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Riverview Psychiatric Center–Primary Avenues for Reporting Incidents and Concerns Generally Effective in Ensuring Timely Attention of Appropriate Authorities; Inconsistencies in Policy, Practice and Documentation Noted; Some Reported Metrics May Be Unreliable, April 2016

Office of Program Evaluation & Government Accountability

Maine State Legislature

FINAL REPORT

Riverview Psychiatric Center–Primary Avenues for Reporting Incidents and Concerns Generally Effective in Ensuring Timely Attention of Appropriate Authorities; Inconsistencies in Policy, Practice and Documentation Noted; Some Reported Metrics May Be Unreliable

Report No. SR-RPC-14

Issues OPEGA noted during this review:

- Some of RPC's policies do not reflect current reporting practices and/or lack clarity, consistency, and up-to-date terminology. (pg. 33)
- Some sections of the Incident Report forms are not completed on a consistent basis. (pg. 34)
- Insufficient documentation exists to monitor adherence to notification and timeline requirements for patient grievances and sentinel events. (pg. 35)
- There is a lack of clarity around RPC staff responsibilities for the mandatory reporting of incidents of abuse, neglect or exploitation. (pg. 36)
- There is a lack of documentation available to systemically monitor violations of the policy governing staff behaviors. (pg. 38)
- Formal, documented administrative follow-up on reported incidents appears inconsistent. (pg. 39)
- The incident report database used to generate performance metrics for reports to external authorities may not have captured all reportable events. (pg. 40)
- RPC's process for categorizing reportable events and causal factors results in two performance metrics being unreliable. (pg. 42)
- RPC continues to address significant, on-going staff shortages and employee concerns related to the overall work environment. (pgs. 44 and 46)

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

April
2016

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Acronyms Used in This Report

ADON – Assistant Director of Nursing
AFSCME – American Federation of State, County and Municipal Employees
AMHI – Augusta Mental Health Institute
ANE – Abuse, Neglect, or Exploitation
APS – Adult Protective Services
BHR –Bureau of Human Resources
CMS – Centers for Medicare and Medicaid Services
CNA – Certified Nursing Assistant
DDPC – Dorothea Dix Psychiatric Center
DHHS – Department of Health and Human Services
DLRS – Division of Licensing and Regulatory Services
DOL – Department of Labor
GOC – Government Oversight Committee
HITech Manager – Health Information Technology Economic and Clinical Health Manager
HR – Human Resources
IQI – Integrated Quality Improvement
MHRT-1 – Mental Health Rehabilitation Technician-1
MHW – Mental Health Worker
MSEA – Maine State Employees Association
NOD – Nurse on Duty
NRI – National Association of State Mental Health Program Directors Research Institute, Inc.
OPEGA – Office of Program Evaluation and Government Accountability
PSD- Program Services Director
RCA – Root Cause Analysis
RM – Risk Manager
RPC – Riverview Psychiatric Center
SAMHS – Substance Abuse and Mental Health Services
SET – Sentinel Events Team
TJC – The Joint Commission

Riverview Psychiatric Center–Avenues for Reporting Incidents and Concerns Generally Effective in Ensuring Timely Attention of Appropriate Authorities; Inconsistencies in Policy, Practice and Documentation Noted; Some Reported Metrics May Be Unreliable

Introduction

RPC is one of two psychiatric hospitals operated by DHHS. In 2014, the GOC tasked OPEGA with a review of RPC as a result of concerns raised by current and former employees.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of the Riverview Psychiatric Center (RPC). OPEGA performed this review at the direction of the Government Oversight Committee (GOC) for the 126th Legislature.

RPC is one of Maine's two State-operated psychiatric hospitals and the only one with a forensic unit. RPC is the responsibility of the Department of Health and Human Services (DHHS). The DHHS Commissioner named a new Superintendent of the hospital in March 2014. The hospital reports publicly to various external entities with oversight responsibilities.

In August 2014, the GOC considered a request for a review of RPC initiated by current and former RPC employees. The GOC added this review to OPEGA's Work Plan in late September 2014 and gave it priority status. OPEGA had conducted considerable work on the request to understand, delineate and triage the myriad concerns raised by multiple complainants. Requestors, and other RPC staff OPEGA heard from, reported incidents and conditions at RPC that presented risk of harm to clients and staff including:

- mistreatment of clients;
- inadequate response to reported incidents;
- unprofessional behavior on the part of staff and management;
- poor supervisory and working relationships; and
- lack of clarity regarding roles and responsibilities.

OPEGA's review focused on avenues available for staff and patients to report incidents and concerns, and the extent to which reported concerns are addressed. We also assessed accuracy and reliability of reported performance measures for the hospital.

OPEGA's review focused primarily on the effectiveness of reporting avenues available to staff and patients and the extent to which reported incidents and concerns are addressed appropriately by responsible parties. We also assessed the accuracy and reliability of performance metrics related to patient treatment and staff and patient safety that are reported by RPC to oversight entities.

OPEGA's work included an extensive review of relevant written RPC policies and procedures, interviews with randomly selected direct care staff and review of documentation and records associated with a randomly selected sample of reported incidents and patient grievances for the period July 2014 through June 2015. See Appendix A for complete scope and methods.

Questions, Answers and Issues

1. To what extent are reporting avenues (staff and patients) effective in ensuring timely and appropriate responses to incidents and concerns affecting patient treatment and the working environment?

See pages 8 - 12 for more on this point

OPEGA identified six key reporting avenues internal to RPC and DHHS for patients and staff to report incidents and concerns, particularly those impacting staff and patient safety and patient treatment and rights. These avenues encompass reporting of:

- incidents;
- staff behaviors;
- abuse, neglect or exploitation;
- workplace injuries;
- sentinel events; and
- patient grievances.

The reporting obligations and procedures for each of these avenues are defined within several written RPC policies. Some are also specified in State statute, related Rules and/or the Consent Decree. Incidents of abuse, neglect or exploitation, as well as workplace injuries, are reported internally through the incident reporting avenue and also have other concurrent reporting requirements.

For five of the six reporting avenues we reviewed, the reporting is done via completion of a specific form, or other formal documentation, that captures details about the incident or patient grievance, with internal distribution of that documentation to RPC's Risk Manager, various management levels within RPC and/or the Director of Human Resources. Certain types of incidents are also reported via formal processes and documentation to other DHHS agencies with responsibility for investigation as appropriate.

Although we noted issues with the quality of the written policy guidance available, we found staff was generally well aware of current reporting expectations, requirements, processes and procedures for all six reporting avenues. We also found that staff and managers have generally been adhering to the current expected reporting processes for the five avenues with formal documentation, based on review of that documentation for the period July 2014 through June 2015. Consequently, we determined that these five avenues should currently be effective in bringing incidents and concerns to the timely attention of individuals in positions of authority within RPC and DHHS for review and subsequent action if necessary.

The sixth reporting avenue was for reporting violations of a policy governing staff behavior and professional conduct. According to the policy, violations are to be reported to direct supervisors or others in the chain of command. There is no formal documentation required and little guidance in the policy as to whether, when, or to whom particular types of behaviors should be escalated. Response to issues and concerns reported by staff are at the discretion of the supervisor or manager receiving the report. Additionally, staff may not feel comfortable reporting on their co-workers or through the chain of command. Consequently, there is risk that violations of a more serious or recurring nature may or may not receive timely review and action by the appropriate levels of management.

2. To what extent are reports of incidents and professional concerns addressed appropriately by responsible parties?

See page 12 for more on this point

The completed forms and supporting documentation OPEGA reviewed for the five reporting avenues with formal documentation typically described any actions taken by RPC staff at the time of the incident, or at the time staff became aware of the incident. Workplace injury report forms and patient grievance forms also typically captured descriptions of next steps or proposed resolutions, though there was no indication of any follow-up to ensure the planned or agreed to actions were taken.

We observed that there were multiple opportunities for incidents and concerns reported through these five avenues to be brought to the attention of multiple individuals in positions with ability and authority to initiate further actions. We noted:

- RPC management is made aware of incidents, injuries and potential violations of patient rights through the review of Incident Reports in the daily morning management meetings and has both the opportunity and authority to assign follow-up actions and/or make systemic changes. Regular attendees of the management meetings that OPEGA spoke with described reviewing Incident Reports at this meeting and indicated that follow-up actions are sometimes assigned to Nurse IV's for the units as a result. There is, however, no formal documentation of specific Incident Reports reviewed at the morning meetings or of any follow-up actions assigned.

- Certain types of incidents require notifications to various parties including patients' families and appropriate external agencies, some of whom have a role in ensuring or advocating for patient safety. Though the documentation of these notifications is somewhat inconsistent, it does appear these notifications are being made.

- Clinical responses to incidents involving patients are addressed through required safety meetings and regular treatment team meetings that happen concurrently, but independently, from the reporting processes. According to RPC, there is documentation of these meetings, and the clinical responses implemented, within patient files and records. OPEGA did not seek to review this documentation given the sensitivity to confidentiality of patient records and the resources RPC would have needed to expend to provide it to us. However, regular attendees of safety and treatment team meetings that OPEGA spoke with described being aware of incidents involving patients, exploring root causes and making adjustments to patient treatment plans as deemed necessary.

RPC also conducts formal, documented follow-up in the form of fact findings, root cause analyses and investigations for certain types of reported incidents. Based on our understanding of when follow-up is expected to occur, it appears there is inconsistency between expected and actual practice. We did not find many instances of documented fact findings or other follow-up by the Risk

Manager associated with the sample of Incident Reports we reviewed, though the sample included 59 events that appeared to meet the criteria for potential follow-up. We also noted that fact findings had been conducted for some patient abuse events in our sample, but not conducted for others.

We also noted that there is opportunity for RPC to more effectively use the information collected via the various reporting avenues to identify trends, themes or recurring situations that may represent issues and risks that should be addressed on a more systemic level. RPC describes monitoring performance metrics, conducting ad hoc analyses and informally monitoring for trends. However, a more formal, ongoing process for analysis and review of data could provide additional insight into root causes of incidents that could be acted on to avoid recurrence of these events.

3. To what extent are data and performance metrics reported by RPC to oversight entities accurate and reliable?

See pages 12 - 14 for more on this point

OPEGA reviewed five selected performance metrics published in RPC's Quarterly Performance Reports related to patient and staff incidents that presented a risk for injury or a rights violation. These metrics were:

- Seclusion Hours;
- Restraint Hours;
- Factors of Causation for Seclusions;
- Factors of Causation for Mechanical Restraints; and
- Patient Abuse, Neglect, Exploitation, Injury or Death.

All of these metrics, as well as many others reported in the Quarterly Reports, are generated from Incident Report data captured in a component of MEDITECH, the electronic health record system.

Through our testing, OPEGA discovered five Incident Reports with reportable events that appear to have not been captured in MEDITECH. RPC subsequently explained that they believed these records had been entered but were not saved because of a computer update to MEDITECH that RPC was unaware was causing problems.

RPC has provided evidence from the vendor that a fix for the computer update has been made and that the issue in question affected 209 reportable events. However, additional description of the computer update issue that OPEGA has received from the vendor still leaves it unclear as to whether this computer update is the cause of the deficiency OPEGA identified or whether there was an impact on reported metrics. We also still lack details needed to assess the potential scope and magnitude of the issue. Consequently, metrics published in RPC's Quarterly Performance Reports have potentially been inaccurate and unreliable, but we cannot say for how long or to what extent.

OPEGA also found that the metrics for Factors of Causation and Allegations of ANE lacked reliability and/or meaning due to the criteria or process applied in determining what should be reported for those metrics. RPC's application of criteria for the Allegations of ANE metric apparently results in the exclusion of cases of witnessed abuse, which are also not captured in any other reported metrics. Additionally, OPEGA observed that RPC's process for assigning Factors of Causation to seclusion and restraint events, by default, always assigns a cause considered acceptable under the Consent Decree. This effectively results in RPC automatically being 100% compliant with the Consent Decree in its justifications for seclusion or restraint and does not allow for causes that may be out of compliance.

4. Are there other areas of concern OPEGA should review that are unaddressed by or further identified as a result of work by oversight and regulatory bodies currently in progress?

See pages 44 - 49 for more on this point

Several concerns emerged from OPEGA's work that were outside the scope of this review. These included staffing concerns and related issues that had also been identified, and are being addressed, as part of the Court Master's ongoing efforts to monitor RPC's compliance with requirements of the Consent Decree Settlement Agreement. The Joint Standing Committee on Health and Human Services, as well as the GOC and OPEGA, have been monitoring the Court Master's efforts, and DHHS responses, to these issues since October 2014 and continue to do so.

The other concerns that emerged appear closely correlated with overall workplace environment and culture issues reflected in the 2013 and 2014 DHHS Employee Engagement Surveys for RPC. RPC and DHHS report having taken, and continuing to take, a number of actions to address areas identified as needing significant improvement. Those areas included:

- Managerial Environment – encompasses communication, approachability and trustworthiness of management, treatment of employees by management and the atmosphere fostered by management;
- Organizational Connectivity – encompasses executive leadership understanding and value of employee contributions and communications from DHHS as a whole; and
- Office Environment – encompasses accountability of co-workers for their actions and co-workers treatment of each other.

OPEGA recommends that the Health and Human Services Committee, as well as the Court Master and GOC as appropriate, continue to specifically monitor RPC's efforts and progress in addressing these areas. We do not suggest any further work be performed by OPEGA at this time other than assisting the Committees in their oversight efforts.

OPEGA identified the following issues during the course of this review. See pages 33 - 49 for further discussion and our recommendations.

- Some of RPC's policies do not reflect current reporting practices and/or lack clarity, consistency, and up-to-date terminology.
- Some sections of the Incident Report forms are not completed on a consistent basis.
- Insufficient documentation exists to monitor adherence to notification and timeline requirements for patient grievances and sentinel events.
- There is a lack of clarity around RPC staff responsibilities for the mandatory reporting of incidents of abuse, neglect or exploitation.
- There is a lack of documentation available to systemically monitor violations of the policy governing staff behaviors.
- Formal, documented administrative follow-up on reported incidents appears inconsistent.
- The incident report database used to generate metrics for reports to external authorities may not have captured all reportable events.
- RPC's process for categorizing reportable events and causal factors results in two metrics being unreliable.
- RPC continues to address significant, on-going staff shortages and employee concerns related to the overall work environment.

Riverview Psychiatric Center Overview

RPC is a 92 bed acute care inpatient psychiatric hospital operated by the State. About 44 of the beds are typically dedicated to forensic patients and 48 beds for civil patients.

The Riverview Psychiatric Center (RPC) is a 92 bed acute care inpatient psychiatric hospital, operated by the State of Maine, under the Department of Health and Human Services (DHHS). RPC is located in Augusta and provides treatment for adults with serious, persistent mental illness and co-occurring substance use disorders that require 24-hour psychiatric services. RPC is also the State's only forensic mental health hospital, providing a wide range of psychiatric services to the correction system and the Maine court system, including care for those committed under the criminal statutes for observation and evaluation, those determined Incompetent to Stand Trial and those committed to the State as Not Criminally Responsible. These individuals require highly specialized programs of both psychiatric care and security not available elsewhere in Maine. Currently, of the 92 beds available in the hospital, RPC typically has 44 beds designated for the forensic population, and the remaining 48 are civil beds.

Multiple entities, both within and external to DHHS, oversee RPC in various capacities.

Multiple agencies oversee RPC in various capacities. The Maine DHHS Division of Licensing and Regulatory Services (DLRS) is the certification and survey agent for the Federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). DLRS also has survey and licensure responsibility for state-licensed hospitals. RPC was formerly certified by CMS, which administers the Medicare program and works in partnership with State governments to administer Medicaid. RPC also receives accreditation through The Joint Commission on Accreditation of Healthcare Organizations (TJC), the national accrediting body for

hospitals. TJC accreditation demonstrates compliance with national standards for health care quality and safety in hospitals.

Maine statute requires all hospitals, including RPC, to comply with DHHS Chapter 112 Rules for the Licensing of Hospitals.

Maine Statute requires all hospitals, including RPC, to comply with DHHS Chapter 112 Rules for Licensing of Hospitals. Licensees must report suspected abuse, neglect, or exploitation (ANE) within 24 hours. RPC reports these types of events to DHHS Adult Protective Services (APS). The Department is responsible for investigating reports of ANE of incapacitated or dependent adults. Additionally, DLRS may investigate complaints, incidents and suspected non-compliance in order to protect patients from ANE and inadequate care or supervision, as well as to determine compliance with Chapter 112 Rules.

RPC is also subject to requirements of the Consent Decree Settlement Agreement for Maine's comprehensive mental health system. The Agreement specifies standards to ensure quality treatment is being provided. Compliance with standards is overseen by the Court Master.

RPC is subject to the requirements of the Consent Decree Settlement Agreement (Consent Decree), which was the result of a class action lawsuit brought on behalf of residents at the Augusta Mental Health Institute (AMHI), the former State psychiatric hospital. The Consent Decree is a legally binding agreement that requires the State to establish and maintain a comprehensive mental health system. Standards described throughout the agreement must be met to ensure quality treatment is being provided. Compliance with these standards is overseen by a court appointed special master (Court Master) who reports to the court. The State is continually held accountable by the court for ongoing compliance with requirements of the Consent Decree.

As a requirement of the Consent Decree, patient advocates are made available to RPC class members. Disability Rights Maine provides full time on-site mental health patient advocacy services at RPC. Patient Advocates are made accessible to patients, and advocates receive copies of reports of allegations of patient ANE, sentinel events and patient grievances. Rules promulgated by DHHS, which are applicable to RPC, include the Rights of Recipients of Mental Health Services, which directs mental health providers to notify patients of their right to receive advocacy services.

RPC publishes the Quarterly Report on Organizational Performance Excellence which describes RPC's status on compliance with regulatory standards and organizational process improvement efforts. The publicly available reports are distributed to various external oversight entities.

RPC publishes the Quarterly Report on Organizational Performance Excellence which describes RPC's status on compliance with regulatory standards and organizational process improvement activities. This quarterly publication is comprised of three sections. The first section reflects performance measures related to the Consent Decree. The second section describes the hospital's performance with regard to Joint Commission performance measures. The third section reports departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. The Quarterly Reports are distributed to the Court Master for the Consent Decree and TJC, and they are made available on the RPC website.

RPC's IQI Department evaluates, monitors and analyzes data for areas of high risk. The Risk Manager reviews all reported incidents at RPC to ensure required documentation is completed and proper notifications are made.

The IQI department of RPC ensures hospital-wide performance improvement in patient care and outcomes. The IQI department evaluates, monitors and analyzes data pertaining to areas of high risk within RPC. This department includes the areas of clinical risk management, utilization review, medical staff credentialing and hospital-wide performance improvement.

The IQI department's Risk Manager reviews all incidents occurring at RPC to assess incidents for risk. The Risk Manager ensures all required documentation is completed and proper notifications within the hospital and to external agencies are made. The Risk Manager also follows up and investigates incidents if more information is needed.

OPEGA's Approach and Overall Results

Selecting Reporting Avenues for Review

OPEGA identified 14 reporting avenues available to staff and five available to patients. We selected six for a more in-depth review. Each of the six is established, or referenced, in written RPC policies.

