CONSULTATION REPORT ON RAWSON-NEAL PSYCHIATRIC HOSPITAL

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INTRODUCTION AND CHARGE

Nevada Governor Sandoval's office and the Nevada Department of Health and Human Services requested that the National Association of State Mental Health Program Directors retain us to conduct this consultation regarding conditions at Rawson-Neal Psychiatric Hospital (RNPH) in Las Vegas. The hospital has been under intense scrutiny by the media and by accreditation agencies in response to recent allegations of inappropriate discharges of patients by bus to other states. We were asked however, not to limit our review to discharge practices but to assess all areas of hospital policy and practice. Further, we were encouraged to offer our candid observations; at no time were we asked or pressured to avoid a difficult topic, or to reduce the standards by which we assessed clinical care. In short, our assignment was to "call it as we see it."

As a preliminary matter, we want to note that hospital and statewide clinical leadership had on their own identified many of the issues noted in this report and initiated steps to address them either before or during our on-site consultation. They not only acknowledged but brought to our attention room for improvement in current services. At every turn, they encouraged and embraced our unvarnished impressions and recommendations. The same was true in our interactions with clinical staff at all levels. Almost without exception, we encountered a genuine interest in finding ways to enhance current services and provide competent and compassionate care to their clients and patients.

Even more importantly, while we made recommendations about the quantity of staff, our opinion of the quality of staff throughout the hospital was quite positive. In other words, despite our findings that there was a need for additional staff, the vast majority of staff members in all departments of the hospital appear to be competent, compassionate, respectful, and dedicated to providing services to people with serious mental illness during the most difficult episodes of their illnesses.

Overall, we found much to admire and praise about the hospital. We also found a number of ways in which we believe that the hospital can improve. As we will explain below, our most positive finding was that virtually every patient with whom we spoke reported feeling safe and respected. This is an unusual and remarkable accomplishment. On the other hand, our most important recommendation for improvement is for an increase in the amount of high-quality, evidence-based psychiatric and psychological treatment beyond the provision of psychotropic medication.

Some of our recommendations will require additional funding to implement. As described elsewhere in our report, we have structured our recommendations to provide maximum benefit at the lowest cost wherever possible. Nevada is by no means unique regarding challenges in mental health funding and

services. Every state currently grapples with issues similar to the ones identified in this report. Indeed, during the past twelve years of fiscal challenges, state mental health systems across the country have experienced severe cuts in funding. While sensitive to fiscal realities and competing needs that the state must balance, the state has asked for our frank assessment and recommendations regarding safe and therapeutic services.

QUALIFICATIONS OF CONSULTANTS

Kenneth L. Appelbaum, M.D.:

Dr. Kenneth Appelbaum currently serves as Clinical Professor of Psychiatry and Director of Correctional Mental Health Policy and Research for the Center for Health Policy and Research at the Commonwealth Medicine division of the University of Massachusetts Medical School (UMMS). He has been on the faculty at UMMS since 1987. In addition to research and teaching activities, Dr. Appelbaum provides consultations to state and federal mental health and correctional systems on safety and delivery of mental health services in both individual facilities and statewide systems. His recent activities include chairing a Massachusetts task force charged with assessing the state mental health system and suggesting mechanisms for improvement; consultations to the Maryland Department of Health and Mental Hygiene regarding care, treatment, and safety at several state hospitals; and ongoing consultations to the U.S. Department of Homeland Security, Office for Civil Rights and Civil Liberties regarding civil rights and mental health services for inmates and patients in detention facilities.

From 1987 – 1998, Dr. Appelbaum served as Forensic Service Director at Worcester State Hospital in Massachusetts with oversight of a court evaluation unit and forensic consultation program. Among his other tasks on behalf of the Massachusetts Department of Mental Health's Division of Forensic Mental Health, he assisted with drafting state regulations regarding qualifications of psychiatrists and psychologists who conduct forensic evaluations for the Commonwealth, helped develop and manage a program to train and designate professionals to do forensic evaluations for the state, served as a supervisor for those trainees, helped implement and run a quality improvement process to monitor their work, and played a leading role in developing a mandatory consultation and review process for privilege or discharge decisions regarding inpatients with histories of serious violence.

From 1998 – 2007, Dr. Appelbaum served as statewide Mental Health Program Director for Massachusetts Department of Correction (DOC) facilities and as a member of the senior leadership team for health care services provided by UMMS to DOC. His responsibilities included supervision of all licensed mental health providers and oversight of all mental health services provided to inmates of Massachusetts DOC facilities, including patients at Bridgewater State Hospital, the state's secure forensic psychiatric facility.

Dr. Appelbaum is a Distinguished Fellow of the American Psychiatric Association and board certified in General Psychiatry and Forensic Psychiatry. He has authored over fifty publications, including peer-reviewed journal articles, book chapters, and other publications, and given approximately one hundred

academic and national presentations. Among other topics, these publications and presentations address competence and responsibility assessments of defendants with mental disorders or developmental disabilities, judicial use of pretrial commitments for forensic evaluation, correctional mental health standards and services, assessment and management of self-injurious and violent behaviors, and prosecution as a response to violence by psychiatric patients. He is former Deputy Editor of the Journal of the American Academy of Psychiatry and the Law, and he continues to serve as a special editor or reviewer for several professional journals, including the American Journal of Psychiatry.

Joel A. Dvoskin, Ph.D.:

Dr. Dvoskin is a clinical psychologist and member of the faculty of the Department of Psychiatry at the University of Arizona College of Medicine. He frequently serves as a member of expert teams for the Civil Rights Division of the U.S. Department of Justice investigating conditions in jails, including the Los Angeles County Jail; as an architectural design consultant for correctional and psychiatric facilities (e.g., St. Elizabeths Hospital in Washington, DC); and as a monitor of settlement agreements and consent decrees over psychiatric hospitals and correctional systems. He has successfully mediated class actions regarding psychiatric hospitals, correctional institutions, and juvenile justice systems, and has consulted to state and local governments in more than half of the United States regarding the provision of mental health services. He also provides training to clinicians throughout North America and Europe in the treatment of persons with serious mental illness and/or substance abuse disorders and in assessing and reducing risk of suicide and interpersonal violence in psychiatric hospitals and criminal and juvenile justice settings.

