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To: Beth Ashcroft, Director, Office of Program Evaluation and Government Accountability

From: Ricker Hamilton, Deputy Commissioner of Programs, DHHS

Re: Final Report of OPEGA on 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—*outstanding questions*

### **Recommendation 3.**

#### **OPEGA Questions:**

As part of RPC's completed review of the grievance procedures and the training of staff on documentation, has RPC now:

1. Revised the process to incorporate the proposed solution that was being captured on a separate document into the Grievance form?
2. Reinforced with staff the need to get the patient to sign the form?
3. Required as part of policy/procedure that the staff should put a notation on the Grievance form if the patient refuses to sign?

#### **RPC Response:**

1. After careful review of hospital processes, review of the Rights of Recipients guidance, and based on the recommendation of Patient Advocates about our responses, the hospital will continue to use a separate document for the proposed solution to grievances. The hospital has revised the Grievance form to allow patients more space to write their complaint. The response form is attached to the original grievance when the case is closed.
2. Staff who respond to Grievances have participated in training about how to respond which includes having patients sign the form once the resolution has been presented.
3. Staff will note when the patient refuses to sign the Grievance form.

### **Recommendation 4.**

#### **OPEGA Questions:**

1. We are unclear from the portion of the response on Page 3, whether RPC understood the point of our recommendation and related issue. Our issue/recommendation is focused on the mandatory reporting requirements for certain professionals that exist in statute. The

statutory..... Is RPC using the term mandatory reporter the same as OPEGA intends in this portion of the response?

2. Have the staff trainings on reporting abuse and neglect pursuant to the Adult Protective Services Act with the Office of Aging and Disability Services that are referenced in the portion of the Response on Pages 1 and 2 already been scheduled and held?
  - a. If yes, did these trainings clarify for staff the specific points OPEGA recommended be clarified regarding individual professional responsibility, and what the individual employee's reporting requirements were when there were multiple witnesses?
  - b. If not, when are trainings expected to be held and are the recommended clarifications going to be part of those trainings?
  - c. Has RPC already incorporated any of the clarifications recommended by OPEGA into written policy or other written guidance for staff? If not, does RPC plan to do this and when it is expected to be done? If RPC does not plan to do this, why? Is it because it sees clarifications as unnecessary, unreasonable or not possible for some reasons? If so, please explain.

**RPC Response:**

1. The Superintendent, Deputy Superintendent, Director of Integrated Quality and Informatics, Staff and Organizational Development Manager, and Risk Manager met with the Adult Protective Services (APS) Program Manager and District Program Administrator to clarify requirements for meeting statutory requirements regarding mandated reporters. The hospital reviewed its reporting practices which APS staff confirmed are congruent with statutory expectations. For each event, APS requests one report from the hospital not a report from each mandated reporter who was present. The APS Program Manager suggested a change regarding internal documentation, it was clear this was a suggestion not a requirement. Regardless, the hospital is including this suggestion in its reporting procedures. There is no confusion among hospital administrative and clinical leadership about who is mandated to report by statute. The hospital has its own policy which augments the statutory requirement and makes all employees mandatory reporters. When this procedure was reviewed with the APS staff, they were in agreement and they acknowledged that this is the same policy requirement in place for many healthcare institutions in the state.
2. Adult Protective Services staff have provided training at the Medical Staff Meeting and the Social Work staff at the hospital. In these trainings, the APS staff reviewed mandatory reporting and their reporting expectations from hospitals. The hospital has made minor revisions to its reporting procedures based on the meeting with the APS Program Administrator and Manager and will train all hospital staff on these reporting requirements and documentation expectations. This hospital-wide training will be completed by July 31, 2016.
  - a. The trainings have been offered by APS about their expectations regarding reporting from the hospital. Where APS standards and not congruent with OPEGA recommendations, the hospital has chosen to follow the APS Act reporting expectations from the hospital.
  - b. Trainings have either been provided or are scheduled for the month of July 2016.
  - c. RPC has made minor changes to its procedures based on recommendations from APS regarding statutorily required reporting from mandated reporters.

## **Recommendation 5**

### **OPEGA Questions:**

1. We are unclear from the responses on Page 2 and 3 whether or not any additional documentation, beyond what was in place at the time of our review, is occurring, or planned to occur with regard to systemically monitoring or tracking/analyzing incidents of violations of the behavior policy. Please clarify if there is, or will be, any documentation of violations (or potential violations) other than the log of disciplinary actions. If no additional documentation is occurring or planned, why? Is this because RPC has determined it is unnecessary, unreasonable or not possible for some reason? Please explain.
2. Is any of the documentation that is being kept being used, or planned to be used, to systemically analyze/monitor staff behavior violations and the degree to which those violating behaviors are contributing to creating or escalating patient incidents?
  - a. If yes, please describe what is being done, or planned to be done, in that regard.
  - b. If not, has RPC removed the requirement in policy for DAFS HR to report quantitative information on the number of instances of violating behaviors to RPC leadership? If not, why not?