OPEGA defined "a reporting avenue available to staff and patients" as a place, person or process in which an individual staff member or patient can directly report an incident or concern. OPEGA identified and catalogued such reporting avenues by reviewing RPC and DHHS policies, DHHS agency rules, applicable State statutes, the Consent Decree and federal regulations. We identified 14 reporting avenues available to staff and five avenues available to patients. We selected six reporting avenues for in-depth review, based on the extent to which each avenue:

- is critical to ensuring timely and appropriate responses to incidents and concerns affecting patient treatment and the working environment;
- addresses matters of urgency or severity affecting the safety of patients and/or staff;
- is accessible to patients and/or staff; and
- requires some type of documentation (to facilitate review).

OPEGA selected the following six reporting avenues for further review. Each of them is established, or referred to, in written RPC policies:

- reporting incidents (PC.3.10.4 Incident Reporting);
- reporting staff behaviors (LD.4.40.3 Behaviors that Undermine a Culture of Safety);
- reporting abuse, neglect or exploitation (PC.3.10.2 Allegations of Client Mistreatment Including Abuse, Neglect or Exploitation);
- reporting workplace injuries (HR.38.0 Work-Related Injuries – Illnesses);
- reporting sentinel events (PI.2.30.1 Sentinel Events Policy); and
- filing patient grievances (RI.2.120 Patient Concern/Suggestion/Grievance).

The reporting avenues serve several purposes including:

- complying with government regulations and Consent Decree requirements;
- assisting management in identifying safety risks;
- ensuring those in positions of authority have information to take action as warranted; and
- providing data for monitoring trends and generating performance metrics.

These reporting avenues have several purposes. First, they are designed to comply with State and federal regulations and Consent Decree requirements. Second, they assist management in identifying situations that may pose risk to patient and staff safety. Third, they ensure that those in a position of authority have the necessary information to determine root causes and take action, as necessary, to prevent recurrence. Finally, these reporting avenues provide data necessary to monitor trends over time and some of them are the source of data used to generate performance metrics included in RPC's Quarterly Reports.

Assessing Effectiveness of Reporting Avenues

Assessing Reporting Avenue Design

OPEGA first assessed the design of each reporting avenue against a set of criteria relevant to ensuring timely and appropriate responses to reported incidents and concerns.

OPEGA's assessment of the effectiveness of the reporting avenues in ensuring timely and appropriate responses to incidents and concerns began with evaluating the design of each avenue against several criteria:[1]

- the purpose of the reporting avenue is defined;
- critical reporting avenue objectives receive attention and review from management, and performance on those objectives is monitored regularly;
- roles, responsibilities and authorities for reporting and responding to reports are clearly defined, including who is to report, who is to respond and in what situations;
- processes and procedures for reporting are clearly defined, including what is to be reported, and when and how one reports;
- processes and procedures for responding to reports are clearly defined, including when and how one responds;
- written documentation exists covering roles, responsibilities, authorities, processes and procedures for reporting and responding to reports; and
- pertinent information is identified, captured and distributed to the right people in sufficient detail, in the right format and at the appropriate time to enable them to carry out their duties and responsibilities.

The extent to which the design met the criteria varied across the six avenues. Overall, however, we found the reporting processes as designed – if adhered to and documented consistently - should result in the appropriate individuals receiving reports in a timely manner for review and action.

OPEGA relied primarily on RPC's written policies, supplemented with information gathered through interviews with the Risk Manager, IQI Director and Human Resources Director, to understand the expected current process and procedures for each reporting avenue.

The extent to which any specific reporting avenue met the above criteria varied across avenues. Further description of each avenue is included in the following sections of this report. Overall, however, OPEGA found that, for five of the avenues, the reporting processes as designed—if adhered to and documented consistently—should result in the appropriate individuals receiving reports in a timely manner for review and action.

The exception was the reporting avenue for inappropriate and unsafe staff behaviors for which we determined there was more risk that violations may not receive timely review and action by appropriate levels of management.

The exception was the reporting avenue for staff behaviors that undermine a culture of safety where we determined the less formal reporting process created risk that violations may not receive timely review and action by the appropriate levels of management. This is discussed further in the following section of this report specific to that reporting avenue and in Recommendation 5.

In addition, although the fundamental structures of the five reporting avenues appear effective, OPEGA identified issues with written guidance available for staff. See Recommendations 1 and 4 for further discussion.

[1] OPEGA established the set of criteria based on a review of the United States General Accounting Office's Standards for Internal Control in the Federal Government (known as the Green Book), the GAO's Internal Control Management and Evaluation Tool, and the World Health Organization's WHO Draft Guidelines for Adverse Event Reporting and Learning.

Assessing Communication and Staff Understanding

OPEGA next evaluated whether RPC was effectively communicating reporting expectations and procedures to staff. We assessed the communication methods used, which included several levels of formal training for new employees annual refresher training for all employees, and communication of policy updates to all employees throughout the year.

OPEGA next evaluated whether RPC was effectively communicating reporting expectations and procedures to staff. We assessed the communication methods used and staff's understanding of the reporting avenues we had selected for review.

RPC's training program covers all hospital policies. RPC's Staff Development Coordinator described to OPEGA the current training programs for new and existing staff and OPEGA reviewed related training materials.

For the last 18 months, the new employee training program has consisted of:

- an initial one week of classroom learning;
- two subsequent weeks of shadowing a mentor on their unit;
- a series of supplemental, two to four hour trainings and orientations occurring throughout the employee's first six months on the job.

The classroom-learning component covers several topics including human resources policies, risk management and mandatory reporting, patient rights and the Consent Decree. At the conclusion of classroom orientation, staff sign that they have received, read and understood the policies.

During the mentoring period, the new employee and mentor cover a multitude of subject areas, including specific policies and the location of all RPC policies. Each subject area requires a signoff of both the new employee and the mentor to acknowledge they have reviewed it. The new employee, mentor, supervising nurse and charge nurse, also sign off the entirety of the unit orientation. Supplemental training over the course of the employee's first six months covers twelve topic areas including co-occurring conditions, therapeutic boundaries and recovery philosophy and care.

RPC requires annual training (based on the employee's anniversary date) for all employees. Over the course of the year, employees have access to sixteen training packets covering different competencies; they must review the packets and take a quiz. The quiz includes questions from all competency areas and employees must score at least 80%. Any policy updates initiated by the Superintendent over the course of the year are communicated to employees directly through emails or conveyed through Department heads who ensure that their employees read and understand the new policies.

We also assessed understanding of the six reporting avenues by conducting interviews with 26 randomly selected direct care staff. We found they were generally well aware of the current reporting expectations, processes and procedures for all six reporting avenues.

OPEGA conducted interviews with staff to assess the effectiveness of RPC's training and communication efforts and staff members' understanding of the reporting avenues and their specific reporting responsibilities. We randomly selected 26 employees, representing 10% of RPC's direct-care staff, to participate in structured interviews.

In these interviews, staff members were asked how each of the reporting avenues worked and their role in identifying and reporting incidents. We found that staff was generally well aware of current reporting expectations, requirements, processes and procedures for all six reporting avenues. The exception was a lack of clarity,

and inconsistent understanding among staff, on mandatory reporters' individual responsibilities for reporting ANE incidents directly to DHHS Adult Protective Services in addition to internally within RPC. This issue is discussed further in Recommendation 4.

In interviews staff also commented on other matters they felt affected the operations of the hospital, staff wellness or patient care. Several themes emerged related to staffing and the work environment that were outside the primary scope of OPEGA's review.

In addition to structured questions related to reporting, staff members were also provided with an opportunity to discuss with OPEGA any issues that they felt affected the operation of hospital, staff wellness or patient care. From these additional comments, several themes emerged related to staffing and the work environment. These concerns, discussed further in Recommendations 9 and 10, included:

- the number of patient assaults and staff injuries;
- lack of staffing and related issues like mandatory overtime;
- difficulties associated with implementation of the new Acuity Specialist positions;
- RPC operating below capacity and with empty beds while admissions were being denied;
- lack of effective communication and/or comprehensive of issues between floor staff and administration; and
- senior management's hiring practices, like filling positions without posting them and filling positions with persons not qualified.

Lastly, OPEGA reviewed a sample of reports from five of the six reporting avenues for the time period July 2014 to June 2015. There was no readily available documentation for efficiently assessing adherence for the reporting avenue associated with unacceptable staff behaviors.

Assessing Adherence to Reporting Requirements and Expected Practices

Lastly, OPEGA reviewed available documentation associated with a sample of reports from each reporting avenue to test adherence to reporting requirements and expected reporting practices. The samples were randomly selected from the time period July 2014 through June 2015, though stratified to ensure capture of certain types of events. The sampling methodology is described in Appendix A. There was no readily available documentation for the reporting of staff behavior that allowed OPEGA to efficiently assess adherence for this reporting avenue. This is discussed further in Recommendation 5.

Overall, the documentation reviewed indicates that RPC staff and managers have been generally adhering to reporting requirements and expected practices. We noted, however, several opportunities to improve documentation.

The specific documentation we reviewed for each reporting avenue, as well as the results of our testing, are discussed in the following sections of this report. We noted several opportunities to improve documentation, and RPC's use of documented information, as described in Recommendations 2, 3, 6 and 8. Overall, however, the documentation we reviewed indicates that RPC's staff and managers have generally been adhering to reporting requirements and current expected reporting practices.

Assessing RPC Response to Reported Incidents and Concerns

OPEGA also sought to assess the extent to which reported incidents and professional concerns are addressed appropriately by responsible parties within RPC, both administratively and clinically.

OPEGA also sought to assess the extent to which reported incidents and professional concerns are addressed appropriately by responsible parties. We focused on responses within RPC itself from both an administrative and clinical perspective. Descriptions of response specific to each reporting avenue are included in the following sections of this report.

To the extent it was available, we reviewed documentation of administrative follow-up actions considered, planned or taken in response to our sample of reports from each avenue. We also conducted interviews with members of RPC's administrative team including the Superintendent, the IQI Director, Risk Manager, Clinical Director and Director of Psychology.

Multiple opportunities exist for incidents and concerns to be brought to the attention of those with the ability and authority to initiate action. Administrative and clinical staff we spoke to described follow-up actions being assigned or taken.

To assess clinical responses to patient incidents, OPEGA spoke with individuals that regularly participate in safety or treatment team meetings. These included a Psychiatric Nurse Practitioner and a Social Worker. We did not seek to review documentation of clinical responses to the reported incidents in our sample that may have resulted from safety meetings or regular meetings of patient treatment teams. This documentation resides in patient records and, given the sensitivity to confidentiality of those records, would have required RPC to expend significant resources to provide it for OPEGA review.

We generally observed that there were multiple opportunities for incidents and concerns reported through five of the six avenues to be brought to the attention of multiple individuals with ability and authority to initiate further action – both internal and external to RPC. The administrative and clinical staff we spoke with described follow-up actions being assigned and taken, depending on the nature and severity of the incident or concern.

Documentation of follow-up responses was consistently present for some reporting avenues. However, available documentation for administrative follow-up on Incident Reports was more limited and suggested inconsistencies in practice with regard to formal, documented follow-up efforts.

For some reporting avenues, documentation of proposed responses or follow-up actions was required as part of the established process and was consistently present on the reporting forms and related documents we reviewed. For Incident reporting, however, available documentation of administrative follow-up was more limited. From the documentation that did exist, it appeared there was some inconsistency in practice with regard to formal, documented follow-up in the form of fact findings, root cause analyses and investigations. This issue is further discussed in Recommendation 6.

Selecting and Assessing Performance Metrics for Accuracy and Reliability

RPC collects and analyzes data to generate metrics published in the Quarterly Report on Organizational Performance Excellence.

RPC collects and analyzes aggregate data to generate metrics that are reported to, and used by, various oversight entities to monitor compliance performance and compliance. These metrics are published in RPC's Quarterly Reports on Organizational Performance Excellence and many of them are also utilized internally at RPC for strategic process improvement.

At the time of our review, there was a total of 88 metrics published in the quarterly reports. OPEGA identified 19 of these as indicators of patient and staff safety, patient treatment and the overall work environment. We ultimately selected five of these metrics for in-depth review, based on the extent to which each metric appeared to be:

- used for monitoring compliance with the Consent Decree;
- utilized by the Joint Commission to assess compliance with national standards;
- an indicator of safety risks for patients and/or staff;
- an indicator of potential patient rights violations;
- relevant to potential concerns identified during OPEGA's preliminary research on this project; and
- risk of inaccuracy due to potentially weak controls.

OPEGA identified 19 metrics in the Quarterly Report that are indicators of patient and staff safety. We selected five of those for more in-depth review.

The five performance metrics selected for further review were:

- Seclusion Hours;
- Restraint Hours;
- Factors of Causation for Seclusions;
- Factors of Causation for Mechanical Restraints; and
- Patient Abuse, Neglect, Exploitation, Injury or Death.

We reviewed the data collection process and tested a sample of reportable events captured in the Incident Report database. We also tested a sample of Incident Reports that had not been entered to the database.

The data for these five metrics originates from information on Incident Report forms that is captured in MEDITECH. OPEGA assessed the accuracy and reliability of each metric through review of controls in the data collection process and testing of a stratified, randomly selected sample of events. Table 1 shows our sample size for each type of event reported in the selected metrics.

Table 1: Population and Sample Sizes of RPC Events Reported in Quarterly Report Metrics July 2014 - June 2015

Type of Event	Population of Events	Sampled Events	Percentage
Seclusion	368	36	10%
Mechanical Restraint	31	3	10%
Abuse, Neglect, or Exploitation	153	16	10%

Source: Data file provided by RPC from MEDITECH

We noted several issues impacting the accuracy and reliability of certain reported metrics.

For that sample, we compared information in MEDITECH to supporting documentation. We also tested a sample of Incident Reports not entered to the MEDITECH to ensure that reportable events documented on Incident Reports were appropriately captured and included in the corresponding quarterly report metric. We noted several issues with the data collection or criteria applied to the collected data that impacted the accuracy, reliability or value of reported metrics. These are discussed in Recommendations 3, 7 and 8.

Reporting Incidents

Process Description

RPC's Incident Reporting process is the primary reporting avenue for events that occur at the hospital.

Completion of Incident Report Forms

> **Incident:** "any happening that is not consistent with the normal or usual operation of the hospital" and includes "the potential for client harm, injury, property damage or legal liability."
> *Source: Incident Reporting Policy PC.3.10.4*

RPC's incident reporting process is the primary, and often first, reporting avenue used for events that occur at the hospital. Any staff member who identifies an incident as defined in the policy has a responsibility to complete an Incident Report form. A sample of an Incident Report form is in Appendix C. The Incident Report form is used to document the basic facts of the incident and includes several components:

Any staff member who identifies an incident has responsibility to complete an Incident Report form at the time of the incident or as soon as possible after it occurs.

- the time, date and location of the incident;
- staffing levels at the time of the incident;
- individual(s) involved;
- patient behavior;
- notifications made;
- a narrative description of the incident;
- any actions taken; and
- signoffs for the report author and supervisor.

The staff member completes the form at the time the incident occurs or as soon as possible after it occurs. The form is then signed by the staff member's supervisor and completed forms are given to the Nurse IV during the day shift, or the Nurse On Duty (NOD) during off hours, for review. Completed Incident Reports are forwarded to the Risk Manager.

The form is signed by the staff member's supervisor. Completed forms are given to the Nurse IV or NOD for the unit and forwarded to the Risk Manager.

Since January 1, 2015, RPC has utilized pre-numbered Incident Report forms with certain number ranges assigned to the different units of the hospital. Employees taking an Incident Report form to fill out must indicate the form number and their name in the log book maintained on the unit. This new effort ensures all forms are accounted for and submitted to the Risk Manager. Opportunities to improve the effectiveness of this control, and utilize it more fully, are discussed in Recommendation 7.

Administrative Review and Action on Incident Reports Submitted

Each weekday morning, the administrative team meets with three main objectives: to discuss any new admissions, to review any Incident Reports that have been submitted since the previous meeting, and to discuss administrative and regulatory issues and updates. The overall purpose of the meeting is to bring awareness of the preceding 24 hours at RPC to the administrative level.[2] Each Nurse IV brings a

[2] Morning management meeting attendees include the: Superintendent; Chief Operating Officer; Directors of: Nursing, Psychology, Social Work, Rehabilitation Services, Facilities, and Integrated Quality Informatics; Clinical Director, Nurse IV for each unit, Risk Manager, Safety Compliance Officer, Field Investigator, and Admitting Nurse.

copy of any Incident Report form from their unit that was submitted since the previous meeting, and reviews its contents with the rest of the meeting attendees. The Risk Manager brings the original Incident Report form as a verification to ensure no incident reports are missing.

RPC's administrative team reviews submitted Incident Reports at management meetings held each weekday morning. This is an opportunity to ensure all incidents have been appropriately addressed and to assign follow-up actions if needed. Meeting attendees also described looking for trends or patterns reflected in the Incident Reports reviewed.

This process of reviewing each Incident Report submitted was described as an opportunity to bring awareness to administration, to process incidents from various perspectives by the disciplines represented, to ensure all incidents are addressed and to designate appropriate follow-up actions to the incident, if needed. These actions may be directed to the Nurse IV, the Director of Psychology or other staff, and were described by the Superintendent as being informal directives that were not documented. If there is no identifiable concern, no further actions will be taken. If more information is needed, a fact finding or root cause analysis may be assigned to Risk Management/IQI. Although not done formally or quantitatively, meeting attendees described looking for trends and patterns reflected in Incident Reports from the perspective of their discipline.

More formal follow-up actions may also be taken, as warranted, in the form of documented fact findings, root cause analyses and investigations conducted by the Risk Manager, Field Investigator or Human Resources.

Beyond the morning administrative meeting, additional investigatory activities (fact findings, investigations or root cause analyses) may be conducted as necessary. RPC conducts fact findings, which include a review of relevant documentation and interviews with those involved to assess the accuracy of the reported facts. Investigations are conducted for more serious allegations to determine the facts and whether statutes, regulations or policies have been violated. During the time period covered by OPEGA's review, fact findings were conducted by the Risk Manager. In mid-2015, a Field Investigator position was added, who now also conducts fact findings. The results of any investigation are reviewed with the Superintendent.

Clinical Response to Patient Incidents

Clinical decisions regarding patients are made by patients' treatment teams which meet at regularly scheduled intervals independent from the Incident Reporting process.

Clinical decisions regarding patients are made by patients' treatment teams at meetings that are independent from the incident reporting process.[3] The treatment team meets at regularly scheduled two week intervals to discuss a patient's treatment. The team assesses patient safety and immediate medical issues and identifies short and long-term goals and measurable interventions. Longer-term forensic patients and non-acute patients can extend treatment team meeting intervals to once per month, if decided on by the team. Patients are present for a large portion of the meeting and able to actively participate in their treatment planning and setting meeting agenda items. Clinical decisions resulting in goal changes are recorded in the patient's treatment plan. Documentation also occurs via the Treatment Plan Meeting form, where minutes and participant signatures are recorded, as well as the Nursing Assessment of Suicide Risk form.

Patient's treatment teams review adverse patient incidents (i.e., seclusion, restraint, assault, etc.) at mandatory safety meetings. These occur within 72 hours of a patient

[3] At a minimum, the treatment team consists of a psychiatric provider (psychiatrist or nurse practitioner), social worker, nurse, and the hospital's treatment team coordinator. Dependent on a patient's treatment needs, it often also includes a psychiatrist, peer support specialist, and recreational therapist. As needed, an occupational therapist, medical provider, dietician, and chaplain may also be included.

