting "po or IM" orders, and monitor compliance.
19. Revise policy on verbal orders to define when and how orders are used (e.g., limitations as to type of drug).

[1] Excluding recommendations listed in the Life Safety Code section.

20. Implement monitoring of timeliness and content quality of history and physicals.
21. Review practices to ensure records are completed within time frame. Develop tracking system.
22. Develop process to have new orders reviewed by a pharmacist at all times.
23. Submit dietary manual to medical staff for approval.
24. Manage the environmental services vendor to improve the cleanliness of the facility.
25. Prohibit patient and staff food items from being stored in the same refrigerator.
26. Because people are using their hands to put a scoop into the ice chest, establish a cleaning schedule, and monitor to ensure that schedule is followed.
27. To avoid sharps injuries, the sharps containers must be secured wherever they are used in the hospital.
28. Integrate lab reporting into infection identification process.
29. Develop a log of infections.
30. Update Infection Control policies and assure compliance with CoPs and best practices. Add policies such as exposure control, use of disposable equipment, cleaning patient care and non-patient care areas.
31. Integrate review of the video into staff self-evaluation of restraint and seclusion episodes.

PATIENT RIGHTS

1. Post notice on patient rights.
2. Ensure the Important Message from Medicare is delivered within two days of discharge.
3. Revise complaint and grievance policy and procedure.
4. Monitor compliance with grievance policy, and report to Governing Body each quarter.
5. Include notice in admission policy that physician may not be on-site 24/7.
6. Develop policy on advance directives, and monitor compliance.
7. Develop procedures to ensure compliance with patient's right to appeal premature discharge.
8. Develop staff education material about protecting patient rights. Use numerous examples in training.

QAPI PROGRAM

1. Revise program document to include more direction about setting priorities, methodology for fixing problems, reporting results, and accountability.
2. Provide education to hospital staff, not just QAPI staff, so they can implement the program effectively.
3. Integrate into QAPI program a review of medical emergencies to determine whether addition medical physicians are needed.
4. Improve the comprehensiveness and goals for reviewing restraints and seclusion episodes within the QAPI program. In addition to assuring compliance, look for opportunities to reduce the use of restraints and seclusion.

5. Integrate grievance policy monitors into QAPI program.
6. Develop monitors for all clinical contractors.
7. Develop medical staff monitoring process to provide information that can be used for appraisal of privilege competence.
8. Integrate rehabilitation services into the QAPI program.
9. Implement monitoring process for Environmental Services.
10. Redesign and implement a new Infection Control program that complies with best practices.
11. Integrate reconciliation into QAPI to achieve full 100% understanding of the reasons why medications were not used.
12. Integrate wastage documentation problems into QAPI process.
13. Integrate timeliness and lost specimens for lab services into QAPI program. Monitor compliance of lab vendor with CAP or TJC accreditation and proficiency testing.

LEADERSHIP AND MANAGEMENT

1. Engage leadership in QAPI process, and demonstrate leadership in addressing problems. The consultants will work with the interim CEO to provide training and coaching assistance to managers.
2. Teach management what to monitor, how to assess measures, and strategies for interventions and corrective action.
3. Ensure that all employees and contract staff have been trained and are competent in the Restraint and Seclusion policy and procedures. Ensure that documentation is in each person's personnel folder.
4. Implement reorganization plans for non-professional clinical staff, and monitor effect on staff retention. Efforts need to be undertaken to eliminate use of agency staff and entice BHTs to extend their service at ASH.
5. Define and implement cultural changes that expand upon the existing expressed values of caring for patients and a sense of family. The new cultural elements will include actively seeking problems so they can be fixed, using performance measurement as a source of institutional pride, permitting task conflict without relationship conflict, and fostering shared and mutual accountability.
6. Develop an internal monitoring program to detect changes that affect the quality of care provided.
7. Develop a system for CMO oversight and evaluation of services.
8. Notify medical staff and clinical areas when medical staff privileges are granted or reapproved.
9. Develop scope and complexity statement for radiology services, to be approved by medical staff and Governing Body.
10. Develop scope and complexity statement for rehabilitation services, to be approved by medical staff and Governing Body.
11. Revise UR policy to detail how to address determinations that services are not medically necessary.
12. Add system-level studies of utilization to UR program.

13. Begin a process for computerizing QAPI data (including infection control and prevention).
14. Contract with a nurse with a master's degree in psychiatric nursing to consult with Director of Nursing as required in CoPs.

GOVERNING BODY

1. Develop well-defined reporting requirements, including formats and key questions to be answered, an agenda for the important programs, and projects that should report to the Governing Body. These requirements will ensure that Governing Body oversees medical staff oversight, grievances, and contract services.
2. Coach the Governing Body to take an activist role in assessing CEO and organizational performance and intervening constructively to promote desired outcomes.
3. The Governing Body or its executive committee should meet to monitor performance more frequently than quarterly, at least until stable acceptable results are achieved.
4. Ensure that all contracts include quality performance measures and that these measures are monitored and reported to Governing Body.
5. Develop a list of contractors, their quality requirements, and date quality reports are due.

APPENDIX A

Root Cause Analysis