Dr. Dvoskin served as Acting Commissioner of Mental Health for the State of New York, overseeing 31 state psychiatric hospitals, 25,000 staff, and the outpatient care of New Yorkers with serious mental illness. For eleven years prior to that he served as Director of Forensic Services and Associate Commissioner for Forensic Services for the New York State Office of Mental Health, overseeing the forensic and correctional mental health systems for the State of New York, and directly supervising three free-standing maximum security forensic psychiatric hospitals, two forensic units, and fifteen prison mental health programs. In 1984, he founded the Kirby Forensic Psychiatric Center in New York City.

Dr. Dvoskin is a Diplomate in Forensic Psychology of the American Board of Professional Psychology and a Fellow of the American Psychological Association (APA) and the American Psychology-Law Society. He was formerly President of Division 18 of the American Psychological Association (Psychologists in Public Service) in 2000-2001, and President of the American Psychology-Law Society, Division 41 of the APA, in 2006-2007. He has authored more than 60 articles and chapters in professional journals and texts, and serves on numerous editorial boards for professional journals in psychology, psychiatry, law, and criminal justice.

Dr. Dvoskin has conducted comprehensive reviews and consultations for state hospitals in North Carolina, Maryland, Maine, Utah, Washington, the District of Columbia, Colorado, and Georgia.

SOURCES OF INFORMATION:

1. Site visit to Rawson-Neal Psychiatric Hospital, including the Psychiatric Observation Unit (POU) during the week of May 6 – 11, 2013;
2. Review of selected policies and procedures;
3. Review of accreditation and certification surveys and investigations by the Joint Commission and the Center for Medicaid and Medicare Services;
4. Confidential interviews with key leaders of the hospital;
5. Confidential interviews with leadership of the Nevada Department of Health and Human Services;
6. Confidential interviews with middle managers and line staff in all areas and shifts of the hospital;
7. Confidential interviews with patients in all areas of the hospital;
8. Tour of the capital plant of the Rawson-Neal Hospital, including proposed renovations of the Stein Building;
9. Interviews with advocates including representatives from the National Alliance for Mental Illness and Nevada's Protection and Advocacy system;
10. Interviews and meetings with service providers in Clark County;
11. Review of patient records;
12. Review of randomly selected treatment plans and discharge plans.

FINDINGS AND RECOMMENDATIONS

Introductory Remarks:

Our report presents ten recommendations that address:

1. Treatment Services;
2. System Capacity;
3. Treatment Teams;
4. Treatment and Discharge Planning;
5. Suicide Prevention;
6. Staffing;
7. Policies and Procedures;
8. Staff Morale;
9. Documentation; and
10. Quality Improvement.

Our report also highlights several of our more noteworthy positive findings. As part of our review, we saw impressive examples of good intentions, care, and treatment at the hospital. The mere fact that we have made recommendations should not be construed as indicating an absence of excellent individuals and practices. We have yet to encounter a perfect facility or system. Although every facility, including RNPH, has room for improvement, not all embrace the opportunity to do so. In that respect, our most

overarching positive finding concerns the earnest desire that we encountered at every level at RNPH and among statewide leadership to make things better.

Detailed findings and recommendations:

As noted above, virtually every patient that we interviewed reported feeling safe and respected at the hospital. We rarely encounter facilities where patients express positive feelings to this extent. Further, we observed many interactions between staff and patients that confirmed this report. This was especially true regarding Mental Health Technicians (MHTs), who provide the majority of direct patient contact on the wards. The importance of this observation cannot be overstated; when patients do not feel safe, it is almost impossible for them to begin to recover from exacerbations of serious mental illness.

Positive Finding 1: Patients at RNPH feel safe and respected.

Our most important recommendation for improvement is the need for a significant increase in psychiatric, psychological, and allied treatments in addition to the medications currently used. In large part due to the need for additional psychologists and social workers, these professionals are currently providing few, if any, opportunities for group or individual psychotherapy, behavioral therapies, discharge planning groups, and other forms of treatment aimed at the acquisition of pro-social and psychosocial skills. Although RNPH has an active and productive group of activity and rehabilitation therapists, the activities and treatments they provide are not generally tied to individualized skill deficits and treatment plans.

Our recommendations regarding staffing enhancements and changes in the organization of treatment teams should allow for a dramatic increase in group, individual, and behavioral therapies that are directly related to amelioration of patient-specific skill deficits and specifically mentioned in each patient's treatment plan. All professional staff and treatment team members should have some involvement in leading or co-leading treatment groups, and each patient should have at least 3 (and preferably 4) hours per day on non-holiday weekdays for group or other therapeutic programming consistent with individualized treatment plans, unless clinically contraindicated. To the extent that leisure and recreational programming are provided, they should be more likely to occur during evenings and weekends.

We were impressed with the motivation, enthusiasm, and productivity of the allied therapy department, which provides activities therapies to patients, and often represents the only treatment other than medication that would occur during an entire day. However, although such therapies as open gym or general leisure activities can serve as an important part of the patient's experience, they are no substitute for treatment that is specifically targeted to the individually assessed risks and skill deficits that led to the patient's hospitalization.

The hospital also may not be taking full advantage of available adjunct services for patients. For those with substance use problems, AA and NA meetings happen only once a week, and could probably be scheduled at a greater frequency as they had been in the past. Community resources for programming

to assist patients with smoking cessation may also be available (e.g., through the American Cancer Society). Peer services can also provide a valuable resource for support and recovery.