Treatment teams review adverse patient incidents at mandatory safety meetings required to occur within 72 hours of certain events. This is an opportunity to debrief with the patient, discuss how to prevent future incidents and update patient treatment goals if needed.

incident and include the same providers that attend treatment team meetings, along with the patient. Staff we spoke to that regularly participate on treatment teams described a safety meeting as debriefing the incident with the patient, identifying what could have been done better, discussing future prevention of incidents and updating the patient's treatment goals if needed. Staff that have not attended the safety meeting are made aware of any goal changes via the patient chart and the daily end-of-shift report. RPC management described safety meetings as patient-focused meetings, where staff encourage the patient to explain what, if anything, staff may have done differently to avoid another incident, and to inform the patient of things that were done well, in attempts to avoid future incidents.

Capture of Incident Report Data for Reporting

Although Incident Reports can capture a wide range of events, their primary use is to capture *reportable* events, those required to be reported to various oversight entities. The number of RPC reportable events (by category and the unit on which they occurred) captured on Incident Report forms between June 2014 and July 2015 is presented in Table 2.

Table 2: RPC Reportable Events Captured in MEDITECH July 2014 - June 2015

Type of Event	RPC Unit					Total
	Upper Kennebec	Lower Kennebec	Upper Saco	Lower Saco	Other RPC	
Patient Incident	71	379	84	983	6	1523
Seclusion	7	88	9	264		368
Manual Hold	17	97	7	246		367
Drug Administration Error	19	36	46	38		139
Abuse	18	69	17	27	1	132
Patient Injury	24	52	30	17	7	130
Patient on Approved Leave From Hospital	24	2	29	8		63
Mechanical Restraint		2	1	28		31
Exploitation	3	2	6	8		19
Privacy Violation Internal		1	3	2		6
Complex Medication Error		1	2	2		5
Privacy Violation Internal and External		1		3		4
Neglect				1	1	2
Elopement		1				1
Privacy Violation External				1		1
Total	**183**	**731**	**234**	**1628**	**15**	**2791**

Source: Data file provided by RPC from MEDITECH

The primary purpose of Incident Reports is to capture events required to be reported to various oversight agencies.

The Risk Manager identifies which Incident Reports contain reportable events and highlights the relevant information on copies of the Incident Reports. The copies are sent to the Data Entry Clerk at Dorothea Dix Psychiatric Center (DDPC) to be entered into the MEDITECH, the electronic health records system, which RPC refers to as the Incident Report database. The Clerk reviews the form for accuracy

RPC's Risk Manager identifies which Incident Reports have reportable events and sends copies of them to DDPC for entry into the Incident Reporting database. The data entered is used to calculate metrics that populate the tables and graphs in RPC's Quarterly Reports.

and clarifies any data questions with the Risk Manager at RPC, or IQI's HITech Manager. The HITech Manager is responsible for compiling the RPC Quarterly Reports on Organizational Performance Excellence. The HITech Manager reviews the data entered into MEDITECH and uploads it to NRI on a monthly basis. NRI is an organization that collects performance data and performs analysis for the Joint Commission.[4]

NRI tests the data for errors such as missing fields or duplicative data, and either accepts the file or rejects it. In the event that an upload fails, IQI staff correct errors and resubmit the file. Once the data is accepted, NRI calculates several metrics and a report is made available for download from NRI to RPC, the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC). Data and metrics are pulled from the reports and used to populate the tables and graphs appearing in RPC's Quarterly Reports.

Results of OPEGA's Assessment and Testing

Effectiveness of the Incident Reporting Avenue

OPEGA's review of the Incident Reporting policy found it no longer accurately reflected the entirety of RPC's current expected practice. Nonetheless, RPC staff we interviewed had an excellent understanding of the current process.

OPEGA's review of the incident reporting policy found that it no longer accurately reflected the entirety of RPC's current incident reporting practice. This and similar issues from other policies are discussed further in Recommendation 1.

Nonetheless, RPC staff have an excellent understanding of the current incident reporting process. All 26 staff members we interviewed accurately described the general reporting process, including when and how reports are to be made and what types of events require an Incident Report. It appears RPC has successfully communicated that any event—regardless of the severity—meeting the general definition of an "incident" as described in policy is to be reported. Twenty-five of 26 staff members were aware that the incident reporting process was described in a written policy. All respondents indicated they either knew where to access the policy or an appropriate person to ask for guidance (for example, a Nurse IV or the Risk Manager). OPEGA specifically asked those interviewed whether they had ever been instructed by a supervisor to not report a particular incident and all said no.

OPEGA also selected and reviewed a sample of 100 Incident Reports to test RPC's adherence to expected reporting practice. The sample reviewed included 77 Incident Reports that had been entered to MEDITECH, encompassing 204 events of seclusion and restraint; allegations of ANE; patient injuries; hands-on-hold; and other incidents involving patients. The percentage of events captured in MEDITECH that were encompassed in our sample is shown in Table 3. The remaining 23 Incident Reports we reviewed were selected from the population of Incident Reports that had not been entered to MEDITECH.

[4] NRI is a national organization that works with state agencies, the Federal Government, and other entities to provide quality improvement and performance measurement services for psychiatric hospitals through data analysis and support, technical assistance, and reporting services to meet The Joint Commission reporting requirements.

Table 3: Population and Sample Sizes of RPC Reportable Events Captured on Incident Report Forms July 2014 - June 2015			
Type of Event	Population of Events	Sampled Events	Sampled Percentage
Patient Incident	1523	80	5%
Seclusion	368	47	13%
Manual Hold	367	38	10%
Abuse - Sexual	64	8	13%
Abuse - Physical	53	7	11%
Abuse - Verbal	15	2	13%
Patient Injury	130	13	10%
Mechanical Restraint	31	4	13%
Exploitation	19	4	21%
Neglect	2	1	50%
Other	12	0	0%
Total	**2584**	**204**	8%
Source: Data file provided by RPC from MEDITECH			

We tested various sections of the Incident Report form for completion to provide some measure of the extent to which key components of the incident reporting process were followed.

We reviewed a sample of 100 Incident Report forms. The forms had been appropriately completed with the exception of noted inconsistencies in supervisory signatures and the documentation of notifications made.

- Identifying Fields. All four fields on the top line of the form were completed on 94 Incident Reports. The remaining six Incident Reports forms all had a single field missing.

- Narrative Description. The author provided a narrative description of the incident on all 100 Incident Reports.

- Actions Taken. Ninety-three Incident Reports either had this section completed (87) or completion was unnecessary (6) as the incident required no action.

- Supervisory Signatures. Thirteen Incident Reports did not have a supervisory signature as required by policy.

- Required Notifications. Report authors can select between "Yes," "No," and "N/A" options to identify whether certain notifications were made as per policy to patient representatives and external agencies. OPEGA observed approximately 20% of the reportable incidents had at least one or more notifications left blank.

Overall, we found the forms to be appropriately completed with the exception of noted inconsistencies in supervisory signatures and the documentation of notifications made. These inconsistencies are discussed further in Recommendation 2.

RPC staff told OPEGA that follow-up actions stemming from reported incidents are sometimes assigned at morning management meetings though those assignments are not captured in documentation.

Our file review indicated the Risk Manager had taken some follow-up action for nine of the 100 Incident Reports sampled. Documentation of a "fact finding" by the Risk Manager existed for three of these.

OPEGA expected to see more documented follow-up associated with our sample based on our understanding of the types of situations where formal follow-up was expected to be performed.

OPEGA tested a sample of 25 Incident Reports that had not been entered into the database. We discovered five had reportable events that should have been captured, potentially impacting the accuracy and reliability of reported metrics.

Response to Incident Reports

OPEGA understood from interviews with administrative staff that follow-up actions are sometimes assigned to Nurse IV's from review of Incident Reports at the morning management meetings. There is, however, no documentation from those meetings that captures any follow-up actions that have been assigned.

The file review indicated that the Risk Manager had taken some follow-up action for nine of the 100 Incident Reports OPEGA sampled. Documentation of a "fact finding" by the Risk Manager existed for three of these. OPEGA reviewed the fact finding files and found the documents generally included descriptions of the incident, the allegation and interviews with those involved. One of the three files included notation of further action to be taken to try to prevent a recurrence of the situation causing the incident.

OPEGA observed that a number of Incident Reports we sampled did not seem to warrant any follow-up response beyond the actions taken at the time of the incident. However, based on our understanding of when follow-up reviews, fact findings, investigations and/or root cause analyses are performed by the Risk Manager, we expected to see more documented examples of those. We noted that the three documented fact findings we reviewed were related to incidents of sexual or verbal abuse, but other incidents of this nature in our sample did not result in a documented fact finding. These apparent inconsistencies in follow-up expectations and practice are discussed in Recommendation 6.

There was one Incident Report in our sample for which an HR Investigation was considered. No formal investigation was completed, however, because the HR Director reviewed video of the situation and determined the allegation of staff misconduct was false.

Metrics Generated from Incident Reports

OPEGA tested a sample of Incident Reports that had not been entered to MEDITECH to determine whether they had been appropriately excluded, i.e. did not contain any reportable events. Based on records for the pre-numbered Incident Report forms, we identified a population of 494 Incident Reports numbers used since January 1, 2015 that were not included in the data file we obtained from RPC. We randomly selected a sample of 25 (5%).

Twenty three of the 25 Incident Report forms were completed and available for our review. Of the remaining two, one was voided and one was otherwise missing according to notations in the unit's distribution log. OPEGA reviewed the 23 completed Incident Reports and identified five with reportable events that should have been captured in MEDITECH, including one patient fall and four abuse events (which were appropriately reported to APS). Consequently, the metrics published in RPC's Quarterly Performance Reports have potentially been inaccurate and unreliable. The potential cause and impact of this are discussed further in Recommendation 7.

We also tested the accuracy of start and end times entered to the database for 36 seclusion events and three restraint events. We found the database times were consistent with the times recorded on both the relevant Incident Reports and monitoring logs.

Data for the seclusion and restraint metrics OPEGA reviewed originates from the hospital's monitoring sheets used to check and log the patient's condition during seclusion and restraint events. The data is recorded on the Incident Report form and then input into MEDITECH. OPEGA tested a sample of 36 seclusion events and three restraint events to determine whether start and end times recorded on the Incident Reports were consistent with those on the monitoring sheets. We found that times were consistent for 33 of the 36 seclusion events and all three restraint events. Of the three seclusion events in which times did not align, none of the differences exceeded six minutes.

OPEGA also sought to assess the accuracy of the times of seclusion and restraint events logged in MEDITECH. This was complicated by the fact that MEDITECH does not allow for overlapping times of reportable events (i.e. a patient can't be subject to a seclusion, restraint or hands-on-hold at the same time). As a result, times entered into MEDITECH are often adjusted by one minute and single events of seclusion may be split into multiple events of shorter duration upon data entry. For example, a patient in seclusion subject to a momentary hands-on-hold would be reflected in MEDITECH as a first seclusion of shorter duration, a one minute hands on hold, and a second seclusion consisting of the remaining time. All three events would be entered without overlapping times.

Allowing for this in our testing, we found that 33 of 36 seclusion events and all three restraint events had Incident Report times and times entered in MEDITECH that were acceptably within one minute of each other. Of the three seclusion events that did not pass our test, two were within five minutes. The third was due to an Incident Report involving two seclusion events that occurred within a short time period of each other being inaccurately entered in MEDITECH as one longer seclusion event.

Lastly, OPEGA reviewed the process for generating the statistics for two metrics, Factors of Causation and Allegations of ANE. We noted the processes used negatively impacted the reliability and meaning of those metrics.

RPC also reports the "factors of causation," which are the reasons and causes the seclusions or restraints were necessary. Three categories of causes were reported in the quarterly reports reviewed: "Danger to Self/Others," "Danger to Self," and "Danger to Others." OPEGA notes that RPC's described process for capturing the information for these metrics, by default, assigns an acceptable cause to each instance of seclusion or restraint. See Recommendation 8 for further discussion.

The final metric we reviewed for accuracy captures allegations of physical, sexual or verbal abuse occurring at the hospital involving either RPC patients or staff. All allegations of abuse are captured in MEDITECH regardless of when, where or who they involve. Consequently, the HITech Manager performs a quarterly process to determine events meet RPC's criteria for inclusion in this metric. OPEGA observed that, as a result of this process, two instances of witnessed abuse were excluded from reported metrics. This issue is described in greater detail in Recommendation 8.

Reporting Abuse, Neglect or Exploitation

Process Description

Completion of Incident Report Forms

RPC policy informs staff how to respond to incidents of patient abuse, neglect or exploitation (ANE) which includes reporting when ANE may have occurred.

In accordance with the Consent Decree, RPC policy is intended to protect the right of clients to be free of ANE and the fear of being abused, neglected or exploited. The RPC policy entitled "Allegations of Client Mistreatment Including Abuse, Neglect or Exploitation" informs RPC staff how to respond to incidents of ANE. The policy requires employees to protect clients, prevent ANE from occurring and to report when ANE may have occurred. The policy states that RPC has a zero tolerance policy for ANE with employee discipline or corrective action up to and including termination when abuse or neglect by staff is confirmed.

Abuse –the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes, or is likely to cause, physical harm or pain or mental anguish, sexual abuse or sexual exploitation. Abuse includes the deprivation by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental and psychosocial well-being. Abuse includes acts and omissions, or the use of seclusion or restraint as a form of punishment, or in any other manner, which is inconsistent with the hospital's policy,

Neglect – an act or omission, which threatens a person's health or welfare by placing the person at risk of physical or mental injury or impairment, or deprivation of essential needs or lack of protection from these.

Exploitation- the illegal or improper use of an adult's money or property for another person's profit or advantage.

Source: RPC Policy PC.3.10.2, Mandatory Reporting: Allegations of Mistreatment Including Abuse, Neglect or Exploitation

A staff member that observes, or learns, of an ANE incident notifies their supervisor and completes an Incident Report. All allegations of ANE are expected to be reported regardless of when or where the patient alleges the event occurred.

This policy implements Adult Protective Services Statute (22 MRSA Ch. 958-A) and DHHS Rules for the Licensing of Hospitals 10-144, c.112. There are two major parts of this policy that are of particular interest for this OPEGA review: (1) the process for reporting of incidents of ANE and (2) the preliminary review/fact finding/investigations process.

Under RPC's current process for responding to and reporting alleged incidents of ANE, a staff member that observes, or learns, of such an incident first ensures the client's safety, then immediately notifies their supervisor and completes an Incident Report form by the end of the shift. The expectation is that all allegations of ANE are reported regardless of when or where the patient alleges the event occurred.

Though the initial reporting follows Incident Report procedures, ANE incidents have specific notification requirements pursuant to the ANE policy, including a notification to DHHS Adult Protective Services (APS).

The initial reporting of ANE follows the incident reporting procedures. An ANE incident, however, has specific notification requirements and procedures pursuant to the ANE policy. Specifically, the ANE policy states that the Charge Nurse informed of the ANE incident is required to makes a series of notifications including the Nurse IV (or NOD during off hours), the client's guardian, the client advocate and DHHS Adult Protective Services (APS). The notification to APS, which was formerly done via a phone call, is now done online via computer with a confirmation report automatically sent back to RPC's Risk Manager.

Administrative Review and Action on Reports of ANE

The ANE policy also specifies formal follow-up for reports of ANE. IQI staff OPEGA interviewed indicated that parts of the follow-up process are not as formal as the policy implies, particularly regarding documentation.

The Administration becomes aware of, reviews and takes action as necessary on reports of ANE in the same manner as all other Incident Reports. Although the incident reporting policy does not specify any formal follow-up for reports of ANE, the ANE policy does. The ANE policy indicates that the Program Services Director or NOD will conduct a preliminary review and write a report and recommendation to the Superintendent as to whether there is probable cause to proceed with an investigation. The policy also states the Risk Manager will review this "fact finding" of the incident with the Superintendent, who will decide if there is probable cause to warrant an investigation. The policy seems to imply that investigations would primarily be conducted for situations where it is staff that has potentially committed an act meeting the criteria for ANE. Lastly, the policy specifies how an investigation will be conducted and what is to be included.

IQI staff OPEGA interviewed indicated that the preliminary review or fact finding process is not as formal as the ANE policy implies, particularly regarding documentation. See Recommendation 1 regarding policies and Recommendation 6 regarding administrative follow-up on reported incidents for further discussion.

Results of OPEGA's Assessment and Testing

OPEGA's review of the written ANE policy found it no longer reflected current practices. We also observed a lack of clarity and consistency in the relevant policies that could impact reporting. Lastly we noted that RPC's policies do not provide any guidance for staff as to their individual statutory responsibilities to report ANE directly to APS.

OPEGA reviewed RPC's written policy describing the reporting of ANE and found that it no longer reflected current practices regarding assignment of certain responsibilities and the manner in which the Superintendent is informed of the incident. OPEGA also observed a lack of clarity and consistency in written policies, which can adversely impact reporting. These and similar issues from other policies are discussed further in Recommendation 1.

OPEGA also compared RPC's ANE reporting policy with reporting requirements in statute and the Consent Decree. Maine Statute (22 MRSA, Ch 958-A §3477) requires specified professionals to immediately report to DHHS when the person knows of, or has reasonable cause to suspect, ANE. The mandatory reporters specified in statute are:

- allopathic or osteopathic physicians;
- registered or licensed practical nurses;
- certified nursing assistants;
- social workers;
- psychologists;
- mental health professionals; and
- unlicensed assistive personnel.

We noted that, although several RPC employee classes are mandatory reporters, RPC's policy does not provide any guidance as to the individual's responsibility to report to APS under the statutory mandatory reporting requirement. Our interviews with RPC staff also indicate inconsistencies in staff's awareness or understanding of their individual responsibility to report directly to APS in addition to reporting internally within RPC. This lack of clarity surrounding the expectations for mandatory reporters and the risks it presents is described further in Recommendation 4.

OPEGA reviewed a sample of 20 Incident Reports with events of ANE. Nineteen of the 20 had the notification to APS recorded on the form. OPEGA confirmed with APS that it had received reports of all 20 events.

OPEGA reviewed a sample of 20 Incident Reports capturing events of ANE[5] to determine whether they were appropriately reported to APS in accordance with required timelines. Notification to APS was indicated on 19 out of the 20 Incident Report forms. For the one form that did not have notification to APS checked off, RPC was able to provide an email confirmation from APS that the abuse event in question had been reported. OPEGA then checked with APS and confirmed that it had received reports from RPC coinciding with the dates and times of all 20 events.

Three of the 20 events had not been reported to APS within 24 hours as required but two of these incidents had mitigating factors that explained the delay.

Suspected events of ANE not only need to be reported, but reported within 24 hours (per Chapter 112 Section 1.6.4 Rules for the Licensing of Hospitals). Three of the 20 events we sampled were not reported within one day, but two of these incidents had some mitigating factors:

- One incident was brought up in a treatment team meeting days after it had actually occurred. Once aware of the incident, RPC staff filed an incident report and reported the alleged abuse to APS.
- In a second incident, the primary issue captured on the Incident Report was a police response to a complaint the police determined to be unsubstantiated and the report author did not contact APS. When the Incident Report was reviewed by the Risk Manager, she noticed a reference to the patient being called names by staff and she reported the alleged verbal abuse to APS. This illustrates the effectiveness of the Risk Manager's review of Incident Reports.