### **RPC Response:**

1. Tracking of Behaviors that Undermine a Culture of Safety is done through the log of disciplinary actions. RPC is not planning additional tracking mechanisms at this time. Employee actions that lead to a violation of this policy would be subject to disciplinary action and therefore, tracked on the log. Other employee behaviors that do not rise to the level of a policy violation are managed through the course of normal supervisory action. It is impractical to track casual conversations between an employee and their supervisor. Should there be continuing behaviors after the supervisor has initially addressed such with an employee, the steps of progressive discipline will be followed.
2. RPC currently tracks the number and duration of specific events in the hospital, including, but not limited to: Seclusion, patient to patient assaults, Hands on Holds, patient to staff assaults, employee injuries, STAT calls, patient self-abuse etc. This information is reviewed by Executive Leadership on a weekly basis. Trends regarding unit and shift are evaluated and investigated as appropriate. Additionally, events involving patients are reviewed via the Incident Report system. When there is a question regarding employee involvement in the incident, or if there appears to have been inappropriate patient treatment, a thorough investigation is initiated. These investigations involve the employee, any potential witnesses, a review of video recordings as well as review of the patient's medical record. If allegations are substantiated, appropriate personnel action is taken. Should that action be disciplinary, it is added to the Discipline log.

## **Recommendation 7**

### **OPEGA Questions:**

1. The first portion of OPEGA's recommendation is that RPC should further explore the cause of the Incident Report not being in MEDITECH.....Is this because RPC has decided that it will do no further exploration of that? Does RPC intend to look at whether any of the previously reported metrics should be updated? In other words, does RPC have any intention of implementing the first portion of OPEGA's recommendation? If not, why not?

2. The second part of RPC's response on Page 3 implies new controls have been implemented to ensure all reportable incidents are entered. Have new controls been added? Please describe specifically what controls are now in place.
3. OPEGA recommendation for implementing additional controls to address weaknesses in data collection and reporting was also for the grievance database. We see nothing in RPC's response that speaks to actions taken for the grievance database. Has DHHS Internal Audit reviewed the processes for data capture and entry into the grievance database to identify weaknesses?
  - a. If so, have additional controls been added?
  - b. If these steps have not been taken yet, is this something RPC/DHHS is planning to do? If not, why not? If so, when is that expected to happen?

**RPC Response:**

1. RPC and State OIT staff conducted an extensive exploration of the problem. Meditech, the vendor was contacted about changes to their coding that caused the problem. The hospital does not believe there is any additional useful information to be gathered. RPC/DHHS are actively engaged in the final stages of building and implementing a new Electronic Health Records system which is scheduled to go live in approximately 3 months. All available hospital and OIT resources continue to be devoted to this new project and not focused on resolution of the 5 cases identified by OPEGA.
2. RPC staff have implemented new controls for ensuring that all cases are available in Meditech. All reportable event forms sent for data entry are compared to the Incident Reporting number in Meditech. Any missing data are then entered and the system is rechecked to ensure that the Incident Report information is included. This control will become moot once the new Electronic Medical Records system is implemented in the next 3 months as staff on each unit will enter the Incident Report directly into the new EMR.
3. The hospital has not asked the DHHS Internal Auditor to review the legacy Grievance Database because grievances will be entered into the new Electronic Medical Record database. Once the new system is in place, a review of systems would be appropriate and a better use of staff resources. There are multiple controls in place to ensure that the hospital enters all grievances into the database. The Peer Support Office at the hospital collects and transfers all grievances to the Superintendent's Office. The Peer Support Office maintains a copy of the grievance which is compared to what is entered into the system. There is a review of grievances by the Patient Advocate and this information is reported to the hospital's Human Rights Committee. The data entry clerk for grievances tracks all grievances all provides written follow-up to staff who are responding to the grievances.

**Recommendation 8**

**OPEGA Questions:**

1. Has RPC taken any of the specific actions OPEGA recommended in the first paragraph under OPEGA recommendations above to address the criteria and reporting for Abuse and Neglect metric in the Quarterly Reports?
  - a. If yes, which actions have been completed or are in progress?
  - b. For any of the recommended actions not completed, or in progress, does RPC intend to take those steps or has RPC determined it is unnecessary, unreasonable, or not possible to take those actions? Please explain.
2. Has RPC discussed the standards for reporting factors of causation with the Court Master yet?
  - a. If so, when did that occur and what was the result, i.e. have any changes been made, and, if so, what were the changes?
  - b. If RPC has not yet discussed this issue with the Court Master, when is that expected to occur?

**RPC Response:**

1. The recommendation from OPEGA is still under review. The hospital reported the data in alignment with its long standing practice. Once the review is completed and a decision is made, that information will be incorporated into our data dictionaries for data collection and reporting. This should be completed by August 1, 2016, which is when the next quarterly report is due to be released.
2. RPC is reviewing the Consent Decree requirements and hospital reports on causation factors. The determination of the causation factors for many events do not neatly fit into the discrete categories as outlined in the Consent Decree. A thorough review of data definitions, determination of causative factors, and past coding practices are being reviewed to inform the hospital staff and the Court Master. The review and any possible recommendations on the data collection and reporting will be discussed with the Court Master at a regularly scheduled monthly meeting.