Fresh air and natural light can have mental health benefits that rival those of medication and other therapeutic interventions. Despite comfortable, sunny weather during our site visit, we saw only a few occasions of patients having access to the enclosed outdoor spaces at the hospital. Because many psychotropic medications interfere with the body's ability to regulate its temperature, precautions about dehydration and exposure to heat or sunny conditions are indicated during hot weather. Under more clement conditions, however, ample opportunities for outdoor access should be made available.

In addition to outdoor access and activities, patients can benefit from access to calming environments. Comfort rooms can provide a therapeutic retreat from more stressful settings on an inpatient unit. These rooms, one of which already exists on the POU, offer physically comfortable settings with soothing visual, auditory, olfactory, and tactile stimuli. They can help decrease agitation and aggression and foster development of skills, such as distress tolerance, that can also be used after discharge. Each unit at the hospital currently has a room available when needed for seclusion and restraint. Because the hospital has succeeded in limiting the use of these interventions, it may be feasible to convert at minimal expense one of those rooms to a comfort room that both units can share, allowing two units to share the remaining seclusion and restraint room.

We observed at least two other environmental changes that the hospital might consider. First, the absence of clear signs identifying each building on the RNPH campus can be confusing and disconcerting, especially for newly admitted patients. Second, frequent use of the hospital's public address system interrupts conversations and would interfere with conducting productive group and individual therapy. Many of the announcements that we heard could have been replaced by telephone calls, text messages, or pagers. We especially recommend consideration of alternatives to hospital-wide announcements regarding behavioral or other events that require staff support from other units. As an alternative, designated members of a staff response team could be issued pagers or cell phones and notified by text message whenever their presence is required to resolve a crisis.

Regarding treatment-related terminology at the hospital, some charts used the words "compliance" or "noncompliance" when referring to whether a patient was taking a prescribed medication. This terminology implies an act of passive acquiescence and as such, is best to avoid. Patients may have reluctance to take beneficial medications for many reasons, which treatment providers need to explore, understand, and generally respect. To that extent, medication discussions always involve some degree of negotiation about specific agents, dosages, timing, or other factors. Without self-motivation to take medication, a patient's mere compliance with physician orders will likely cease after discharge, if not sooner. An alternative term, such as adherence, that implies a patient's agreement with medication recommendations is preferable. More importantly, it highlights an active partnership between physician and patient and the importance of supporting a patient's self-motivation to take a helpful medication. In a similar vein, attention to patient motivation, including strategies such as Motivational Interviewing, can be beneficial in improving long-term patient outcomes.

In rare instances, patients have serious psychotic disorders but little appreciation of their conditions and thus no motivation for treatment. RNPH refers to the ongoing use of court-approved psychotropic medications as a "denial of rights" case. This terminology, however, is inaccurate and misleading. These cases actually illustrate careful attention to patient rights. The treatment occurs after a court process attends to the individual's rights and determines the legal appropriateness of treatment. In fact, it would constitute neglect and a denial of a patient's psychiatric needs to not seek judicial adjudication of competency in such instances. When reasonable clinical concerns arise that a patient lacks capacity to make informed treatment decisions due to the effects of serious mental illness, treatment providers have clinical and ethical, as well as legal, obligations to seek court review of the circumstances. Failure to do so would abandon to ongoing psychosis and illness those individuals who lack accurate appreciation of their conditions, pose a serious danger to themselves or others, or lack the capacity to make informed and voluntary decisions about their psychiatric care. For all these reasons, it is mistaken to refer to these procedurally correct instances of court-approved involuntary treatment as a denial of rights. At the time of our site visit, RNPH had only five patients receiving such court-approved treatment. We found no actual instances in which patients had their rights denied.

> **Recommendation 1 (Treatment Services): a) Increase the amount of high-quality, evidence-based treatments beyond the provision of psychotropic medication; b) The Allied therapy department should construct a "menu" of the skill-based programs that they can provide, and treatment teams should refer patients to specific programs based on the individualized treatment needs and skill deficits of each patient; c) Explore opportunities to increase peer services and programming and services to assist patients with substance use problems; d) Increase outdoor access as safety allows; e) Create comfort rooms accessible to patients on each unit; f) Put up simple, clear signage identifying each building; g) Consider ways to decrease use of the public address system; h) Use terminology that emphasizes the importance of active, self-motivated medication use rather than passive compliance with medical advice; i) Consider training some clinicians in Motivational Interviewing or similar strategies aimed at improving patients' readiness for change; and j) Eliminate use of the term "denial of rights" for patients who appropriately receive involuntary treatment after court proceedings that uphold, rather than deny, their legal rights. Instead, we recommend simple, accurate terms such as "involuntary medication."**

Although treatment at RNPH currently consists almost entirely of medication management, we found no notable instances of over or under use of medications. This is an important and positive finding that indicates attentiveness of the clinical staff to psychiatric assessment and management. In poorly run facilities that lack adequate engagement with patients, one often finds either neglect of medication needs or excessive use and sedation. Patients at RNPH, however, did not appear overly sedated or with unaddressed agitation. For the most part, patients also reported satisfaction with their medication management. The one notable exception to satisfaction was a patient receiving treatment based on court approval following judicial determination of incompetence to make an informed choice. A private interview with the patient confirmed the presence of active and significant psychotic symptoms and the absence of appreciation of the need for treatment by the patient. This case illustrates accurate

assessment and steadfast management of a serious psychiatric condition. As illustrated by this case and others we reviewed, treatment teams and individual practitioners generally had good knowledge of their patients' psychiatric conditions and an appropriate approach to use of medications.

Positive Finding 2: Patients at RNPH generally appear to have psychotropic medications prescribed in an appropriate and competent manner.

Several issues relate to use of bed capacity and use at RNPH. Patients at the hospital sometimes need single rooms. This can occur, for example, with patients who are especially vulnerable, predatory, or behaviorally disruptive. When this happens, the unit must "block" a bed because all rooms are set up for double occupancy. In actual practice, however, patients sometimes get admitted to those blocked beds and sleep on a mattress in a common area. This inappropriate arrangement compromises care for unstable patients in need of acute hospitalization.