The remaining ANE incident that was not reported within one day was reported on an Incident Report on February 24, 2015 and reported to APS on February 26th. RPC could not provide justification for this delay.

Issues previously noted from OPEGA's testing of the Incident Report process also relate to ANE reporting. These include potentially inaccurate metrics and inconsistencies in formal administrative follow-up.

Other relevant results for the ANE reporting avenue from OPEGA's testing of the incident reporting process are described in that section of this report. These include our observations that not all allegations of ANE appear to have been captured in MEDITECH (see Recommendation 7) and that two instances of witnessed abuse were not reflected in RPC's quarterly reports (see Recommendation 8). As a result, RPC's metrics related to ANE are potentially inaccurate and unreliable. Our observation about the frequency of administrative follow-up, and the apparent inconsistency in when a fact finding, or other follow-up, is conducted by the Risk Manager, also applies to reported ANE incidents we reviewed. This issue is discussed further in Recommendation 6.

[5] OPEGA's sample of 20 ANE incidents included 16 Incident Reports that had been entered to the Incident Report database and were part of our larger sample of 100 Incident Reports. The remaining four ANE incidents in our sample were from Incident Reports that had not been entered to the database and were part of our larger sample of 25 non-database Incident Reports.

Reporting Workplace Injuries

Process Description

RPC policy for workplace injuries requires an employee who suffers a work-related injury or illness to complete and provide an Employee First Report of Injury to the supervisor. RPC's Incident Reporting policy also requires the employee to complete and submit an Incident Report form.

Completion of Employee First Report of Injury and Incident Report Forms

RPC's policy for workplace injury reporting requires any employee who suffers a work-related injury or illness on the job to notify and provide a completed Employee's Report of Injury, Exposure or Medical Condition (Employee First Report of Injury) to his/her supervisor. The policy requires notification to HR within 24 hours of an injury, or as soon as possible, but no later than 7 days after the injury depending upon the level of treatment required.

RPC's incident reporting policy also requires the employee to complete and submit an Incident Report form. The process for completing that form is described in the Reporting Incidents section of this report.

RPC Response to Employee First Reports of Injury

If the injury is serious and medical care is necessary, the supervisor notifies Human Resources (HR) and the employee is taken to the hospital emergency room. If the injury is not serious, but medical care is necessary, the injured employee goes to a State-contracted care provider, such as Workplace Health, for treatment when practicable.

The Workplace Injury Reporting policy requires the supervisor to submit the employee's report, along with a completed Supervisor's Report of Employee's Injury to Human Resources within 24 hours of receiving the employee's report. The Supervisor's report includes a description of actions that could be taken in the future to avoid or reduce the risk of reoccurrence.

The workplace injury reporting policy requires supervisors to submit the Employee First Report of Injury and a Supervisor's Report of Employee's Injury, Exposure or Medical Condition (Supervisor's Report of Injury) to HR within 24 hours of receiving the Employee First Report. Samples of these report forms are in Appendix C.

The Supervisor's Report of Injury contains information about how and why the injury happened, what risk mitigation strategies were attempted at the time of the event and what actions could be taken in the future to avoid, or reduce, the risk of reoccurrence. The workplace injury reporting policy also requires that the Risk Manager receive a copy of the Supervisor's Report when an injury involves a physical plant safety issue so that the Risk Manager can notify the Safety Officer to address unsafe conditions.

Other responses to reports of employee injuries through the incident reporting avenue are described in the Reporting Incidents section of this report.

Results of OPEGA's Assessment and Testing

All 26 RPC employees OPEGA interviewed were aware of the injury reporting policy and 22 were able to describe the process.

All 26 RPC employees interviewed by OPEGA had an awareness of the workplace injury reporting policy. Twenty-two of the interviewees were able to describe the injury reporting process, in general, including when and how injury reports are to be made and what types of events require an Employee First Report of Injury. The other four did not mention this form.

OPEGA obtained a data file of employee injuries from RPC and tested a randomly selected sample for adherence to the expected process in terms of documentation and timelines. There were 237 reported employee injuries with a date of injury in the time period July 1, 2014 through June 30, 2015 and OPEGA's sample included 47 (or 20%) of those.

OPEGA reviewed files for a sample of 47 staff injuries, representing 20% of reported injuries from July 2014 through June 2015. We found that RPC substantially follows the timeline and documentation requirements in the workplace injury policy.

OPEGA reviewed files for the selected sample of injuries on-site with RPC HR staff. There was one injury in the sample for which no files were available for review, resulting in 46 files reviewed. Documents available for review included the Employee First Report of Injury and the Supervisor's Report of Injury.

OPEGA found that RPC substantially follows the documentation requirements of the workplace injury reporting avenue. Specifically, in the sample files reviewed:

- 91% had an Employee First Report of Injury submitted to HR within 7 days of injury, as required; and
- 83% had a Supervisor's Report of Injury completed and submitted to HR within 24 hours of the supervisor being notified, as required.

For most of the injuries in our sample, an Incident Report form had also been submitted as required by the Incident Reporting policy.

OPEGA tested for evidence that an Incident Report was filed for the sampled injuries as required by the incident reporting policy. In 89% of the injuries reviewed, there was an Incident Report filed. OPEGA has included an observation about improving the cross-reference between the workplace injury reporting policy and the incident reporting policy in Recommendation 1.

In terms of response to the employee reports of injury and how they are addressed, OPEGA considered several factors:

- first, whether medical care is provided to injured employees when necessary;
- second, whether the documented process is followed for injuries resulting from safety issues related to the physical plant;
- third, whether processes are followed to support the employee when the injury is the result of an assault; and
- fourth, whether measures are taken to address the cause of injury when not a physical plant issue.

OPEGA observed that injured employees routinely access medical care when needed after an injury.

OPEGA found that:

- Injured employees routinely access medical care when needed after an injury. The injured staff received medical care (including first aid) in 59% of the files reviewed. Among those that did not receive medical care, 95% of the injuries were described as relatively minor, including cuts, scratches and bruises.
- Relatively few employee injuries, 9% of the sample, are caused by deficiencies in the safety of the physical plant. We did no further assessment of adherence to reporting policy for this type of incident.
- The primary cause of injury is patient assault. This was the cause of injury in 83% of all injury files OPEGA reviewed. RPC reported to OPEGA that they implement a Wellness After Assault Process for such injuries;

We also observed that patient assault was the cause of injury in 83% of the files we reviewed. RPC told OPEGA they implement a Wellness After Assault Process for such injuries but there was no documentation of this in the files we reviewed.

however, there was no documentation of this process in the files OPEGA reviewed. Consequently, we did not test the implementation of and adherence to this process.

- For the injuries caused by patient assault or other factors unrelated to physical plant safety, 62% of the Supervisor's Report of Injury forms had documentation of immediate measures taken in response to the incident. The most frequently reported measure taken was immediate action to calm the assaultive patient. In addition, 83% had documentation of additional measures planned to be taken to help prevent recurrence of a similar incident.

Reporting Sentinel Events

Process Description

A Sentinel Event is a serious and unexpected event that results in, or creates serious risk of, a catastrophic outcome. RPC's Sentinel Event policy defines the types of events that are considered Sentinel Events noting that they are unrelated to the natural course of a patient's treatment.

Reporting of Sentinel Events

A sentinel event is a serious and unexpected adverse event occurring in a health care setting that results in, or creates serious risk of, a catastrophic outcome, including death or serious injury. In RPC policy, a sentinel event is defined as an event that is unrelated to the natural course of the patient's treatment including, but not limited to:

- patient death, including suicide, within 72 hours of discharge;
- major permanent loss of function present at time of discharge of the patient or within 24 hours of discharge;
- sexual assault;
- patient transfer to another health care facility;
- wrong site surgery, including surgery related to dental procedures; and
- other serious reportable events as defined by the National Quality Forum and specified in DHHS Rule, including death or serious injury of a patient or staff member resulting from physical assault occurring within the healthcare setting.

Any RPC staff member who discovers a Sentinel Event must make a verbal report to the Superintendent, or designee, who then notifies the Risk Manager.

Any RPC staff member who discovers a sentinel event must make a verbal report to the Superintendent, or his/her designate, and the Superintendent notifies the RPC Risk Manager. When a sentinel event occurs, there are a series of required notifications that must be made. The Risk Manager is required to notify the DHHS Sentinel Event Team (SET) within one day. The SET is responsible for investigating sentinel events at hospitals in the State. Notification to the SET requires calling the SET hotline and faxing a Sentinel Event Notification form to SET. A sample of the form is in Appendix C.

The Risk Manager is required to notify DHHS's Sentinel Event Team (SET) within one day. Several other parties must also be notified within one day.

If the event has resulted in a patient death or permanent loss of function, the Risk Manager separately notifies the DHHS Division of Licensing and Regulatory Services (DLRS). Although SET is a unit within DLRS, these notifications are separate because the SET does not share reports with others within DLRS.

Several other parties must also be notified within one day, including the Court Master, the DHHS Commissioner and the patient's family and/or guardian. The Superintendent must also notify in writing Disability Rights Center, employer of the Patient Advocates, within seven days of the event.

Also within one day, the IQI staff is required to initiate a Root Cause Analysis (RCA) to understand the underlying causes of the problem. The final report on the RCA must be completed, validated by the Superintendent and submitted to the SET within 45 days.

RPC Response to Sentinel Event Reports

Also within one day of a sentinel event, RPC's sentinel event policy requires IQI staff (often the Risk Manager) to initiate a Root Cause Analysis (RCA) to understand the underlying cause of the observed problem. The RCA is conducted by gathering and analyzing information regarding the event. The final report on the RCA must be completed, validated by the Superintendent and submitted to the SET within 45 days of the event. SET may accept the report or return it to RPC for further work and resubmission for final approval.

RPC is also required to develop and implement a plan of action to address identified root causes. The Sentinel Event policy requires monthly reporting on progress in implementing that plan and a final report on the outcome to the hospital's executive leadership.

Additionally, the sentinel event policy requires RPC the development and implementation of a plan of corrective action to address the root causes and opportunities for improvement identified in the RCA. The corrective action plan must include specific measures to determine progress in implementing the specified actions.

RPC's sentinel event policy also requires monthly reporting on implementation of corrective actions to the hospital's quality/performance management committee. A final report on the corrective action plan's outcome must also be made to the hospital's executive leadership.

Results of OPEGA's Assessment and Testing

Current practice for reporting Sentinel Events, as described to OPEGA, appears consistent with written policy.

Current practice for reporting of sentinel events at RPC, as described to OPEGA, is consistent with the written policy. However, we note that the policy does not specify which RPC staff position or individuals are responsible for ensuring implementation of the required corrective action plan and for preparing the monthly and final reports on corrective actions. See Recommendation 1 for further discussion.

Sentinel Event occurrences are rare. OPEGA reviewed the files associated with the one event that occurred in our study period, and the next most recent event from June 2013. We observed there may be need for further clarity on the definition of Sentinel Event and the threshold for reporting them to SET.

Occurrences of sentinel events are very rare. OPEGA reviewed the one sentinel event that occurred during our study period, in August 2014, along with the next most recent sentinel event, which had occurred in June 2013. We reviewed the reporting process followed for these two events from discovery through to the completion and acceptance of the root cause analysis report.

In the case of the August 2014 sentinel event, the reporting process was actually initiated by the DLRS rather than RPC after the event and resulting injury to a staff member were reported in a newspaper article. RPC explained that the injured employee came back to work after leaving the emergency room and returned to normal duties. It was not until a period of time after the assault that RPC was aware of the magnitude of the results of the assault. The fact that DLRS contacted RPC about reporting this event, rather than RPC discovering and reporting it as a sentinel event upon occurrence, raises questions as to whether there is sufficient clarity regarding the definition of a sentinel event and the threshold for reporting of such events to the SET. See Recommendation 1 for further discussion.

We also found that RPC's documentation does not provide information to track compliance with notification requirements. Although we observed marked improvements in the quality of the RCA reports between the first and second sentinel events, both were significantly delayed beyond the 45 day timeline.

We found that the documentation maintained by RPC for sentinel events does not systematically provide the information necessary to track compliance with notification requirements following an event. Additional details are included in Recommendation 3.

OPEGA observed marked improvement in the structure, content and specificity of the Root Cause Analysis report between the two sentinel events reviewed. The RCA for the more recent event, provided a thorough analysis of the event and plan of corrective action, including implementation. In both cases, however, the Root Cause Analysis was significantly delayed beyond the 45 day time line set forth in DHHS Rule and RPC policy, with no available documentation of extensions granted by the SET.

Reporting Staff Behaviors

RPC policy establishes a code of conduct for staff intended to create and maintain a culture of safety and quality. The policy defines acceptable behavior and establishes a zero tolerance for undermining behaviors.

Undermining behaviors are defined as those that adversely affect the teamwork essential to client safety and quality of care. The policy includes specific examples of acceptable and unacceptable behaviors.

All undermining behaviors are to be reported verbally or via email using the chain of command. Employees can report to another manager or Human Resources if they are uncomfortable reporting to their direct supervisors.

Process Description

Reporting Violations of Staff Behavior Policy

RPC's Behaviors that Undermine a Culture of Safety policy establishes a code of conduct intended to create and maintain a culture of safety and quality in which all personnel take responsibility for, and are supported in, reporting behaviors that undermine that culture. The policy defines acceptable behavior for staff, establishes a zero tolerance for undermining behaviors, outlines how to report such behaviors and describes how RPC addresses them. It encourages prompt identification and resolution of alleged undermining behaviors by providing a variety of methods, from informal interventions to disciplinary actions, to modify behavior.

RPC defines behaviors that undermine a culture of safety as any staff behavior that adversely affects "the teamwork essential to client safety and quality of care." Examples are: abusive behavior towards clients or staff; demeaning behavior such as name-calling; outbursts of anger; refusal to cooperate with other staff members; criticism of caregivers in front of other clients or staff; and failure to adequately address safety concerns or client care needs expressed by another caregiver. Acceptable behaviors include, but are not limited to: effective teamwork and collaboration; clear, direct and honest communication; encouragement; accepting constructive feedback; and respect for clients, staff and family members.

The policy states that all behaviors that undermine a culture of safety will be reported. The staff member subjected to the behavior, or any staff member, can report such behavior verbally or via email using the chain of command, beginning with their direct supervisor. Employees can report to another manager or Human Resources if they feel uncomfortable reporting to their direct supervisor. Behavior by a staff member that places anyone (staff or patient) at high risk of imminent danger is to be reported to the Superintendent and an Incident Report may also be filed.

Behavior placing anyone at high risk of imminent danger is to be reported to the Superintendent. RPC typically places the employee who is the subject of such a complaint on leave pending an investigation.

Supervisors are to enforce this policy using a graduated intervention process conducted by the supervisor and, if necessary, Human Resources. Any associated documentation is kept in unit files until after an employee's annual review. Only documentation related to a disciplinary process becomes part of an employee's permanent record.

OPEGA found the written policy to be specific and comprehensive in establishing expectations for staff behavior. Staff we interviewed showed an understanding of the content of the policy, though were not always familiar with the name of the policy.

OPEGA was unable to perform any further assessment of adherence to expectations and reporting requirements, due to the informal nature of the reporting process and the lack of formal documentation available.

RPC Response to Reported Violations of Behavior Policy

Supervisors are responsible for enforcing this policy using a graduated process for intervention conducted by the supervisor and, if necessary by Human Resources. This process includes:

1. informal conversations for single incidents;
2. non-punitive awareness interventions when data reveals patterns;
3. leader developed action plans if patterns persist (primarily attendance issues); and
4. HR disciplinary processes if previous interventions are insufficient.

In the instances when a staff member's behavior puts anyone in imminent danger, RPC typically places the employee who is the subject of the complaint on administrative leave pending a personnel investigation.

Supervisors may generate notes or other documentation as part of report intake and initial intervention. Supervisors maintain these documents in the "unit files", which are not part of the employee's permanent record and are not retained after the employee's annual performance review. If an initial report leads to a disciplinary review, HR creates and stores the required disciplinary process documentation in the employee's permanent personnel file.

Results of OPEGA's Assessment and Testing

OPEGA found the written policy to be specific and comprehensive in establishing the expectations for staff behavior and conduct. OPEGA asked questions regarding this policy during the 26 RPC staff interviews and initially found that RPC employees were relatively unfamiliar with the policy on Behaviors that Undermine a Culture of Safety. However, this may have been due to their unfamiliarity with the specific name of the policy. Awareness among interviewees improved after OPEGA modified the interview question to remove the wording of the policy title and instead provide examples of certain behaviors. Despite not being familiar with the exact phrase, staff exhibited an understanding of the behaviors addressed by the policy and the actions to take if it is not followed.

Beyond this, however, OPEGA was unable to perform any testing or assessment of adherence to expectations associated with this reporting avenue. There are no specific forms for reporting violations of this policy, no specific section on the Incident Report form to indicate when staff behavior of this nature is part of an incident, and no other formal documented means through which reported violations are captured and tracked.

The policy states that HR reports to RPC leadership "quantitative information regarding the number of incidents that undermine a culture of safety." However, as reported to OPEGA, RPC does not report on this data because, typically, reported behaviors are addressed verbally at the Supervisory level. According to RPC's HR Manager, supervisors at RPC work effectively through discussions with staff to address and correct behaviors such that there are few behaviors that go beyond this more informal level.

OPEGA's observations on this policy, and the reporting it requires, are discussed further in Recommendation 5.

Filing Patient Grievances

Process Description

RPC policy describes how patients should submit Grievances and the process required for any required response by RPC. Patients can seek assistance filling out the form from staff, Patient Advocates and Peer Support Specialists.

Completion of Grievance Forms

Patients who feel their rights have been violated can file a grievance. Patients can grieve any possible violation of their basic rights as defined in Statute (22-A MRSA §206.4) and DHHS Rule 14-193 Ch.1: Rights of Recipients of Mental Health Services. The RPC policy entitled "Patient Concern/Suggestion/Grievance" (grievance policy) describes how patients should submit grievances and the process for any required response by RPC. The grievance policy is provided to patients upon admittance and is available on each unit along with Grievance forms. A sample of the Grievance form is in Appendix C.

Patients can ask an employee, Patient Advocate or Peer Support Specialist for assistance with filling out the Grievance form. Peer Support Specialists, contracted through Amistad, Inc., provide support and assist patients in communicating with staff at RPC. They often assist patients with filling out Grievance forms and encourage patients to resolve situations that are not rights violations with staff before filing a grievance. Additionally, a patient's guardian, attorney, designated representative or advocate, or other persons "specifically aggrieved" can file a grievance. Grievance forms, and locked boxes to place them in, are available on each unit and in the treatment mall and cafeteria.

Peer Support Specialists collect Grievance forms from locked boxes on each unit each business day morning, provide copies to the Advocacy Office and the patient, and submit forms to appropriate RPC staff for response. If a Grievance involves an allegation of ANE, the ANE reporting process is initiated.

Peer Support Specialists for each unit collect Grievance forms from the boxes each business day morning, provide copies to the Advocacy Office (Disability Rights Maine) and the patient, and submit forms to the appropriate RPC staff for response. If a grievance involves an allegation of abuse, the ANE reporting process is initiated.

RPC Response to Grievances Submitted

There are three levels of grievances. There are established time frames for RPC to respond to the patient with a decision or recommendation and timeframes for the patient to appeal. The Peer Support Coordinator and Patient Advocates monitor and track grievances for compliance with response timeframes and patient appeals.

There are three levels of Grievances with established timeframes for RPC response and patient appeals. Grievances are tracked by the Peer Support Coordinator and Patient Advocates.

Level I Review: The reviewer, either a Nurse IV or ADON (Assistant Director of Nursing) must make a recommendation/propose outcome by end of the 5th regular business day, unless a 5-day extension is requested by the reviewer and granted by the Superintendent. A patient has 10 days to appeal a Level I decision. The appeal of a Level I grievance is processed by the Superintendent as a Level II.

Level II Review: The Superintendent must complete review/propose a written outcome to the patient within 5 regular business days. The patient has 10 days to appeal the decision to the Commissioner, which initiates a Level III Review. Additionally at Level II, the Superintendent may determine the grievance is without merit and, if the Patient Advocate agrees, will inform the patient who may appeal that decision to the Maine Superior Court.

Level III Review: The Commissioner must respond to Level III request within 5 days; response may be to schedule an administrative hearing. The DHHS Commissioner, or designee, reviews the Hearing Officer's recommendation and issues final agency action, which may also be appealed to Maine Superior Court.

Patients may indicate on the form that their grievance is 'urgent.' The Peer Support Specialist refers such grievances within one working day to the Superintendent who determines urgency. A Level II grievance proceeding is initiated within three working days for grievances the Superintendent determines are urgent. Those not determined to be urgent are addressed as Level I grievances and go to the first party reviewer, usually the Nurse IV on the patient's unit, the Program Services Director (PSD) or, occasionally, the Risk Manager or the Medical Director.

RPC's first party reviewer documents the proposed response or decision on the Grievance form. The patient receives a copy for review, and signs and dates the form to indicate they have received the proposed solution. The form also describes the patient's appeal options.

The first party reviewer (also referred to as the "responder") for any grievance prepares the proposed response or decision and documents this response on the Grievance form. The patient is given a copy of the form to review the response and indicates they have received the form with their signature and date. There is a statement above the client signature line regarding acknowledgment of receipt of a copy of the grievance and proposed solution, and describing appeal options. Patients may appeal decisions made for Level I and II grievances within RPC and DHHS. Patients dissatisfied with a Level III resolution may appeal to the Maine Superior Court.

The first party reviewer sends copies of Grievance forms to the Superintendent's Office where information from the form is entered into a database. RPC uses this database to generate metrics that are published in the Quarterly Reports.

Capturing Grievance Data for Reporting

The first party reviewer sends copies of Grievance forms to the Superintendent's Office. Information from the forms is entered into the database maintained by Substance Abuse and Mental Health Services (SAMHS). The Superintendent's Office updates this database once the grievance is resolved. RPC uses this database to generate metrics on the number of grievances and response timeliness rate that are published in its Quarterly Reports.

Results of OPEGA's Assessment and Testing

RPC staff OPEGA interviewed all accurately described the Grievance process and their roles in providing forms or assisting patients in completing forms. Patient Advocates and Peer Support Specialists we spoke to indicated that RPC also communicates with them about their roles and the processes and procedures to follow.

OPEGA initially sought to interview patients to determine how well the grievance process is understood by patients. However, after consultation with the Attorney General's Office, RPC administration and medical staff, it was determined that such interviews had the potential to adversely affect patient treatment. Instead, OPEGA interviewed Patient Advocates and Peer Support Specialists who work closely with RPC patients, but are employees of external agencies. The Advocates and Peer Support Specialists indicated that RPC communicates to them about their roles in the grievance process and what policies and procedures to follow. OPEGA also asked the 24 relevant RPC direct care staff interviewed for this review about grievances; all 24 accurately described the process for patients to submit grievances and their role in either providing the forms or assisting in the completion of forms.

To test for adherence to the expected grievance process, OPEGA reviewed a sample of grievances. OPEGA obtained a data file from SAMHS and selected a random sample of grievances occurring in the time period July 1, 2014 through June 30, 2015. The sample included 28 Level I grievances and six Level II

grievances representing 10% of all grievances in the time period. There were no Level III grievances in the time period. The sampled grievances represented all 4 units of the hospital.

OPEGA reviewed the files for a sample of 34 randomly selected Grievances. We found that RPC substantially met the required timelines for distribution of forms to the appropriate reviewer and for the Superintendent's determinations regarding urgency.

OPEGA conducted a file review for the selected sample of grievances on-site at RPC. OPEGA found that RPC substantially met the required timelines of the grievance policy for distribution of the Grievance forms to the appropriate reviewer and the Superintendent's determinations regarding urgency. The requirement that the Level I reviewer provide a proposed solution to the grievant was met consistently. The requirement that the Superintendent offer a proposed outcome to the grievant in the form, or a personal letter for Level II grievances was also met consistently.

It was difficult to confirm adherence to certain other required points and timelines in the grievance process due to the format of the Grievance form and inconsistency in terms of patients completing certain portions of the form. OPEGA was limited in our ability to confirm that the timeline of five business days for reaching a Level I decision (or 10 days with an extension) had been met. The only apparent way to determine when the decision was made is the patient acknowledgement signature and date. However, patients did not consistently sign the form or include a date beside their signature, and sometimes refused to sign the form. Twelve of the 28 Level I grievances were not signed and/or dated by the patient within five business days of the date of receipt by the responding party. Two of the 12 had patient signatures greater than five business days from date of receipt with no evidence of an extension being granted. In the other ten instances, OPEGA was unable to determine when the decision was made and provided to the patient due to various combinations of patient signature and date issues.

Inconsistencies in, or lack of, patient signatures and dates on Grievance forms made it difficult to confirm adherence to certain other requirements and timelines in the Grievance process for 13 of the 34 Grievances sampled.

There were three of the six Level II grievances we tested that also did not have patient signatures. For these, as well as the Level I grievances without any patient signatures, we were unable to confirm adherence to the requirement that the patient be informed of the decision or proposed resolution.

In addition, RPC staff explained to OPEGA that they were trying a new process in which the grievance reviewer produces a separate document, aside from the Grievance form, where a statement of facts and a proposed resolution is recorded. OPEGA observed four records in the sample that used this new process. In each case, the separate document contained a statement indicating the date it was provided to the patient, however, there was no place for a patient signature on the new document and the patient had not signed the Grievance form. Without a patient signature, there is no evidence that the patient received the proposed resolution and was made aware of his appeal rights.

Overall, we found the process being followed to be in alignment with the Grievance policy and the Rights of Recipients of Mental Health Services.

Overall, OPEGA found the RPC grievance process to be in alignment with policy and in compliance with the Rights of Recipients of Mental Health Services. The issues regarding patient signatures are addressed in Recommendation 3.

While OPEGA did not specifically test the accuracy and reliability of data in the grievance database, we did note the potential for control weaknesses associated with the database and the data collection process. This concern is discussed further in Recommendation 7.

Recommendations

1 *RPC Should Update its Reporting Policies to Reflect Current Practice and Improve Clarity and Consistency*

A number of written RPC policies OPEGA reviewed no longer reflected current reporting practices. We also noted policies that lacked clarity, as well as inconsistencies between policies.

RPC reviews and updates policies as needed every three years on a staggered schedule. Practices related to several of the reporting avenues we reviewed have recently changed, however, and those changes are not reflected in the current policies. For example:

- The Risk Manager described to OPEGA the current practices for reporting and responding to incidents and these practices were also reflected in a document RPC provided to the Legislature's Appropriations and Financial Affairs Committee. OPEGA observed the incident reporting policy has not been updated to reflect changes in roles, responsibilities and authorities for reporting and responding to incidents; as well as Management's process for responding to reports. IQI staff acknowledged that the current incident reporting policy does not match practice. They explained that the new practice had been in a period of testing and once RPC is satisfied that it is working as intended, the policy will be updated accordingly.

- Sections of the ANE policy are not consistent with current practice. The Risk Manager now performs responsibilities previously assigned to the Nurse on Duty. The Superintendent now receives verbal reports and recommendations regarding the incident during the morning administrative meetings instead of receiving and reviewing written reports. The Risk Manager may now initiate an investigation without specific directive from the Superintendent.

- Both the incident reporting policy and the ANE policy mention the Program Services Director (PSD) position as having responsibilities under the policy, but according to the Director of IQI, the PSD position is not used in the capacities mentioned in the two policies any longer.

In addition to written policy not reflecting current practice, OPEGA observed a lack of clarity and consistency, specifically surrounding investigations, notifications and definitions, which can adversely impact reporting. For example:

- Multiple guidance documents contain definitions of sentinel events, including state statute, DHHS Rule, the RPC sentinel events policy and DLRS Sentinel Event Notification and Near Miss Reporting Form. These definitions vary in the level of detail and specific language used to define a sentinel event. RPC policy has not incorporated the recently revised DHHS Rules Governing the Reporting of Sentinel Events, which addresses such definitional issues.

- DHHS Chapter 112 Rules for the Licensing of Hospitals requires APS to be notified within 24 hours of a suspected event of ANE, but RPC's policy does not mention the 24 hour requirement.

- The incident reporting process is described in the sentinel event policy, but the definition of an incident is inconsistent between the sentinel event policy and the incident reporting policy.

RPC policies are used to train staff on proper procedures, communicate expectations and serve as an on-the-job reference document for staff. Policies that lack sufficient and current guidance are ineffective for these purposes and may in turn result in inconsistent and possibly noncompliant actions.

Recommended Management Action:

RPC should review the full list of specific issues and observations OPEGA identified for each policy in Appendix B and make corrective updates to clarify language and definitions to improve the overall clarity of each policy and establish consistent definitions and expectations across related policies. RPC should update policies to reflect current practice; in particular, policies surrounding Allegations of Client Mistreatment Including Abuse, Neglect, or Exploitation and should be revised immediately, even if outside the regular schedule for updating these policies.

RPC Should Review and Revise, as Necessary, Certain Sections of the Incident Report Form and Related Policy

The section of the Report form used for documenting notifications made is not completed on a consistent basis. We also noted that supervisory signatures on the form were inconsistently obtained.

Several of the RPC policies reviewed, as well as other authoritative documents, include requirements for notifying particular parties of certain incidents, often within specified timeframes. These include the patient's family/guardian, the Client Advocate, Adult Protective Services and the Superintendent or the Administrator on Call. The Incident Report form has a section for documenting the parties notified of the incident and the time the notification was made. It lists all possible parties that need to be notified with "Yes," "No," and "N/A" options. This appears to indicate that staff is expected to choose one of these options for each party. However, OPEGA's review of 100 Incident Report forms found about 20% of the reportable incidents with at least one or more notifications left blank.

The "Description" and "Action(s) Taken" sections of the Incident Report form require a supervisor signature. The incident reporting policy states that "The Supervisor line should be signed by the Charge Nurse, Nurse IV, PSD or NOD. Do not sign as your own supervisor." In practice, if the staff person completing the Incident Report is in a supervisory position, RPC does not require their supervisor to sign the supervisor line. Even allowing for this, OPEGA found instances in which the reporter was not a supervisor and there was no supervisor signature in the "Description" section, instances in which there was no supervisor signature in the "Actions Taken" section and some that did not have a supervisor signatures in either section.

The incident reporting policy does not provide any guidance on how to complete the Incident Report form. It also does not indicate the intended purpose of the notification section or the supervisory signature. OPEGA notes, however, that the

inconsistencies in documentation we observed may undermine RPC's ability to identify and monitor which notifications are made in response to any given incident, and assure compliance with policies, rules, statute and the Consent Decree. It also appears that the purpose associated with supervisory signatures may not always be met.

Recommended Management Action:

RPC should reevaluate the purpose and process of documenting notifications made, and the purpose of the supervisor signature lines on the Incident Report form. Once the purpose and proper use of these sections of the Incident Report form is determined, RPC should revise the policy to specify the purpose of these sections and then revise the form, if necessary, to capture all information needed to achieve the defined purpose. RPC should then train their staff on proper notification procedures and proper completion of the notification and supervisor signature line sections of the Incident Report form.

RPC Should Improve the Use of Documentation to Monitor Adherence to Policy Requirements for Grievance and Sentinel Events

OPEGA found missing or incomplete documentation for both patient grievance and sentinel events reporting avenues. Lack of documentation impedes RPC's ability to monitor adherence to policies and rules.

The grievance policy and DHHS Chapter 1 Rules, Rights of Recipients of Mental Health Services, both require a formal written response from the responder to the grievant within a certain timeframe. It also requires the grievant be notified of the opportunity to appeal the decision, which also must be made within a certain timeframe. Evidence of meeting these timelines requires the completion of the patient Grievance form by the patient, specifically the signature and date lines below the statement affirming receipt of a copy of the Grievance form and proposed solution and describing the 10 day appeal window. Patient signature and date lines regarding these acknowledgements were not completed consistently on all Grievance forms reviewed, sometimes because patients refused to sign. For 10 of the 28 Grievance forms OPEGA reviewed, we were unable to determine when the decision was made and provided to the patient due to patient signature and date issues.

In addition, RPC explained that they are trying a new process in which the grievance responder produces a separate document that includes a statement of facts and a proposed resolution. The proposed resolution on this separate document is not recorded on the Grievance form in the section so designated and there is no acknowledgement of patient receipt on either form. Therefore, there is no way for RPC to show that the response was provided to the grievant within the timeline, or at all, and no way to show that the grievant was made aware of their opportunity to appeal the decision. There were four grievances in our sample of 28 that used this process.

Statute and DHHS Rule require notification to the Sentinel Event Team (SET) by the next business day after a sentinel event has occurred or the next business day after the facility discovers that the event occurred. RPC's sentinel event policy outlines additional notifications that it requires immediately, within one day, and within seven days. OPEGA observed that completion of the form for reporting sentinel events and near miss events provides the documentation necessary to assess compliance with the notification to SET. However, there is no standard form or documentation in place for the additional notifications required by the sentinel events policy. Thus, RPC is unable to monitor compliance with its policy to ensure appropriate parties are notified in a timely manner.

Recommended Management Action:

As RPC formalizes its new process for documenting proposed solutions to grievances, it should incorporate the description of the proposed solution into the Grievance form, reinforce with appropriate staff the need to obtain patient signature, and require some notation on the Grievance form if patient refuses or is unable to sign the acknowledgement.

RPC should establish means to document the notifications required by RPC policy for the reporting of sentinel events.

RPC Should Clarify Responsibilities of Staff who are Mandatory Reporters of Abuse, Neglect or Exploitation

Maine Statute lists seven categories of professionals required to immediately report to DHHS when the person knows of, or has reasonable cause to suspect, patient ANE. Statute also states that whenever possible, the Department and state licensing boards of professionals required to report under this section shall collaborate to facilitate the dissemination of information regarding the duty to report and the reporting procedure.

The mandatory reporters specified in statute include several RPC employee classes. OPEGA noted that RPC's written policies and procedures address RPC's requirement to report incidents of ANE to DHHS Adult Protective Services (APS) ensuring that the institution's responsibility to report under the DHHS Rules for the Licensing of Hospitals is met. The policy is silent, however, on any guidance as to the individual's responsibility to report to APS under the statutory mandatory reporting requirement. We note that adhering to the policy should not, nor does it appear to, preclude individual reporting.

To test staff's understanding of their role as mandatory reporter, OPEGA interviewed RPC staff and asked how they reported ANE. Only 13 of 26 of RPC staff interviewed by OPEGA indicated that they themselves would contact APS if they observed incidents of ANE. The remaining staff either did not mention contacting APS at all (10 staff) or indicated a supervisor would do so (three staff), even though both of these actions would not meet the staff member's individual responsibility to report as mandated. Nine of these 13 were Mental Health Workers, two were Nurses, one was an Acuity Specialist and one was an Intensive Case Manager.

RPC Risk Management and Training staff, as well as DLRS staff OPEGA spoke to indicated that in cases where multiple mandatory reporters witness a reportable event, it is common for only one person to report the incident. This practice would also appear to be non-compliant with statute.

The Consent Decree states all staff shall be required to report instances of patient abuse, neglect and exploitation immediately and reports shall be made to the superintendent with a copy to the patient advocate. OPEGA noted the following comments in a consultant's report to the Court Master from her visit to RPC in Sept. 2014:

- Continuing effort is required to ensure that all staff understand the mandate for reporting any suspected ANE of class members.
- The Consent Decree language should be modified to specify that timely reporting of abuse and neglect cases should be made to Adult Protective Services (APS), Licensing, the Court Master and Plaintiffs' Counsel.

Having only one person report an incident of ANE to APS, rather than all witnesses, seems to have become a common practice. Both DLRS and the RPC Staff Development Coordinator said that it is a "cultural" thing in the health care community. Additionally, RPC stated it does not believe all its staff are mandatory reporters, mentioning Mental Health Workers in particular. OPEGA observes that the category of "mental health professionals" is not defined in the mandatory reporting statute and it is unclear whether or not Mental Health Workers would be included in that category.

RPC's policy addresses RPC's reporting requirements while statute addresses the individual's requirements, but it would seem RPC policy should also advise staff on their individual statutory responsibility. Otherwise, there is potential for individual staff to be out of compliance with statute, which could lead to loss of their individual professional license. There is also the potential that no report will be made if all witnesses believe another witness is reporting.

Recommended Management Action:

RPC should clarify which staff are mandatory reporters and reconcile hospital reporting requirements with individuals' professional mandatory reporting requirements. RPC should also clarify reporting requirements in incidents where there are multiple witnesses to the event. RPC should incorporate all clarifications into policy and train staff accordingly.

5

RPC Should Develop and Implement a Method to Track and Monitor Unacceptable Staff Behaviors

RPC's policy on Behaviors that Undermine a Culture of Safety intends to create and maintain a culture of safety and quality for patients and staff. It establishes a code of professional conduct for staff and a standard of zero tolerance for certain behaviors. The policy defines unacceptable behavior and outlines the process for reporting and intervening to address such behavior. The policy also requires Human Resources to report to RPC leadership quantitative information regarding the number of instances of such behaviors. This requirement suggests to OPEGA that RPC leadership intended to monitor the degree to which violations were occurring.

Among the complaints OPEGA had received in advance of this review, there were examples of staff behaviors, both subtle and overt, that are captured within the definition of behaviors that undermine a culture of safety. These behaviors were alleged to affect patients' behavior, causing or escalating patient episodes.

According to the policy, all behaviors that undermine a culture of safety are to be reported through the chain of command. The nature of this process is such that many reported behaviors are handled verbally at the supervisory level and do not result in any paperwork or tracking of reported violations. The policy outlines information that must be gathered on each alleged behavior, but there is not a mechanism by which this information is recorded and retained. As a result, the incidence of such behaviors cannot be quantified. OPEGA confirmed that, in practice, Human Resources is not reporting quantitative information on behaviors that undermine a culture of safety to RPC Leadership.