Local emergency rooms often have waiting lists of patients believed to require inpatient hospitalization. In an effort to provide these emergency rooms with relief, RNPH has done an admirable job of maximizing the efficiency of the admission process. One practice, however, had involved temporarily exceeding the capacity of the POU in anticipation of discharges that had not yet occurred. Although well-intentioned, the use of these so-called "ghost beds" places undue pressure on the staff of the POU and may interfere with safety and clinical care of patients. We were informed that this practice had ceased several weeks before our visit, a decision with which we agree.

Another circumstance for single housing involves patients who require isolation due to contagious diseases such as actual or suspected active tuberculosis. Effective infection control in these instances has historically required negative pressure rooms to prevent flow of pathogens into other areas of the hospital. This can be achieved either with expensive capital renovations or with the use of less costly, portable, high-efficiency particulate air (HEPA)-filtration units. The hospital has neither of these options available at the present time.

Our review focused primarily on inpatient treatment, and we can offer only limited impressions regarding outpatient services. It appears, however, that some patients who could or should be served in other settings or levels of care have limited, if any, access to those services. For example, the system would likely benefit from new placement options for individuals in need of detoxification from alcohol or other substances of abuse (e.g., a sobering center), for persons who do not need hospitalization but would profit from a few days of crisis or respite care, and for those who require transitional housing to assist with successful reintegration into the community. Availability of other community resources, including peer services such as consumer-run drop-in centers, also deserves consideration. In addition, the system lacks extended length of stay beds for the relatively small number of patients who need more than a brief hospitalization at RNPH. Expansion of community-based resources might help to free-up some existing inpatient beds to become longer-term placements. Developing or expanding all of these levels of care would also relieve some of the pressure currently experienced by existing components of the system, including emergency rooms, the POU, and inpatient beds. We understand

that the state had begun to review these needs and had initiated steps to address some of them even before our consultation.

> **Recommendation 2 (System Capacity): a) Establish criteria for single bed housing and do not admit patients to the resulting blocked bed; b) The capacity of each unit, including the POU, should be respected and adhered to by admissions staff; c) If the hospital continues to house patients who require medical isolation due to contagious diseases, some form of acceptable infection control protection must be used; and d) Consider options for expansion of community-based resources that could help relieve current pressures and bed shortages in the system.**

Patient care would benefit significantly from revision and enhancement of treatment team structure at the hospital. Currently, key members of the treatment team, including nurse managers, psychologists, and some social workers are required to cover an entire pod, which consists of two teams serving units of 20 patients each. Inpatient caseloads of 40 patients, especially on units with average length of stay of under a month, make it difficult for staff to adequately know and serve each patient. This impairs the ability of each treatment team to maintain therapeutic and integrated treatment, including individualized treatment and discharge plans, and appropriate therapies for each patient served by the team. Equally important, strong treatment teams can dramatically improve the therapeutic alliance between patients and clinical staff.

Effective treatment teams need designated team leaders who have overall responsibility and authority over how the unit operates. Two prevailing, practical models exist for unit-based team leadership, each of which provides a single point of clinical and administrative accountability for each team. Under a strictly medical model, the psychiatrist serves as team leader. An alternative model identifies the licensed mental health professional best suited to serve as team leader on each unit. Each model has advantages and disadvantages. In our opinion, RNPH should have the flexibility to determine which model works best for them so long as a single identified person has clinical and administrative oversight of each unit. All other unit based-staff should report and be administratively accountable to the unit director.

Supervision at RNPH currently follows a “silo” model in which staff report primarily up to their hospital-wide discipline chiefs. This model does not allow for sufficient direct oversight of unit-based activities and can lead to lack of cohesion within the treatment team. Creation of empowered Unit Director positions will require redefinition of the roles of discipline chiefs. Although no longer providing direct supervision to each category of professional staff, discipline chiefs will still have extremely important roles to play in the hospital. For example, within their professional discipline they will need to set practice standards, oversee credentialing, assist in recruitment, assess staff competencies, and arrange and provide ongoing educational and training activities. They should continue to play an essential role in quality improvement projects within their own discipline and throughout the hospital. They can also play a new or greater role in establishing relationships with universities and discipline-specific training programs. Expanding internship and other training opportunities across multiple clinical specialties at RNPH would enrich programming and provide opportunities to recruit new employees after graduation.

As one existing example, we were impressed with the hospital's psychiatric residency program, and its productive and mutually beneficial collaboration with the medical school at the University of Nevada-Las Vegas. Finally, the clinical experience and expertise of the discipline chiefs will prove to be invaluable assets in managing challenging patients; including those with the most concerning histories of violence.

Treatment teams at RNPH meet on a daily basis other than weekends and holidays. We commend this practice. The team meeting provides a forum for communication of information and coordination of care, and in almost all hospital settings should occur at least weekly, and preferably more often as already occurs at RNPH.

Team meetings, however, do not uniformly have any MHTs in attendance. The absence of MHTs at these meetings impairs team functioning and effectiveness. Among all staff, MHTs usually have the greatest amount of direct patient contact. Their valuable observations and insights can inform assessment, care, and treatment services. Their presence at team meetings also provides them with the same information as other team members about patients on the unit. This helps ensure that they interact with patients in a manner consistent with other team members and with the goals and strategies outlined in individual treatment plans.

As currently constituted, none of the treatment teams or inpatient units at RNPH have a specialized focus. The hospital, however, has a sufficient number of units and a large enough patient population to support creation of at least one, if not more, specialized units that allow concentration of staff expertise and more targeted programming. Examples of potential specialized patient populations or services include patients with histories of severe trauma, cognitive impairments, schizophrenia, bipolar disorder, comorbid medical or other conditions, or treatment modalities such as Dialectical Behavior Therapy (DBT) or Social Learning Environments. Efficient use of beds, however, would require sufficient numbers of appropriate patients to keep any such units running at or near capacity at all times. The hospital might best start by piloting creation of a single specialized unit, and there will always be a need to retain some unspecialized settings to meet more general needs, including flexible management of beds.