OPEGA observed that the incident reporting policy requires that incidents involving potentially unacceptable staff conduct be referred to Human Resources for investigation. However, we noted that there is no requirement that violations of the Behaviors Policy, or behaviors requiring referral to HR, be recorded on an Incident Report. OPEGA also observed that very few of the Incident Reports we reviewed discuss whether staff conduct contributed to the incident. It also does not appear the Risk Manager, Human Resources, or others conduct regular analyses of reported incidents to determine whether staff conduct is part of the root cause. We did not see evidence of staff behaviors or conduct being formally considered as potential contributing factors to patient incidents as part of any documented follow-up to Incident Reports we reviewed.

The lack of documentation on behaviors that undermine a culture of safety limits RPC management's ability to monitor the occurrence and impact of such behaviors on staff and patients at RPC.

Recommended Management Action:

RPC should develop and implement a method for more systemically monitoring the occurrence of behaviors that undermine a culture of safety and the degree to which they contribute to patient incidents.

6

RPC Should Clarify Expectations for Formal Administrative Follow-up on Reported Incidents

OPEGA observed inconsistencies between expected practice and actual practice with regard to the conduct and documentation of formal administrative follow-up actions on reported incidents of seclusion and restraint and allegations of ANE. A lack of clarity around what type of follow-up is expected and in what circumstances, may be contributing to these inconsistencies.

OPEGA noted the following:

- The incident reporting policy, which covers internal reporting of seclusions, restraints and allegations of ANE, has very limited guidance on expected follow-up actions.

- The policy on Mandatory Reporting: Allegations of Mistreatment Including Abuse, Neglect or Exploitation references and describes the process for initial fact findings, review of fact findings by the Superintendent, and subsequent investigations as warranted. The policy appears to require written documentation of the fact findings. It also seems to imply that investigations would primarily be conducted for situations where there may be staff misconduct.

- In February 2015, RPC provided a written document to the Joint Standing Committee on Appropriations and Financial Affairs describing RPC's response to certain types of incidents occurring at the Hospital. That document states "all incidents that include allegations of violation of patient rights, patient abuse or patient neglect are reported to the required regulatory bodies and are reviewed using either a fact finding, full investigation or root cause analysis." The current practice RPC described to OPEGA, however, is less universal. For example, RPC explained that there is not a fact finding, investigation or root cause analysis in cases of alleged ANE that is reported to have occurred somewhere other than RPC.

- RPC's IQI staff explained that they conduct a fact finding, investigation or root cause analysis when an Incident Report indicates that a potential violation of policy, or a potential violation of patient or staff rights, and Human Resources conducts an investigation if there appears to be staff misconduct involved.

The sample of Incident Reports OPEGA reviewed included 59 that were events of seclusion, restraint or allegation of ANE. Nine of the 59 had some follow-up, or attempted follow-up, action by the Risk Manager. For, three of those nine there was formal fact finding documentation that OPEGA reviewed. Two were incidents of sexual abuse and one was an incident of verbal abuse. Of the three fact findings we reviewed, one had information about subsequent actions to be taken to help prevent further incident.

In the sample of 100 Incident Reports OPEGA reviewed, we observed that some incidents did not seem to warrant any follow-up response beyond the actions taken at the time of the incident. However, based on the information in policy and written material provided to the Legislature, as well as descriptions by IQI staff, we expected to see more documented examples of fact findings and/or root cause analyses associated with our sample.

OPEGA also noted that the three documented fact findings we reviewed were related to incidents of sexual or verbal abuse, but other incidents of this nature in our sample did not result in a documented fact finding. Based on our review of the fact findings, OPEGA was unsure why these incidents and not others received a fact finding, as the events described did not appear to be unique from others in the sample. We asked RPC if there was any written guidance they used that would explain this and were told that there is no specific policy that specifies which events or allegations are subject to fact findings.

Recommended Management Action:

RPC should establish in policy the criteria to be used for determining when formal administrative follow-up should occur following an incident, what form it should take and how it should be documented. This will ensure that all incidents of a given severity (for example, an allegation of sexual abuse) are subject to the same level of review and scrutiny and documented accordingly. RPC should also include guidance on what the scope of each form of follow-up should include. In doing this, we suggest that RPC consider establishing scopes that allow for some assessment and gathering of information as to the root cause(s) of the incident, i.e. triggers of patient behavior.

Any future descriptions of RPC's follow-up processes that are shared publicly should reflect the instances in which fact findings, investigations or root cause analyses will actually occur.

RPC Should Implement Controls to Ensure Reporting of Incidents and Grievances Is Accurate and Reliable

OPEGA sampled 25 Incident Reports *not* included in MEDITECH and discovered five of them (20%) contained reportable events (one patient fall and four allegations of abuse) that should have been captured for reporting. Our sample of 25 was drawn from a population of 494 Incident Report numbers used since January 1, 2015 that were not included in the data file we obtained from RPC.

The RPC Risk Manager believed she sent these Incident Reports to DDPC for data entry and RPC was unaware that the reportable events had not been appropriately captured. RPC attempted to reenter the five Incident Reports OPEGA identified and found that the records entered were not being saved. RPC later learned, and explained to OPEGA, that a vendor-controlled update to MEDITECH caused the issue in question. When the system's settings were restored to those prior to the update, the problematic Incident Reports were able to be saved.

RPC has since provided evidence from the vendor that a fix has been made and OPEGA has sought additional description of the computer update problem from the State's Office of Information Technology and the vendor. It is OPEGA's current understanding that a field was missing from the data entry screen and this field is required for records to be selected in queries of events run against MEDITECH. This would mean that the records are in MEDITECH but just not able to be queried. The vendor was able to run a routine to populate the missing field and reports that this affected 209 reportable events that were captured in MEDITECH.

This description leaves it unclear whether this computer issue is actually the cause of the deficiency OPEGA identified. It is also still not known, even if this was this issue, to what degree it impacted the metrics generated from MEDITECH that are published in RPC's Quarterly Performance Reports. Lastly, we still have no details concerning the duration of the issue or the specific types of reported incidents affected, which prevents us from establishing the impact of the issue. As a result, there is a risk that all metrics generated from MEDITECH stemming from Incident Reports are inaccurate and unreliable.

The undetected exclusion of these reportable events from MEDITECH highlights that RPC's current process for incident reporting does not possess sufficient controls to ensure all Incident Reports are successfully logged. We also noted other control weaknesses in the data collection process.

Since January 1, 2015, RPC's incident reporting process has utilized pre-numbered Incident Report forms with certain number ranges assigned to the different units of the hospital. The pre-numbered forms are a control intended to ensure all Incident Reports are accounted for and submitted to the Risk Manager. While this control is an improvement over previously unnumbered and unassigned forms, OPEGA found that no proactive monitoring was occurring to detect whether any Incident Report forms were not being submitted. Additionally, we noted there were no reconciliation efforts to ensure all Incident Reports sent by the Risk Manager to DDPC for entry were successfully entered into MEDITECH. These noted control weaknesses create the potential for reportable events to be omitted from the MEDITECH and the subsequent reported metrics, and for these omissions to again go undetected.

OPEGA noted that the grievance database may also have similar control weaknesses. The grievance database is the source of data for RPC's metrics related to patient grievances. Data entry for grievances occurs at RPC while DHHS's Office of Substance Abuse and Mental Health Services (SAMHS) maintains the database and generates reports required by the Consent Decree. It appears neither the Data Manager at SAMHS, nor the person responsible for entering grievance data at RPC, have any role in validating data entered into the database. Although OPEGA did not test the data for reliability and accuracy, the lack of controls over data collection creates a risk that resulting metrics may be inaccurate.

Recommended Management Action:

RPC should further investigate and confirm the cause of the Incident Reports with reportable events being inappropriately excluded from MEDITECH. Once confirmed, RPC should assess and quantify the impact of the issue on the relevant performance metrics based on the duration of this issue and which types of records were impacted. RPC should report this information back to the Joint Standing on Health and Human Services and the Government Oversight Committee, along with a plan for updating any impacted metrics.

RPC should also consult with DHHS Internal Audit staff to design and implement additional controls to address weaknesses in the processes for data collection and reporting for both incidents and grievances.

8 *RPC Should Ensure That Reported Metrics for Factors of Causation and Allegations of ANE Are Accurate and Meaningful*

In addition to not all reportable events being captured in MEDITECH, OPEGA identified two concerns with the current process or procedure employed by RPC to determine and categorize events for reporting in particular metrics. Specifically, we noted:

- instances of staff-witnessed incidents of ANE being excluded from the Allegations of ANE metric; and
- a process for assigning Factors of Causation for seclusion and restraint events that, by default, always assigns an acceptable cause.

Allegations of physical, sexual or verbal abuse captured in MEDITECH include all allegations of abuse regardless of when and where the alleged abuse occurred or who was the perpetrator. The data published in RPC's Quarterly Performance Reports, however, is intended to only capture allegations of ANE occurring in the hospital. In the process of selecting the events that should be captured for the metric, IQI's HITech Manager reviews the copies of the Incident Reports that have allegations of ANE and notes pertinent information in an Excel file. This information includes whether the allegation occurred during the patient's stay at RPC, if the abuse involved an RPC staff person or another RPC patient, and whether the allegation was ultimately selected for inclusion in the quarterly report.

OPEGA reviewed the HITech Manager's Excel file for all four quarters of 2015 and noticed two instances of abuse witnessed by staff were not selected for inclusion in the quarterly report metrics. IQI staff explained that the cases were not included as the metric is for reporting allegations of ANE and these incidents were witnessed rather than alleged. OPEGA confirmed with IQI staff that the witnessed incidents of ANE are not otherwise captured in any quarterly report metrics.

OPEGA reviewed relevant documents related to the Consent Decree. The Standards for Defining Substantial Compliance states that "Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶¶ 192-201 of the Settlement Agreement." This is also the language that accompanies the count of such

allegations in the quarterly reports. Paragraph 197 of the Settlement Agreement, which describes the data associated with patient abuse, neglect and exploitation, states that "all allegations and findings of patient abuse, neglect and exploitation shall be collected and analyzed."

OPEGA believes the Consent Decree intent associated with the metric for ANE is to capture all incidents of ANE regardless of whether they are alleged or witnessed. The exclusion of witnessed events from the quarterly report metrics provides an inaccurate measure of incidents of ANE occurring at the hospital.

Similarly, RPC's process for categorizing and reporting the Factors of Causation leading to seclusion and restraint events impacts the accuracy and meaningfulness of those reported metrics. The quarterly reports contain a breakdown of the reasons or causes seclusion or restraint was necessary. The three categories of causes reported are "Danger to Self/Others," "Danger to Self," and "Danger to Others."

The Standards for Defining Substantial Compliance indicates that both seclusions and restraints are to be employed only when absolutely necessary to protect the patient from causing physical harm to self or others—which mirrors the categories used by RPC. The use of seclusion is also allowed for the "management of violent behavior," but this category does not appear in RPC's quarterly reports. The established threshold for substantial compliance is 95% of seclusion events and 95% for restraint events based on two quarters of data.

OPEGA attempted to determine the accuracy of the reported causes in MEDITECH, for our sampled events, by comparing them to the relevant Incident Reports. We observed that RPC's Incident Report forms do not contain a check-off list that matches the categories of causes entered to MEDITECH and used for reporting the metrics. We sought out a crosswalk between the fields on the Incident Report form and the categories of causes, but learned that no formal crosswalk exists. IQI staff explained to OPEGA that the Data Entry Clerk enters causes to MEDITECH according to her training that "Danger to Self/Others" is always selected in instances of seclusion or restraint unless it is explicitly stated on the Incident Report form that it is one of the other causes.

In reviewing past quarterly reports, OPEGA also observed a period spanning three quarterly reports in which nearly all seclusion events were categorized as "Danger to Others." This was a departure from both past and present practice. IQI staff explained that a backup staff person had performed the data entry during that period and must have used the wrong category as a default.

OPEGA notes that the described process for determining Factors of Causation does not include consideration of the acceptable cause for "management of violent behavior". We also note that the process, by default, always assigns an acceptable cause to each instance of seclusion or restraint. This effectively results in RPC automatically being 100% compliant with the Consent Decree in its justifications for seclusion or restraint and does not allow for causes that may be out of compliance.

Recommended Management Action:

RPC should revise the criteria for the ANE metric presented in the quarterly reports to ensure that both alleged and witnessed events are included. RPC should then incorporate these revised criteria into a formal, written procedure. Report metrics should be amended to reflect the revised criteria.

RPC should also align the reported "factors of causation" categories with the specific criteria for utilizing seclusion and restraint from the Consent Decree Settlement Agreement and Amendments and include a category to capture causes that do not meet the criteria. Incident Report forms should then be revised to align one-to-one with the expanded factors of causation. The review and validation of the coding of factors of causation should be incorporated into the Risk Manager's existing review of completed Incident Reports.

RPC Should Proactively Monitor Overtime for Individual Direct Care Staff

The Consent Decree requires RPC to maintain certain staffing levels on each unit and each shift. Treatment plans may additionally call for specific staffing levels for individual patients such as 1:1 or 2:1. RPC has been experiencing a significant, continuing staff shortage that has resulted in a reliance on overtime, including mandated overtime, to meet these requirements. Mental Health Workers (MHW's) and Nurses, in particular, are frequently asked or mandated to work additional shifts.

The staffing shortage and its impacts, including the amount of overtime required and increased safety risks, were among the themes of concerns that emerged from interviews with RPC staff and additional unsolicited comments OPEGA received. Staff reported being very stressed and tired, and that there is poor morale at RPC. Reasons cited by RPC management and staff for the shortage include:

- a large number of vacant positions;
- positions not being filled in a timely manner;
- many employees being out on Family Medical Leave and Workers' Compensation; and
- employees who have doctors' notes for work restrictions, including limits or exemptions for overtime hours.

Although RPC had been working to address these issues during OPEGA's review, progress had been slow. OPEGA raised concern about the impact of the staffing shortage, particularly the overtime situation, on staff and patient safety to DHHS senior management, the Court Master and the GOC in August 2015. Since that time, the GOC has made inquiries of the Department and the Court Master seeking to understand the severity of the situation and the level of safety risk, as well as the Department's efforts to address it and the challenges being faced. The Court Master also further assessed the staffing and overtime concerns as part of his consultant's site visit to RPC in September 2015 and his own follow-up to the consultant's findings.

The Court Master's consultant found that staffing on units was not stable for a variety of reasons including:

- coverage for one-to-one patient staffing being absorbed within minimum staffing requirements;
- reliance on temporary nurses to fill nursing mandates and temporary or part-time psychiatry positions to fill vacancies; and
- acuity specialists that were hired to supplement staff serving as direct care staff.

In December 2015, the Court Master briefed the GOC on these results noting that overtime hours for MHW's at RPC had been about 2000 hours per month over the last year, with mandated overtime for a shift of over four hours running from 50 to 100 hours a month. Overtime hours for RN's had been six to seven hundred hours a month with about 20 mandated shifts.

In its response to the Court Master's findings and in a January 2016 briefing to the GOC, DHHS cited a number of significant challenges in adequately staffing RPC with qualified individuals, many of which are challenges commonly faced by state-run psychiatric hospitals across the country. Nonetheless, RPC has been very focused on filling vacancies and recently provided OPEGA with a summary of recruitment efforts which include:

- continuously posting all direct care positions on State of Maine online resources (Bureau of Human Resources, DHHS, RPC and Department of Labor webpages) along with jobsinme.com;
- periodically placing newspaper advertisements for MHW, Acuity Specialist and RN positions in the Maine Sunday Telegram, Kennebec Journal and Morning Sentinel;
- implementing an online exit interview survey that is sent to all departing employees to identify trends in retention issues;
- hiring a Recruitment and Retention Specialist to develop relationships with area colleges, universities and nursing programs;
- sending direct recruiting mailings to more than 100 individuals identified by the Muskie School of Public Service as having MHRT-1 certification, to CNAs who are active on the registry in the Augusta area, and to more than 10,000 licensed RN's in Kennebec, Lincoln, Sagadahoc, Somerset, Waldo, Knox and Androscoggin Counties.
- reaching agreements with both AFSCME (American Federation of State, County and Municipal Employees) and MSEA (Maine State Employees Association) to waive internal posting requirements for vacant direct care positions in order to accelerate the time frame in which internal transfers happen, allowing candidates from outside the bargaining units to be hired more timely;
- holding an RPC specific job fair at the hospital on February 2, 2016 that was attended by more than 50 potential applicants; .
- attending numerous career fairs at colleges and universities across the State; and
- conducting a salary study of direct care positions to insure that salaries for direct care staff remain competitive.

RPC is receiving additional on-going support from the Department of Administrative and Financial Services Bureau of Human Resources. This includes one additional HR Manager on-site on a routine basis, assistance with recruitment activities from an HR generalist, and assistance with routine matters provided by the DHHS HR Service Center. RPC reports that efforts to date have resulted in more than half of the vacant positions identified on December 12, 2015 being filled, plus the additional vacancies created by resignation since then.

In January 2016, the Court Master briefed the GOC on his follow-up and shared the results of a staffing analysis he had done with data provided by DHHS. He reported that, as of January 19, 2016, RPC still had 51 vacancies out of a total of 364 positions, with 47 of those vacancies being direct care positions. Three of 20 authorized acuity specialist positions were vacant, 13 of 124, or 10%, authorized MHW positions were vacant and 23 of 87 authorized nursing positions were vacant. The Court Master filed a progress report with the Court in early February 2016 that included formal recommendations for RPC action, several of which relate to staffing issues.

Even with the extra recruitment efforts RPC is making, it may still be some time before the amount of overtime required is reduced to more desirable levels. Thus, risks associated with staff working excessive hours remain high. For example, there is risk that employees who are working excessive hours may make mistakes, such as medication errors, or fail to notice conditions that could pose potential safety risks for staff or clients. Additionally, staff working overtime may be assigned to units other than where they typically work. They may be unfamiliar with the patients and the triggers that may provoke patient episodes which can lead to unsafe situations for staff and patients. Lastly, those working excessive hours may experience high levels of stress that impact their personal health.

Recommended Management Action:

RPC should track shifts and hours being worked by individual direct care staff to proactively identify those regularly working excessive hours in a week and/or contiguous or multiple shifts with little rest time in between. This will allow RPC management to better assess the level of safety risk associated with overtime across the hospital. It will also allow for proactive intervention to reduce overtime hours for particular employees at risk.

10

The Legislature and Court Master Should Monitor RPC Progress in Improving the Work Environment

Several concerns emerging from OPEGA's interviews with RPC staff, and unsolicited comments received by OPEGA, correlate closely with overall workplace environment and culture challenges reflected in the Employee Engagement Surveys conducted by DHHS in 2013 and 2014. OPEGA reported on the Department-wide results of those surveys in an April 2015 Information Brief on DHHS Workplace Environment and Culture, noting that results for RPC in particular were concerning. The response rate for RPC employees on the 2014 Survey was 45.2%, compared to a 76.8% response rate for the Department as a whole. Ratings given by employees who did respond suggested the need for

significant focus on improving in several areas critical to having a work environment conducive to employee retention and productivity.

The surveys administered in 2013 and 2014 represented a proactive effort by the Department to understand employees' perspectives on the work environment. OPEGA judged the survey results to be reliable and relevant given the survey design, the manner in which the survey was conducted and the response rate. At the time OPEGA issued its Information Brief, DHHS was taking a number of actions to improve employee engagement across the Department and OPEGA made suggestions for additional improvement opportunities DHHS could consider as it continued with those efforts. DHHS planned to continue with Department-wide surveys every two years to assess the progress made.

Given the concerns emerging in this review, OPEGA asked DHHS and RPC to describe efforts made to specifically address challenge areas reflected in the 2014 RPC Employee Engagement Survey including:

- Managerial Environment – encompasses communication, approachability and trustworthiness of management, treatment of employees by management and the atmosphere fostered by management;
- Organizational Connectivity – encompasses executive leadership understanding and value of employee contributions, and communications from DHHS as a whole; and
- Office Environment – encompasses accountability of co-workers for their actions and co-workers treatment of each other.

RPC reported that the focus has been on enhancing the flow of communication throughout the organization, and supporting and reinforcing an environment of safety within RPC. Efforts to enhance communication have included:

- Daily meetings of RPC leadership to review all Incident Reports from the previous day. Attendees include: the Superintendent; Chief Operating Officer; Directors of Nursing, Psychology, Social Work, Facilities and Integrated Quality Informatics; Clinical Director, Nurse IV for each unit, Risk Manager, Safety Compliance Officer, Field Investigator and Admitting Nurse.
- Weekly unit rounds done by the clinical directors every Friday. The group is composed of the Medical Director, the Director of Nursing and the Director of Psychology. During these rounds on the unit, staff can ask any questions or bring up any concerns with the clinical leadership.
- Town Halls where all staff are invited to attend to ask questions of the leadership in attendance. The Town Halls are usually led by the Superintendent, and the Commissioner of DHHS has also been in attendance to respond to questions. Seven Town Halls have been held since January 2014.
- Daily hospital tours of all units in RPC by the Superintendent and the Medical Director at different times and frequencies in order to be a presence on the units and to respond to on-the-spot questions or concerns.
- Performance Management Teams being appointed from time to time to look at larger issues that affect the safety culture of RPC and make recommendations

to senior leadership. The teams are made up of staff from all areas and levels, with the input and participation from patients. The most recent Performance Management Team dealt with the issue of contraband being brought into RPC for patients that is against policy.

Additionally, RPC has recently hired a Recruitment and Retention Specialist who started in February 2016. The Specialist's duties include administering the Employee Exit surveys RPC began using in December 2015. The Specialist will also do follow-up and outreach, tabulate the results of the surveys, and use this and other information to identify issues that affect retention of qualified staff. Leadership will be able to work on those issues provided by the data collected.

RPC also conducted an employee survey that was completed in January 2015 as a follow-up to the DHHS Employee Engagement survey done in early 2014. The survey was sent out to all RPC employees, with the Office of Continuous Quality Improvement receiving and tabulating the results. The survey focused on three dimensions from the 2014 DHHS Employee Survey – Supervision, Managerial Environment and Office Environment. There were also several questions relating to Employee Safety and Employee Reporting.

The response rate for the follow-up survey increased to 68.8% from the 2014 Employee survey response rate of 45.2%. Results also showed:

- an increase in the satisfaction of employees indicating that their supervisor seems to care about me as a person,
- an increase in the satisfaction with the atmosphere that is fostered by management in the Hospital,
- an increase in the accountability of the people with whom I work for their actions;
- a decrease in the satisfaction with communication from my Hospital; and
- a decrease in the satisfaction with the dignity and respect with which I am treated by the people with whom I work.

Relating to the questions on employee safety, there was a very high percentage indicating a sense of safe environment, adequate training, a safe culture and safety issues being addressed. Relating to employee reporting there was a high percentage of knowing what to report and comfort in reporting client related issues. Areas for improvement noted from the follow-up survey were:

- one in five employees felt uncomfortable in reporting staff related issues;
- one in four employees report that their organization does not have a safe work environment; and
- one in four employees felt that issues reported are not dealt with in a timely fashion.

Recommended Legislative Action:

The Joint Standing Committee on Health and Human Services, as well as the GOC and the Court Master as necessary and appropriate, should continue to monitor RPC's progress in improving the overall work environment. Monitoring activities could include review of Employee Engagement Survey results for 2016 and

periodic inquiry into efforts to address specific challenges identified in that assessment tool, as well as issues identified through employee exit interviews and employee retention efforts.

Acknowledgements

OPEGA would like to thank the management and staff of Riverview Psychiatric Center for their cooperation throughout this review. We also appreciate the information provided by:

- management and staff at the Department of Health and Human Services, including the Division of Licensing and Regulatory Services and Adult Protective Services;
- the Court Master;
- the Department of Administrative and Financial Services Bureau of Human Resources and Office of Information Technology.

Lastly, we thank the Attorney General's Office for their research and guidance regarding access to confidential records at RPC.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided RPC and DHHS an opportunity to submit additional comments after reviewing the report draft. The Department's response letter can be found at the end of this report.

Appendix A. Scope and Methods

The scope for this review, as approved by the Government Oversight Committee, consisted of four questions. To answer these questions fully, OPEGA used the following data collection methods:

- document reviews including laws, rules, policies and related materials;
- staff interviews; and
- file reviews for a sample of incidents, employee injuries, sentinel events and grievances.

Document Review

OPEGA reviewed relevant documentation to understand the context and regulatory guidance for reporting avenues. Specific materials reviewed include, but are not limited to:

- federal laws and regulations;
- Maine Statutes;
- Consent Decree Settlement Agreement including amendments and related documents;
- DHHS agency rules governing the licensing of hospitals; abuse, neglect and exploitation; sentinel events; and other relevant matters; and
- RPC policies and procedures related to the reporting avenues.

Staff Interviews

OPEGA interviewed RPC staff members for two purposes: (1) to assess employee understanding of RPC's policies related to reporting avenues and (2) gather contextual information about hospital policies, procedures and practices as related to reporting avenues.

(1) To assess employee understanding of policies, OPEGA selected and interviewed a random sample of 10% of RPC's direct-care employees. The sample was stratified to reflect the proportional distribution of the three major categories of employees: Nurses, Mental Health Workers and Other. A sample of 26 names was selected using a random number generator. The employee list was sent to Human Resources at RPC who assisted in scheduling our interviews. The list of 26 included six staff that no longer worked at the hospital or were on leave, so six replacements were randomly selected. The 26 interviewees represented the following staff positions:
   - Mental Health Workers(12)
   - Nurses (8)
   - Other direct care workers (6)

(2) OPEGA also conducted interviews with additional RPC employees, primarily management level staff, as needed to understand various issues related to the scope questions. These included:
   - Superintendent
   - Clinical Director
   - Director of Psychology
   - Integrated Quality and Informatics (IQI) Director and Staff
   - Human Resources Director and Staff
   - Staff Training and Development Coordinator
   - Director of Psychology
   - Director of Social Work
   - Patient Advocates
   - Peer Support Specialists

File Reviews

Incident Reports, including Abuse, Neglect or Exploitation

RPC provided a data file generated from MEDITECH that contained reportable *events* occurring between July, 1 2014 and June 30, 2015 that had been entered to MEDITECH. There were 2,584 events in the data file representing at least 1,415 individual Incident Reports. Multiple events may be captured on one Incident Report. We were unable to determine the exact number of Incident Reports represented in the data file as some Incident Report numbers were duplicated in the file and for other records the field was blank.

From this data file, OPEGA drew a sample that met the following conditions:

- captured at least one Neglect event; and
- captured at least 10% of the population for each event category (other than Patient Incident) that had 10 or more events in the sample period.

Table A: Population and Sample Sizes of RPC Reportable Events Captured on Incident Report Forms July 2014 - June 2015

Type of Event	Population of Events	Sampled Events	Sampled Percentage
Patient Incident	1523	80	5%
Seclusion	368	47	13%
Manual Hold	367	38	10%
Abuse - Sexual	64	8	13%
Abuse - Physical	53	7	11%
Abuse - Verbal	15	2	13%
Patient Injury	130	13	10%
Mechanical Restraint	31	4	13%
Exploitation	19	4	21%
Neglect	2	1	50%
Other	12	0	0%
Total	**2584**	**204**	8%

Source: Data file provided by RPC from MEDITECH

OPEGA's sample was drawn in two stages. First, OPEGA randomly selected a sample of 10% of each of three event categories—Seclusion, Restraint and all Abuse. OPEGA then identified the Incident Reports associated with these sampled events and queried the data file to identify additional events recorded on these same Incident Reports. To meet sampling conditions outlined above, OPEGA then randomly selected additional events in several categories. Some of the corresponding Incident Reports for those events also had seclusion, restraint or abuse events that ended up being captured in our sample. The final sample selected included 77 unique Incident Reports representing 204 events. Table A presents the population of events by type in the data file and in the sample selected.

OPEGA learned that the Incident Reports entered to MEDITECH contains *reportable* events, which is a subset of all events captured on Incident Report forms. To provide a comprehensive test of incident reporting, OPEGA also sampled Incident Reports not included in MEDITECH. Since January 1, 2015, RPC has assigned and logged blocks of pre-numbered Incident Report forms to the hospital units. Using the log of assigned Incident Report numbers by unit, and the completed Incident Report numbers received by IQI, OPEGA identified 494 Incident Report numbers that had been sent out to units, used by staff, but were not existing in the data file we obtained from RPC. Using a sampling rate of 5%, OPEGA drew a random sample of 25 of these Incident Reports.

OPEGA submitted to RPC the sample of 77 Incident Reports entered to MEDITECH and 25 that were not. After accounting for two Incident Reports from the sample of 25 that were voided or missing, there were 100 Incident Reports available for OPEGA's testing of adherence to the incident reporting process. Twenty of the 100 Incident Reports selected included ANE events and OPEGA determined this sample was sufficient for also testing adherence with the specifics of the abuse, neglect or exploitation reporting process.

OPEGA conducted on-site testing of Incident Report records, in the presence of IQI Director and the Risk Manager, over the course of three days at RPC: November 10, 30 and December 7, 2015. OPEGA staff reviewed hard copies of the 100 sampled incident reports and related supporting documentation. In the case of Incident Reports with events of seclusion, restraint or abuse, the supporting documentation included any note in the medical file referencing the sampled incident. The Monitoring Sheet used to document seclusion and restraint events was also reviewed for Incident Reports with those events.

Workplace Injuries

RPC provided OPEGA with a data file containing reported workplace injuries with a Date of Injury between July 1, 2014 and June 30, 2015. The data file contained 237 records and OPEGA randomly selected a 20% sample of those records (47) for testing.

OPEGA conducted on-site testing of workplace injury records on December 2 and 22, 2015. OPEGA staff reviewed hard copies of the sampled injury reports, including the Employee's First Report of Injury, Supervisor's Report of Injury and related supporting documentation. No records were provided to OPEGA for one of the injuries included in our sample. We reviewed the files for the remaining 46 injuries.

Lastly, OPEGA tested for completion of an Incident Report for the injury, which is required by the Incident reporting policy. We reviewed the Incident Report data file provided by RPC and supplemented with a review of hard copy incident reports at RPC on January 14, 2016.

Patient Grievances

OPEGA obtained a data file of patient grievances from DHHS's Substance Abuse and Mental Health Services (SAMHS) office containing grievances submitted by RPC patients between July 1, 2014 and June 30, 2015. OPEGA randomly selected a sample of 10% of the Level I grievances (32). We also added to our sample all six Level II grievances in the data file. There were no Level III grievances.

On January 7, 2016, OPEGA reviewed the sampled grievances on-site at RPC. Materials reviewed included the Grievance form and related supporting documentation. During the on-site file review, two Level I grievances were found to be from the other State psychiatric hospital, Dorothea Dix Psychiatric Center. As a result, the final number of RPC grievances reviewed as 34 (28 Level I grievances and 6 Level II grievances).

Sentinel Events

Sentinel events are rare and there was only one sentinel event during OPEGA's study period of July 2014 through June 2015. Consequently, for this reporting avenue, we decided to include in our sample the next most recent sentinel event, which had occurred in June 2013.

OPEGA conducted on-site review of the sentinel events files for this sample on January 14, 2016. The materials available for our review included the Sentinel Event and Near Miss Reporting form (available for the FY15 event only), the Root Cause Analysis report and the associated Incident Report.

Appendix B. Summary of Noted Issues With Written Policies Relevant to Reporting

Issues of clarity, consistency and up-to-date terminology:

- Terms used loosely, not defined: e.g. "noteworthy situation" (RPC Policy LD.2.20.1); "significant issues/incidents" (RPC Policy LD2.20); "PSD" (RPC Policy PC.5.50); "PR-1B" (RPC Policy PC.5.50)
- Outdated reference to nonexistent office: "Office of Advocacy" (RPC Policy RI.2.120)
- Incident reporting is included in the sentinel events policy but the definition of an incident is worded differently than in the incident reporting policy.
    - From the sentinel events policy: "A system of incident reporting will be utilized to report and track events that are outside of the normal planned activities of client care. These events will include, but are not limited to: patient-to-patient incidents, patient-to-staff incidents, client injuries, client falls and the use of coercive measures. " (RPC Policy PI.2.30.1)
    - From the incident reporting policy: "An incident is any happening that is not consistent with the normal or usual operation of the hospital or any department therein. The potential for client harm, injury, property damage, or legal liability is considered an incident." (RPC Policy PC.3.10.4)
- In the incident reporting policy, the criteria for what constitutes an incident that should be reported is vague and open to interpretation. The policy is also not specific about the timeframes within which reporting is expected to occur. (RPC Policy PC.3.10.4)
- For the incident reporting policy and the ANE policy, the initial reporting of an event is the same, but there are differences in terminology and level of detail in the policies. (RPC Policies PC.3.10.4 and PC.3.10.2)
- Chapter 112 Rules for the Licensing of Hospitals requires APS to be notified within 24 hours of a suspected ANE event, but the RPC ANE policy does not mention the 24 hour requirement. (RPC Policy PC.3.10.2)
- ANE policy refers to reporting to the Office of Elder Services, which is an outdated office name. The policy also contains a section called "Reporting Exceptions…" that is no longer applicable. (RPC Policy PC.3.10.2)
- The ANE policy contains specific language on how Human Resources is to conduct a Fact Finding/Investigation into an allegation of ANE if the allegation involves potential staff misconduct. It does *not* describe how an Investigation is to be conducted if the alleged ANE is committed by someone other than RPC staff. (RPC Policy PC.3.10.2)
- RPC Risk Management wrote a description of Incident Report Investigations for presentation to the Appropriations and Financial Affairs Committee, and described how they conduct Fact Findings/Investigations to OPEGA. However, conducting a Fact Finding/Investigation is not described in any policy (except for the ANE policy in cases of employee misconduct mentioned above).
- Possible circular reference in RPC's Workplace Violence Policy, where RPC policy states that RPC follows DHHS policy and DHHS policy states that RPC has its own policies on this issue. The hyperlink in the RPC policy to DHHS workplace violence policy is also outdated as it points to prior version of DHHS policy. (RPC Policy HR.37.0)

- Multiple guidance documents contain definitions of sentinel events including: State statute, DHHS Rule, the RPC sentinel events policy and DLRS Sentinel Event Notification and Near Miss Reporting Form. These definitions vary in the level of detail and specific language used to define a sentinel event. RPC policy has not incorporated the recently revised DHHS Rules Governing the Reporting of Sentinel Events, which addresses such definitional issues.

Issues of Documentation Not Reflecting Current Practice:

- Both the incident reporting policy and the reporting of ANE policy mention the Program Services Director (PSD) position as having responsibilities under the policy but according to the Director of IQI, the PSD position is not used in the capacities mentioned in the two policies any longer. (RPC Policies PC.3.10.4 and PC.3.10.2)

- Sections G and H of the ANE policy are not consistent with current practice as described to OPEGA by IQI staff. OPEGA understands that the responsibility in Section G.7 is now fulfilled by the Risk Manager rather than the NOD and that the Superintendent gets verbal reports and recommendations regarding the incident during the morning administrative meetings instead of receiving and reviewing written reports. We also understand that the Risk Manager may initiate an investigation without specific directive from the Superintendent. (RPC Policy PC.3.10.2)

- The incident reporting Policy has not been updated to reflect updates in process and procedure; current version of the policy document does not match practice in terms of: roles, responsibilities and authorities for reporting and responding; as well as process and procedures for responding to reports. Current practices were described to OPEGA by IQI staff and were reflected in a document RPC provided to AFA Committee. (RPC Policy PC.3.10.4)

- The written Procedure for Employee Wellness after an Assault and related Post Event Staff Debriefing form, which were provided to OPEGA by the HR Director, describe a process not included in the Work Related Injury/Illness policy. (RPC Policy HR.38.0)

- The Work Related Injuries Policy does not cross-reference to the incident reporting policy even though a Report is required to be completed for a workplace injury. (RPC Policy HR.38.0)

- RPC Policy # LD 4.40.3, Behaviors that Undermine a Culture of Safety states that Human Resources will report to Riverview Leadership *quantitative* information regarding the number of incidents of behaviors that undermine a culture of safety. However, according to HR Director, this is not done because many of the reported behaviors are handled verbally at the Supervisory level, do not result in any paperwork and, therefore, cannot be tracked.

Other General Observations:

- Lack of clear coordination between policies regarding reporting avenues.

- No reference to requirements to report to Court Master in relevant policies.