Although RNPH might choose to have a specialized unit for patients with severe substance use problems and co-occurring mental disorders, integrated treatment for these disorders will also need to occur hospital-wide. As is the case in all state psychiatric hospitals, most patients at RNPH have problems with alcohol or substance use. Given the high prevalence of substance-related problems among people with serious mental illness, all treatment team members need skills to address them. If left untreated, the likelihood increases for negative outcomes, including relapse of substance abuse, exacerbations of psychosis, suicidal behavior, and interpersonal violence.

Research supports integrated treatment of co-occurring disorders, and we believe that the Integrative Treatment Model is an effective approach. The National GAINS Center, the Substance Abuse and Mental Health Administration, the Center for Psychiatric Rehabilitation at Boston University, and the Consensus Project for Mental Health and Criminal Justice of the Counsel of State Governments each have freely available resources supporting this model.

Positive Finding 3: RNPH has daily treatment team meetings consistent with a high standard of care.

Recommendation 3 (Treatment Teams): a) Assign integrated treatment teams to every 20-bed unit at RNPH. In addition to MHTs, include at least a dedicated psychiatrist, psychologist, nurse manager for day and swing shifts, and two social workers on each team based on the current constitution of units; b) Provide Unit Directors with overall responsibility for a twenty-bed treatment team and supervisory authority over all staff; c) Provide Unit Directors with necessary support, training, and appropriate compensation; d) Redefine the role of discipline chief to focus on other important functions that do not involve day-to-day supervisory responsibilities; e) All disciplines, including MHTs, must have representation at all treatment team meetings to ensure communication of important information and coordination of effective care; and f) Consider designating one or more units to serve focused patient needs, services, or diagnoses, but ensure that all treatment team members have training in integrated treatment of co-occurring substance use disorders and mental illness.

Our recommendations for significant expansion of treatment services and reorganization of treatment team structure will facilitate needed improvements in treatment and discharge planning. Many of the treatment plans that we reviewed lacked detailed and specific goals or information. For example, good treatment plans should include targeted behavioral goals and the group therapies or other techniques selected to achieve them. The patient's own priorities and preferences should always inform appropriately crafted treatment plans. Discharge plans also need detailed specificity about aftercare arrangements, including the patient's capacity to safely follow through with those arrangements.

Regarding overall discharge practices at RNPH, we found a complex set of circumstances that defy simple conclusions. Las Vegas is a magnet city that attracts visitors from all over the United States and abroad. Many charts that we reviewed reflect this reality of patients with primary ties outside the state of Nevada. We found nothing *per se* inappropriate with discharge plans that included state-funded arrangements to return these individuals to their places of primary residence. In many cases, helping people to get home safely is a kindness to them and to their families. Some of these written plans, however, lacked adequate specificity of aftercare arrangements. The absence of sufficient details in those cases may simply reflect a failure to fully document arrangements that had been made, but in other instances it appears that adequate follow up arrangements were not made.

In addition, as noted, comprehensive assessments by treatment teams must include explicit attention to a patient's capacity to safely follow the discharge plan. For example, treatment teams should assess and document a client's ability to travel unaccompanied when the plan includes such activities. Many, but not all, individuals leaving a psychiatric hospital have this capacity and do not require chaperones. The mere presence of a mental disorder does not render an individual unable or incompetent to do the ordinary tasks of life, including traveling independently. Comprehensive discharge planning, however, includes an assessment of the individual's capacity to manage the anticipated tasks.

The sparse discharge arrangements that we found in the charts of some patients likely reflect several root causes. Many hospital staff persons told us that they have long felt under pressure to move patients out of the hospital as quickly as possible to free up beds for other individuals in need of admission. Staffing levels have not been commensurate with the sheer volume of POU and hospital admissions, sometimes leaving treatment professionals and discharge coordinators with insufficient time to attend to some details. Locating, contacting, and scheduling aftercare can be a time-consuming, labor-intensive task, especially for out-of-area patients.

Prior to our site visit, problems also existed with scheduling follow-up care for patients in the local area. Instead of providing post-discharge appointment times, some patients were instructed to go to community mental health center walk-in clinics where they might wait for hours or have to return on another day before being seen. This practice impeded access to care and discouraged follow-up for some individuals.

In reviewing numerous discharge plans at RNPH, we noted that the documentation of plans is often spread across several different notes (e.g., a psychiatric discharge summary and a social work discharge note.) As a result, there is not one clearly identified and easily accessible comprehensive discharge planning document. At least two options exist: 1) The hospital may choose to develop a new comprehensive discharge planning document; or 2) Recognizing the axiom that discharge planning should always begin at admission, the hospital might choose to revise the treatment planning document, to include a section explicitly addressing discharge needs and capacities. Most importantly, we recommend that redesigning the format of discharge and treatment plans should be assigned to a multidisciplinary QI project team.

As an overall matter, as is the case throughout the United States, mental health needs in Clark County exceed the system's capacity. Patients in need of psychiatric stabilization, triage, or hospitalization often sit in area emergency rooms waiting for beds. At almost all times, the POU and inpatient units run at full capacity. This reality creates a tension between the benefit of longer inpatient stays and the need to open up beds for those who require admission. Nevertheless, there is room for improvement when developing discharge plans, and treatment plans in general.

> **Recommendation 4 (Treatment and Discharge Planning): a) In treatment and discharge plans, include specific goals that relate to the patient's clinical and functional needs and that reflect as much as possible the patient's priorities and capacity to safely meet those goals; b) Continue the new practice of providing local patients with follow-up community appointments for treatment at the time of discharge from the hospital; c) Discharge plans should include explicit documentation and reference to assessments of each patient's capacity and motivation to follow the discharge plan; and d) Create a QI project team to address the format for documentation of clear and easily identifiable treatment and discharge plans.**

We want to emphasize our findings regarding overall staff culture and demeanor. We did find areas of inadequacy in discharge and treatment planning, along with other areas as noted in our other findings and recommendations. What we did not find, however, was a lack of dedication, competence, or

compassion among the collective staff at RNPH. To the contrary, we almost uniformly encountered professionals deeply committed to the care of their patients, and we note, deeply disturbed by recent events and sometimes sweeping negative conclusions about their dedication. In our opinion, this is an unfortunate aspect of recent events. A more positive and encouraging aspect has been the response by staff at the facility and at the state level. Rather than becoming defensive, they have embraced the opportunity that a consultation like ours affords to bring about positive changes. They recognize, as do we, that no facility or program is perfect, and there is always room for improvement. This recognition on their part is a reflection of the overall professionalism that we found among the staff that we met.

> **Positive Finding 4: Staff at RNPH collectively displayed compassion, competence, and professionalism.**

We reviewed the policies and practices regarding suicide prevention at RNPH. As noted elsewhere in this report, RNPH conducts suicide risk assessments even when there is no mention or indication of suicidality or suicide risk. When too many assessments are conducted, they may have a tendency to become *pro forma*. We recommend doing fewer and better suicide risk assessments, when history, suicide screening, or mental status examination indicates the likelihood of enhanced risk. In addition, every psychiatric hospital should have a suicide prevention committee, which meets at least quarterly, to serve the following functions: 1) Review serious attempts or completed suicides, to identify lessons learned and to track the implementation of any recommendations; and 2) Serve as an ongoing quality improvement project, looking for practices, physical plant issues, scientific studies, and other systemic issues that will enhance suicide prevention efforts at the hospital.

Every unit must have fast access to a safe and effective "cut-down tool" to allow staff to quickly sever a ligature in the event of an attempted hanging. The hospital should also conduct periodic "suicide drills" (analogous to fire drills) to test its responses to predictable forms of suicide attempts, such as hanging, overdose, or cutting.

> **Recommendation 5 (Suicide Prevention): a) Create a suicide prevention committee, which includes staff members from all relevant departments (including physical plant maintenance) that meets at least quarterly to enhance the facility's suicide prevention systems; b) Purchase safe and effective "cut-down tools" for every unit in the hospital, and make them easily accessible to direct care staff; and c) Conduct periodic mock suicide drills to assess the hospital's ability to quickly and effectively respond to attempted suicides and other medical emergencies.**

RNPH allows for an 8½ hour work day for nursing staff, which facilitates a 30-minute cross-shift report. We observed several reports and found them to be informative, and to contribute to the safety and clinical care of the patients.

> **Positive Finding 5: We commend the practice of an extended, 30-minute cross-shift nursing report, which enhances continuity of care across shifts.**

Several of our important findings and recommendations relate to insufficient number and type of staff positions. Although our recommendations below represent barely a 5% overall increase in current hospital positions, the absence of these positions significantly impairs the hospital's capacity to adequately provide services, programming, treatment, and discharge planning.

Safe staffing plans must take into account multiple factors, including patient characteristics, patient flow and turnover, staffing mix, and care delivery model, among others. Important patient characteristic considerations include acuity, diagnoses, and comorbid complications, all of which are on the high end of the spectrum at RNPH. Patients come into the hospital directly from the community with high levels of acuity, severe and persistent mental disorders, and significant substance abuse or medical comorbidities. Admissions and discharges occur at a rapid flow, with average lengths of stay from one to three days in the POU and thirty days in the inpatient units. Delivery of safe and effective care to this population requires a mix of staffing skills that can address crisis stabilization, substance abuse treatment, medication management, behavioral interventions, assessment and training to enhance functional skills, and discharge planning. In most respects, acuity, patient flow, and care delivery needs place RNPH in the upper range of staffing needs.

No universally accepted staffing models exist, and all models require consideration of the factors noted above. Some states, professional organizations, and government agencies in the United States (e.g., U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration) and abroad (e.g., National Institute for Mental Health in England) have established standards or guidelines. Our recommendations represent our view of a minimum level of adequate staffing. Nevertheless, if implemented in conjunction with our other service recommendations, the additional staff should enable the hospital to provide safe, appropriate, and effective care and treatment.

If implemented, our recommendations will increase the management and discharge planning capacity of the POU and enable meaningful treatment beyond just medications for the inpatient population. Inpatient treatment teams, each servicing a 20 bed unit, would have a full time psychiatrist, full time psychologist, and two full time social workers. They would also have a charge nurse, one and a half direct care RNs, and three MHTs on both day and swing shifts. An acuity pool of four additional MHTs would be available to supplement staffing on units as needed (e.g., to assist with one-to-one monitoring). Finally, the hospital currently lacks occupational therapy services that can assist with comprehensive functional assessment and rehabilitation planning. Although a single full-time Occupational Therapist would not suffice to meet many existing guidelines, it will dramatically supplement the capacity of the current activity/rehabilitation staff to assess and serve the patients.

The following table provides a breakdown of additional recommended staff positions:

Position	POU	Inpatient
MHT	4.5	4.0
Social Workers	1.7	4.0
Psychologists	NA	5.0
Occupational Therapist	NA	1.0

As described above, each 20 bed inpatient treatment team must have a full-time charge nurse on day and evening shifts. Although this will require approximately 14 new charge nurses (Psychiatric Nurse III), this goal can be achieved without creating additional positions if some current positions are upgraded.

Recruiting and retaining psychiatrists has become challenging for RNPH. At the time of our visit approximately 50% of positions were vacant and some were filled with contract or *locum tenens* doctors. Excessive use of temporary physicians compromises treatment team coherence and functioning. Psychiatrist salaries at the hospital are reportedly significantly lower than comparable positions in the local area. For example, we were told that Veterans Administration facilities have salaries almost $50,000 greater with comparable benefit packages. In addition, it would expedite hiring if psychiatrists who want to move to Nevada to work at RNPH were allowed to work under temporary or limited licenses while awaiting issuance of their permanent Nevada licenses.

We did not review salary or recruitment issues related to other categories of staff at RNPH, but this would be a useful exercise for hospital administration and discipline chiefs to conduct.

Several job categories have experienced cuts in recent years, including custodial staff. Although the hospital does not assign custodial staff to specific units, it has a sufficient number of individuals to allow this. In other words, each treatment unit would have one assigned custodian, who is in a very real sense a member of the treatment team. As with other members of the treatment team, advantages can accrue when custodians have consistent contact with staff and patients on a single unit.

We were told that discipline-specific representatives, including MHTs, do not always participate in recruitment and selection of professional staff. As a result, the hospital misses out on the unique perspective, experience, and expertise that they can offer when selecting new employees from their profession.

We were also informed that decisions regarding staff positions, including hiring, require administrative approval from officials in Carson City. These approvals can reportedly take weeks or longer to obtain. This impairs the ability of the hospital to make timely decisions and can result in losing good candidates who in the interim accept other job offers. Similar delays can occur in obtaining approval to reclassify positions or reallocate some funding.

Existing state rules appear not to allow salaried medical staff to provide coverage or work extra hours for compensation. This makes sense for less than full time individuals who receive full benefit packages. Contract medical staff and *locum tenens* physicians receive a higher hourly rate of compensation in lieu of a benefit package. Part-time salaried professionals would receive an unjustified advantage if they worked some hours at higher compensation despite already receiving full benefits. The same concern, however, does not apply to full time professionals who are willing to provide extra coverage at an hourly rate. It makes more sense to allow full-time salaried professionals to provide moonlighting coverage rather than hiring even more costly *locum tenens* physicians or using contract professionals who lack familiarity with the system and the patients.

Many employees told us that it has become common practice for people to "burn" their accumulated sick time prior to retiring or otherwise leaving state employment. We are not suggesting that illnesses are necessarily fabricated, but the threshold of severity that keeps a person out of work is subjective, and can be heavily influenced by motivation. Typically, employees with large accumulations of sick leave are some of the most dedicated employees in state service, and it is easy for them to feel that they are being punished for their excellent record of time and attendance when they receive no compensation or reward for months of unused sick leave. As a result, their motivation to come to work can significantly decrease prior to their retirement.

When experienced staff members take extended sick leave, it necessitates hiring temporary back-fill or paying other staff overtime to cover vacant shifts. If, instead, employees could redeem unused sick time at a reduced percent of its salary value (e.g., fifty cents on the dollar), this would provide an incentive for employees not to use it up prior to leaving, ultimately saving the state money.

> **Recommendation 6 (Staffing): a) Increase overall staffing by 8.5 full-time MHTs, 5.7 full-time social workers, 5.0 full-time psychologists, and 1.0 full-time occupational therapist as described above; b) Upgrade a sufficient number of current nursing positions to allow each 20 bed inpatient unit to have its own full-time charge nurse on day and swing shifts; c) Increase psychiatry salaries by at least $40,000 per year, for current and newly recruited psychiatrists, to closer reflect current market conditions and improve recruitment and retention of high quality, permanent employees; d) Consider asking the Nevada Board of Medical Examiners to provide temporary licensure for newly hired psychiatrists who are awaiting issuance of their permanent Nevada licenses; e) Conduct a market analysis of salaries for other disciplines and make necessary adjustments to remain competitive in recruitment and retention; f) Assign one custodian to each of the 9 treatment units; g) Before hiring new employees, get input from current representatives from the same discipline and job assignment; h) If routine operational and hiring decisions continue to require state-level administrative approval, expedite this process to a matter of days, not weeks or months; i) Amend rules to allow full-time salaried physicians to moonlight for extra compensation within the system; and j) Consider buyouts of unused sick time upon retirement.**

Several themes emerged repeatedly in our discussions with staff. One of the more universal comments that we heard concerned staff perceptions that they have little input into development of policies, procedures, and practices that directly affect their work. In addition to its potentially negative effect on staff morale, lack of involvement by direct care staff can compromise the effectiveness of policies in at least two ways. First, direct care staff have unique insights regarding what does and does not work well. Without their perspective, the relevance and effectiveness of policies can suffer. Second, when direct care staff have representation in policy development, they are more likely to understand and embrace the resulting products. We found both confusion and dissatisfaction with some important policies, and we shared their confusion regarding some policies that we reviewed.

For example, we noted some confusion among staff regarding fire drill policy and procedures, such as where to assemble and whether to evacuate the building. In the event of an actual emergency, such confusion could mean the difference between a safe and an unsafe response.

> **Recommendation 7 (Policies and Procedures): a) Utilizing the quality improvement process, the hospital should conduct a comprehensive review and revision of all policies and procedures, with the goal of clarifying and streamlining them; b) Include representatives of direct care staff in the revision and development of all policies that address the functions and responsibilities of their jobs; and c) Review and revise (as necessary) hospital safety policies, especially those regarding fire drills and medical emergencies, and ensure that all hospital personnel understand policies regarding fires or disasters, including evacuation procedures and plans, and respond to drills as if the alarm signaled a real event.**

Another common theme that we heard involved staff perceptions regarding equity and fairness in their treatment. Some, but not all, disciplines and categories of staff believe that treatment by some hospital administrators depends mostly on personal relationships with those administrators. For example, some employees allegedly receive unjustified favoritism in timing and use of paid time off (i.e., vacation). We were unable to investigate the veracity of these allegations, however, the lack of equitable treatment, if it occurs, or the perception of unfairness can create serious problems with morale and job satisfaction.

Along with comments of dissatisfaction, direct care staff had much to say in praise of administrators (e.g., Hospital Administrator, Ms. Szklany) and clinical supervisors (e.g., Dr. White, Chief of Psychiatry) who regularly appear on units and provide them with support and positive feedback. One of the more remarkable things that we heard concerned Ms. Szklany, who reportedly knows nearly all of the hospital staff members by name. The respect that this displays, and the appreciation of the staff, cannot be overstated. In addition to her regular presence on the units, we also heard positive comments about her availability to meet with individuals in her office. Staff perceive some other administrators, however, as less supportive and mostly critical of their performance. Overall morale would benefit if all supervisors modeled their behavior after the examples set by Ms. Szklany, Dr. White, and others like them.

We believe very strongly in the power of positive reinforcement to improve staff performance. We also believe in the principal of progressive discipline, and that discipline should generally be educational in nature. Its purpose is not to punish but to improve performance. On the other hand, there are certain inappropriate staff behaviors that are so serious that they should result in immediate suspension or termination. Examples include direct care staff who fall asleep while assigned critical duties such as suicide watch, staff members who are intoxicated while on duty, and serious cases of patient abuse or neglect.

> **Recommendation 8 (Morale): a) Ensure fairness and equity in the treatment of staff, review and investigate allegations of unjustified disparate treatment, and hold supervisors and managers responsible for clear breaches of these obligations; b) Have hospital administrators and clinical supervisors spend regular time on units to provide consultation and support to treatment teams, and positive feedback for jobs well-done; and c) Although most instances of**

poor performance can be remedied through educational discipline, and employees deserve adherence to a system of progressive discipline, serious cases of employee misconduct should result in immediate and decisive actions, up to and including termination.

The medical record provides a critical tool for communication amongst staff. Clinical care suffers without adequate and accurate documentation. Excessive, redundant, or unnecessary documentation can also compromise care by consuming valuable staff time or by making it more tedious and difficult to find important information amidst the clutter. We heard many complaints about current documentation requirements that staff perceive as duplicative or unrelated to good care. The electronic medical record system, Avatar, was a source of particular dissatisfaction. Problems exist with every electronic record system that we have encountered. Although we did not do a comprehensive review of this issue, we did find some areas for improvement. For example, the hospital uses a fairly comprehensive, written suicide risk assessment instrument for every patient on admission and some other times throughout the hospitalization (e.g., before an attending psychiatrist takes vacation or other temporary absences). When patient history, suicide screening, or mental status examinations reveal concerns about possible suicidality, then comprehensive and excellent suicide risk assessments are appropriate and necessary. Not every patient, however, needs this detailed assessment, let alone at repeated times during the hospitalization. We expect that a careful review would find many other examples of unnecessary documentation, as well as missing documentation.

Further, the existence of an electronic medical record should allow hospitals to avoid redundant documentation. Examples include identifying, demographic, and historical information, as well as overlapping assessments from various clinical disciplines. As a general rule, the goal is to have smarter, not more, documentation.

Recommendation 9 (Documentation): The hospital should conduct a comprehensive review, preferably as a quality improvement project as described below, of documentation practices and make changes that enhance the quality and minimize the quantity of documentation.

The admission unit is a central locus of communication between the hospital and the broader community. They receive a high volume of faxed records and other materials from area emergency rooms that send patients to the hospital, and they have significant photocopying needs. Despite this, they had only older and unreliable fax and copy machines that could not keep pace with the demands. During our visit, however, the hospital made arrangements to provide adequate newer replacements.

Many of the issues we have listed as areas for possible improvement are ideally suited as the subjects of formal quality improvement (QI) projects. While some issues require mandatory, “top down” solutions, most problems are far better solved by the QI process.

Organizations use QI processes to answer several fundamental questions: 1) What tasks define our job? 2) Are we successfully accomplishing our assigned tasks and overarching goals? And, most importantly, 3) How do we know? The results of these self-critical questions will lead to a second set of questions, aimed at identifying areas where improvement is desirable and possible.

Historically, quality was "assured," in a static and often retrospective review of adherence to inflexible standards. This approach works well for certain assessments (e.g. infection control), but lacks the creativity and innovation that characterizes every truly healthy organization. Nevertheless, old-fashioned quality assurance approaches are still an important part of the QI process. RNPH effectively gathers data for quality assurance purposes. They can use this well-developed skill to help implement continuous quality improvement projects and activities.

Another part of the QI process is identification of outliers, and investigation into the reasons for unusual performance, which may be positive or negative. The inquisitive process uses project teams to explore the advantages and liabilities of different approaches to tasks and problems. The teams gather data describing the costs and benefits of current and alternative ways of addressing responsibilities and make recommendations to the organization's executive leadership.

A robust QI process has many advantages. QI project teams typically include individuals from every relevant part of the organization; usually, the only requirement is knowledge about the problem and an interest in making it better. This inclusive approach to problem solving improves morale and maximizes creativity, practical utility, and investment in solutions. The QI process assumes that no one knows more about a job than the person who does that job, and ensures their input into crucial decision.

> **Recommendation 10 (Quality Improvement): a) Establish a robust QI process with project teams that include staff at all levels (especially direct care staff) conducting reviews of meaningful issues that they have identified; b) Create a hospital-wide, QI committee (again involving staff at all levels and from all departments) explicitly tasked with developing and suggesting quality improvement projects or teams aimed at specific issues, processes, or problems; and c) Consider a specific QI project to improve the discharge and treatment planning processes and documentation within the hospital.**

In conclusion, we appreciate the opportunity to provide this consultation. We want to thank the many state officials, hospital administrators, stakeholders, staff, and patients who took time to share their thoughtful and constructive ideas about enhancing services at RNPH. As noted in our report, we found much to commend regarding care and treatment at the hospital. The professionalism and openness of state officials and hospital employees and the extent to which patients feel safe and respected especially impressed us. We also identified areas in need of improvement and have made recommendations to address them. RNPH is by no means unique in this regard. Many hospitals in states across the nation face similar challenges. RNPH, however, is well positioned to meet these challenges through the competence and dedication of its staff and with the state's commitment to provide the hospital with necessary resources.

Respectfully submitted,

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