Appendix C. Examples of Forms Used for Reporting Incidents and Grievances

RPC Incident Report

Employee's Report of Injury, Exposure, or Medical Condition

Supervisor's Report of Employee's Report of Injury, Exposure, or Medical Condition

Maine Sentinel Event and Near Miss Reporting Form

Riverview Grievance Form

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RPC INCIDENT REPORT

Peer Review Document

Protected from discovery per 32MRSA Ch. 48 § 3296

Incident #:15- 0551 **Unit:** _____ **Location:** _____ **Date:** _____ **Time:** _____

Patient Label

Circle Day: M T W T F Sat S

Census: _____ **1:1:** _____

Staffing Level: RFT

Scheduled/Actual (acute units: include both main & SCU in totals)

RN: _____ **LPN:** _____ **MHW:** _____

Attending: _____

O.D.: _____

POTENTIAL RIGHTS VIOLATIONS:

- ☐ Psychiatric Emergency
- ☐ Seclusion
- ☐ Restraints – HOH ____ Mechanical ____
- ☐ Missed Appointment
- ☐ Confidentiality/HIPAA
- ☐ Grievance (not handled in timely way)
- ☐ Not least restrictive care
- ☐ Privacy
- ☐ Search – Unauthorized
- ☐ Unsigned Informed Consent
- ☐ Failure to notify guardian
- ☐ Other

ALLEGATIONS OF:

- ☐ Abuse – Verbal
- ☐ Abuse – Physical
- ☐ Abuse – Sexual
- ☐ Neglect
- ☐ Exploitation
- ☐ Alleged incident does not involve RPC staff, contract staff, volunteers, or students

ACCIDENT:

- ☐ Fall – Witnessed
- ☐ Fall – Not witnessed
- ☐ Injury:
  - ☐ Client
  - ☐ Visitor
  - ☐ Employee

MEDICAL INCIDENT:

- ☐ Medical problem (client)
- ☐ **ELOPEMENT**
  Time Returned: _____

BEHAVIOR INCIDENTS:

- ☐ **STAT** (Staff debriefing required)
- ☐ **Client to Client (Verbal)**
  Instigator initials & #: _____
  Victim initials & #: _____
- ☐ **Client to Client (Physical)**
  Instigator initials & #: _____
  Victim initials & #: _____
- ☐ **Client to Staff (Verbal)**
- ☐ **Client to Staff (Threatening)**
- ☐ **Client to Staff (Physical)**
- ☐ **Self-Injurious Behaviors**
- ☐ **Safety Security – Clinical**
- ☐ **Destruction of Property**

Behavioral Description

- ☐ Agitated
- ☐ Disruptive
- ☐ Destructive
- ☐ Dangerous
- ☐ Threat of Lethal

DOCUMENTATION:

- ☐ Legibility
- ☐ Timeliness
- ☐ Subjective
- ☐ Missing

FACILITY:

- ☐ Safety/Security
- ☐ Duress Pager
- ☐ Property Damage
- ☐ Equipment Malfunction
- ☐ Fire
- ☐ Other

INJURY SEVERITY RATING:

- ☐ No treatment (check this option even if the patient was seen by a medical provider but no treatment was provided)
- ☐ Minor first aid (examples: band aids, cleaning an abrasion, ice packs, over the counter medications, etc.)
- ☐ Treatment by a medical provider (onsite or at ER)
- ☐ Inpatient hospitalization required
- ☐ Death

ACTIONS:

PSYCH MEDS GIVEN (check boxes):

- ☐ PRN Meds Given – Client Willing (PRNY)
- ☐ Meds Given Over Objection
- ☐ Psych Emergency Declared (PEMEDSN)
- ☐ Court Ordered (COURTN)
- ☐ Guardian Permission (GUARDN)

- ☐ **REDIRECT**
- ☐ **TREATMENT PLAN**
- ☐ **QUIET ROOM** (able to leave at will)
- ☐ **ASSISTED WALK**
- ☐ **SECLUSION** In: _____ Out: _____

RESTRAINTS: see below (indicate times)

- ☐ Hands on Hold: From_____ To _____
- ☐ 5-Point Restraints: From_____ To_____
- ☐ Mittens: From_____ To_____
- ☐ Transport Scoop
- ☐ Other

NOTIFICATIONS: (Person notified & time)

- ☐ Family/Guardian Y N N/A _____
- ☐ OES/APS Y N N/A _____
  1-800-624-8404
  www.maine.gov/dhhs/oads/aging/aps/reporting.shtml
- ☐ AOC Y N N/A _____
- ☐ Superintendent Y N N/A _____
- ☐ Client Advocate Y N N/A _____

Objective Description of Event (include precipitating factor(s) if known):

_____

_____

_____

_____

_____

Continuation and Signature on Next Page

RPC INCIDENT REPORT

Peer Review Document

Protected from discovery per 32MRSA Ch. 48 § 3296

Description Continued:

Printed Name:

(Report Author) _____ **Signature:** _____

Supervisor: _____ **Date:** _____

Action(s) Taken: (include medical action, education, and corrective action)

Name/Title: _____ **Supervisor:** _____

Date: _____ **Date:** _____

Comments:

EMPLOYEE'S REPORT OF INJURY, EXPOSURE, or MEDICAL CONDITION

COMPLETE AND RETURN WITHIN 24HOURS TO: Cheryl Burns, Personnel Assistant

1. Name:	2. Social Security #	
3. Home address: Include street, city/town, zip code	4. Date of birth 5. M ☐ F ☐	6. Home phone 7. Work phone
8. Department/Agency:	9. Job title	
10. Work location/crew:	11. Work hours: Circle/Bold Off Days Begin AM ☐ PM ☐ Sun Mon Tues Wed End: AM ☐ PM ☐ Thurs Fri Sat	
12. Supervisor's name:	13. Supervisor's phone:	
14. Date/time of injury Date: Time: AM ☐ PM ☐	15. Date you first thought your medical condition had to do with your work ☐ Date: Time: AM ☐ PM ☐	
16. Date/time you reported your injury: Date: Time: AM ☐ PM ☐	17. To whom did you report your injury?	
18. Did you seek treatment as a result of your injury? Yes ☐ No ☐	19. Who did you treat with?	
20. Who is your PCP (Primary Care Physician)?	21. Address:	
22. Did you lose time from work? Yes ☐ No ☐ Date returned to work?	23. Date(s) missed?	

24. Witnesses: Work phone:
Witnesses: Work phone:

25. Nature of injury/illness (e.g., strain, sprain, fracture, cut, bruise, multiple injuries, etc.)

26. Body part injured (e.g., head, ear, eye, face, arm, hand, shoulder, back, knee). Specify left/right/upper/lower:

27. Injury Source (e.g., machinery, chemicals, vehicle, stairs, person, etc.)

28. Describe fully **how and where** the injury occurred (e.g.,) Struck by….Fell from…Exposed to…etc.

29. Have you ever had a similar injury? ☐ Yes ☐ No If yes, what happened and when?	30. Who did you treat with for similar injury? 31. Do you want to use ☐ sick leave and/or ☐ vacation leave if you miss work due to your injury?
32. Do you work for another employer? ☐ Yes ☐ No Have you lost time from your other employer? ☐ Yes ☐ No	33. Name and address of second employer? Phone number:
34. Signature of employee:	35. Date you completed and returned this form:

SUPERVISOR'S REPORT OF EMPLOYEE'S REPORT OF INJURY, EXPOSURE, OR MEDICAL CONDITION

COMPLETE AND RETURN 24 HOURS TO:

1. Injured Employee:	2. Dept/Division/Bureau:
3. Date and time of injury: Date: Time: AM ☐ PM ☐	4. Injury location:
5. To whom was it reported?	6. Date reported:
7. Date reported as work related:	10. Do you agree with employee's statement of how injury occurred (# 26 through # 29 on "Employee's Report of Injury")?
8. Did you investigate the site of the injury? ☐Yes ☐No Comment:	11. If NO, how different:
9. Did you interview the witnesses? ☐Yes ☐No Comment:	
12. What actions of the employee contributed to the incident?	
13. What actions of other employees contributed to the incident?	
14. What unsafe physical conditions contributed to the incident?	
15. What systems failed?	
16. Suggestions for prevention or correction (include any action already taken):	
17. Did the employee seek medical treatment as a result of the injury? ☐Yes ☐No (If Yes, check ONE box below) 18.☐ Returned to full duty; no lost time beyond day of injury/illness. 19.☐ Returned to temporary modified duty; (some restrictions) with no lost time beyond day of injury/illness. 20.☐ Sent home per doctor's order. 21. Date: 22. Expected to return date:	
23. Supervisor's signature: 24. Print supervisor's name and title:	25. Phone number: 26. Date you completed and returned this form:

Maine Sentinel Event Notification and Near Miss Reporting Form

This form is required pursuant to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events

Use this form to report a sentinel event or a near miss. Forward the completed form to the Sentinel Event Program confidential fax number (207) 287-3251.

1. What is being reported?

   ☐ Sentinel Event
   ☐ Near Miss

2. Today's Date: _____
   Date of Discovery: _____
   Date of Event: _____
   Time of Event: _____AM/PM
   Date of Death (if applicable): _____

3. Patient Age: _____ ☐ M ☐ F Admitting Diagnosis: _____

4. Briefly describe the event including location: _____

---

5. What type of event is being reported? Check all that apply

   ☐ Unanticipated Death ☐ Unanticipated Perinatal Death ☐ Suicide Within 48 Hrs. of Discharge

   ☐ Major Permanent Loss of Function present at discharge ☐ Major Permanent Loss of Function in perinatal infant

   ☐ Healthcare acquired infection

---

6. Unanticipated Death or Major Permanent Loss of Function within 48 hours of treatment? ☐ Y ☐ N

---

7. Unanticipated patient transfer to another facility? ☐ Y ☐ N

---

8. Does this event meet NQF criteria? ☐ Y ☐ N (*If yes, continue on back – check all that apply*)

---

9. Autopsy Requested ☐Y ☐N Autopsy Performed ☐Y ☐N
   Medical Examiner Called ☐Y ☐N Medical Examiner Accepted Case ☐Y ☐N

---

10. Was equipment e.g., IV pump, medication vials, sequestered? ☐ N/A ☐N ☐Y Specify: _____

---

11. Reporter's Name: _____ Title: _____

    Telephone Number: _____ E-mail Address: _____

    Facility Name: _____

State notification of a Sentinel Event is required within one (1) business day of discovery.
Do not delay notification, for any reason, including pending autopsy or Medical Examiner results.

SENTINEL EVENT HOTLINE (207) 287-5813

This information is protected from public disclosure

NATIONAL CONSENSUS EVENTS
NATIONAL QUALITY FORUM SERIOUS REPORTABLE EVENTS

Surgical events
☐ Surgery performed on the wrong body part
☐ Surgery performed on the wrong patient
☐ Wrong surgical procedure performed on a patient
☐ Unintended retention of a foreign object in a patient after surgery or other procedure
☐ Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient
☐ Artificial insemination with the wrong sperm or donor egg
Product or device events
☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
☐ Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
☐ Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility
Patient protection events
☐ Infant discharged to the wrong person
☐ Patient death or serious disability associated with patient elopement (disappearance)
☐ Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility
Care management events
☐ Patient death or serious disability associated with a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
☐ Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
☐ Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility
☐ Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
☐ Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
☐ Patient death or serious disability due to spinal manipulative therapy
Environmental events
☐ Patient death or serious disability associated with an electric shock or electrical cardioversion while being cared for in a health care facility
☐ Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
☐ Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility
☐ Patient death or serious disability associated with a fall while being cared for in a health care facility
☐ Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility
Criminal events
☐ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
☐ Abduction of a patient of any age
☐ Sexual assault on a patient within or on the grounds of the health care facility
☐ Death or significant injury of a patient or staff member resulting from a physical assault (ie, battery) that occurs within or on the grounds of the health care facility

_____Number

Riverview
Grievance Form

Name: _____ Date: _____ Time: _____

Grievance Type: ___ Non-Urgent ___ Urgent (Consider a Level II until reviewed)

Location: _____ Event Date: _____ Event Time: _____

Grievance: _____

Desired Outcome: _____

Client: _____ PSW: _____ Date: _____

Responder: _____ Date: _____

Offered Solution: _____

[ ] Agree [ ] Do Not Agree If more room is needed for documentation please use the reverse

_____ _____

Client Signature Date

[ ] Return to _____ for response by: ____/____/_____ at _____

[ ] Forward to PSD for Step One Response

Received by Unit PSD or designee	Received by Superintendent's Office	Received by Risk Manager Process Tracking
_____ Signature of Recipient _____ _____ Receipt Date Time		

If the client wishes to have this grievance reviewed by the Superintendent, he or she has 10 days to request an appeal. It is recommended that the client request the assistance of the Peer Support Group or Advocate's Office in the filing of this appeal.

Updated 12/2009

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

March 23, 2016

Beth Ashcroft, Director
Office of Program Evaluation and Government Accountability
#82 State House Station
Cross Office Building
Augusta, ME 04333-0082

Dear Ms. Ashcroft:

The Department of Health and Human Services ("the Department" or "DHHS") appreciates the opportunity to respond to the review that the Office of Program Evaluation and Government Accountability ("OPEGA") recently conducted of Riverview Psychiatric Center ("RPC"). It is noteworthy that OPEGA's investigation began during August 2014 and lasted into March 2016, and that it included a thorough review of all the hospital reporting systems and human resources activities. Given the extensive nature of the review—and the significant amount of DHHS staff time devoted to it—we are confident that OPEGA found the Department responsive and helpful in the investigation.

Turning to the report itself, the Department has reviewed the "Confidential Draft" document, focusing on "Issues OPEGA noted during this review" and 10 recommendations that OPEGA provided. Among the nine issues highlighted, the Department would note that five relate to reporting; three to documentation; and the final one to staff shortages and employee concerns about the overall RPC work environment.

ISSUES OPEGA NOTED

The Department believes it is adequately addressing each of the identified issues as summarized below.

Reporting: The Department agrees with OPEGA that certain RPC policies have not reflected established reporting practices and have not been clear regarding staff responsibilities for mandatory reporting of incidents of abuse, neglect or exploitation; that RPC staff should complete all sections of Incident Report forms on a consistent basis; and that the incident report database must capture all reportable events and categorize them appropriately to ensure reported metrics are reliable.

The Department has taken—or is taking—measures to each of these ends, including:

- Updating of policies and procedures regarding incident reporting.
- Updating training modules for staff on reporting of incidents.
- Reviewing database capabilities for inclusion of all incident reports—both for those required for reporting purposes and those not required.

- Building reporting functions for a new Electronic Health Records system to be implemented in 2016—this system will replace the current database for reporting.
- Scheduling staff trainings on reporting abuse and neglect pursuant to the Adult Protective Services Act with the Office of Aging and Disability Services, Adult Protective Services.

Documentation: The Department agrees with OPEGA that RPC must bolster documentation for monitoring staff violations of behavioral policy; that there must be sufficient documentation to monitor responses to patient grievances and sentinel events; and there must be formal, documented follow up to reportable incidents.

The Department has taken—or is taking—measures to each of these ends, including:

- Working with the Department of Administrative and Financial Services' Human Resources Division ("DAFS HR") and unions representing RPC workers to improve staff supervision and monitoring of behaviors that undermine a culture of safety.
- Completed review of grievance procedure and training of staff on documentation.
- Updating Sentinel Event policy and Sentinel Event rules to ensure compliance; reviewing and refining process for Sentinel Event notification.

Staff Shortages and Employee Concerns: The Department is highly focused on these areas. As part its Fiscal Year 2016-2017 budget request, DHHS requested funding for 29 positions at RPC. The Legislature awarded those positions, and RPC is aggressively filling them as well as other vacancies. Riverview Court Master Daniel Wathen confirmed this to the Legislature's Health and Human Services Committee on March 15, noting that the number of vacancies has dropped substantially. Indeed, this figure has declined from more than 75 last year to 23 today, a dynamic reflected clearly in the weekly staffing report that the Department provides to Judge Wathen. Furthermore, the Department accepted the Judge's recommendation that RPC no longer assign Acuity Specialists as Mental Health Workers, and DHHS has engaged a consultant to review RPC's staffing model and recommend possible updates.

RECOMMENDATIONS

OPEGA concludes its report with 10 recommended measures, nine of which it directs to the Department. Notably, six of these recommendations address reporting practices or standards; two address staffing matters; one relates to documentation; and the final recommendation is directed to the Legislature and the Court Master.

The Department believes that RPC already adheres to the recommendations or is in the process of complying with them. Below, in bold, please see OPEGA's nine recommendations directed to DHHS followed by the Department's response to each.

1) **RPC Should Update and Improve its Reporting Policies to Reflect Current Practice and Improve Clarity and Consistency**
   RPC is in the process of reviewing these policies to update language such that it reflects current practices in the hospital and is clear and consistent.

2) **RPC Should Review and Revise, as Necessary, Certain Sections of the Incident Report Form and Related Policy**
RPC has developed procedures and guidance that inform policies to include Incident Reporting; it has implemented an employee training protocol regarding documentation; and the hospital's Risk Manager trains new employees specifically on completing forms.

3) **RPC Should Improve the Use of Documentation to Monitor Adherence to Policy Requirements for Grievance and Sentinel Events**
RPC conducts the required notifications for Sentinel Events. During the OPEGA investigation, RPC produced documentation demonstrating that it had notified the Division of Licensing and Regulatory Services (DLRS) of Sentinel Events using the appropriate DLRS forms.

4) **RPC Should Clarify Responsibilities of Staff who are Mandatory Reporters of Abuse, Neglect or Exploitation**
RPC leadership has communicated clearly to staff members that all staff members are considered mandatory reporters. RPC provided evidence to that effect during the investigation. Furthermore, there is no evidence that RPC did not report incidents of abuse, neglect or exploitation. In fact, every case that OPEGA tested demonstrated that RPC reported the requisite information.

5) **RPC Should Develop and Implement a Method to Track and Monitor Unacceptable Staff Behaviors**
RPC continues to maintain a log of all disciplinary actions. DAFS HR has implemented a training program for supervisors regarding management of employee performance and discipline.

6) **RPC Should Clarify Expectations for Formal Administrative Follow Up on Reported Incidents**
RPC is in the process of developing procedures to this effect.

7) **RPC Should Implement Controls to Ensure Incident Report and Grievance Databases Are Accurate and Reliable**
OPEGA reviewed 25 RPC Incident Reports that were not included in the Incident Report database. Investigators determined that five of those reports should have been included in the database. Upon review of OPEGA's findings, RPC determined that the missing data were entered and captured in the system. Controls for monitoring data entry have been developed to ensure that all reportable incidents are entered. The implementation of a new Electronic Health Records system in 2016 will help alleviate data entry errors.

Notably, of the 25 cases reviewed for abuse and neglect allegations, OPEGA found that all 25 incidents had been properly referred to Adult Protective Services.

8) **RPC Should Ensure That Reported Metrics for Factors of Causation and Allegations of ANE Are Accurate and Meaningful**
RPC has long maintained its current standards for reporting factors of causation. The Court Master is aware of these standards and has not cited them as inadequate or out of compliance with the Consent Decree. Nonetheless, RPC will bring this issue to the Court Master's attention to determine if any actions need to be taken.

9) **RPC Should Proactively Monitor Overtime for Individual Direct Care Staff**
As noted in response to the issues OPEGA raised, the Department has engaged a consultant to review RPC's staffing model and recommend possible updates. Those updates are expected to include recommended measures to monitor and reduce overtime for Direct Care staff.

In addition to the Issues Noted and the Recommendations offered by OPEGA, the Department appreciates OPEGA's acknowledgment of strengths of RPC's current operations. Among those noted in the report, the Department would highlight the following:

- *"OPEGA identified six key reporting avenues internal to RPC and DHHS for patients and staff to report incidents and concerns, particularly those impacting staff and patient safety and patient treatment and rights... For five of the six reporting avenues we reviewed, the reporting is done via completion of a specific form, or other formal documentation, that captures details about the incident or patient grievance, with internal distribution of that documentation to RPC's Risk Manager, various management levels within RPC and/or the Director of Human Resources. Certain types of incidents are also reported via formal processes and documentation to other DHHS agencies with responsibility for investigation as appropriate."*

- *"Although we noted issues with the quality and currency of the written policy guidance available, we found staff was generally well aware of current reporting expectations, requirements, processes and procedures for all six reporting avenues. We also found that staff and managers have generally been adhering to the current expected reporting processes for the five avenues with formal documentation..."*

- *"We observed that there were multiple opportunities for incidents and concerns reported through these five avenues to be brought to the attention of multiple individuals in positions with ability and authority to initiate further actions."*

- *"Clinical responses to incidents involving patients are addressed through required safety meetings and regular treatment team meetings that happen concurrently, but independently, from the reporting processes."*

The Department appreciates the opportunity to respond to OPEGA's report on RPC operations. Whereas the report is the result of a two-year investigation—and extends 50 pages—it is noteworthy that the issues OPEGA highlights are less than sensational, and that the report contains notable praise for current aspects of RPC operations. Nonetheless, the Department is committed to excellence in reporting and documentation standards and has addressed—or is currently addressing—any shortcomings in that area at RPC.

The Department looks forward to responding to any and all inquiries related to issues raised in the report.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv