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# ALBERT J. SOLNIT CHILDREN'S CENTER

## SOUTH CAMPUS

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### On-Site Consultation

August 8-10, 2018



Prepared by



## **I. Overview**

The focus of this consultation was to provide on-site consultation following the decision by the CT Department of Health (DPH) to place the Solnit Children's Center – PRTF on an Immediate Jeopardy (IJ) status, following an on-site inspection of the facility by DPH. This preliminary three day consultation was later expanded to include the work of two additional clinical consultants whose work will be summarized in a separate report. .

## **II. Activities Conducted by Consultant**

1. Preliminary review of policies and procedures related to medical emergencies, intake and admission, levels of observation, suicide assessment.
2. Review of clinical processes and the patient flow from referral/screening to discharge. Particular emphasis on assessment of risk. Review included use of the Columbia Suicide Severity Rating Scale (CSSRS) tool, recruitment of critical staff positions, the use of hospital and per diem staff for coverage. Additionally, discussion included how decisions were made for those referred to the facility, and any exclusion criteria.
3. Review of two closed medical records (patients who were recently discharged and had self harm/suicide ideation as an active problem in their treatment plan).
4. Review of the written proactive environmental risk assessment for the Lakota unit, and discussion with the facility staff on ways to improve the document – to show both the engineering and clinical mitigation steps that have been taken to ensure safety.
5. Environmental rounds on the three residences; Kiwani, Quinnipiac and Lakota.
6. Discussion of items included in the Plan of Correction prepared by the facility following the DPH inspection of 7/16/2018.
7. Three clinical tracers (and a partial review of medication management practices on Lakota).
8. Discussion with staff education and training leadership about competency assessment – specifically for the training described in the Plan of Correction.
9. Discussion with several leadership staff about the process of incident report and review, and their approach to continuous quality improvement at the facility.

### **III. Findings & Recommendations**

- 1) Policies and procedures are in various stages of revision, approval, and implementation. Training for staff has occurred, and staff reported the method of training varied from having staff do a “read and sign” to management staff visiting units to explain the changes. It appears in some cases, staff did not have the chance to discuss the changes. There were many policy changes in a very short time (as necessitated by the IJ status and the POC). There was evidence that some of the critical policies (15 minute checks, observation status) are not being consistently followed. For example, staff on the Kiwani unit said that if a youth is in their bedroom, it was OK to look through the window to assess their status – which is directly in conflict with the stated policy of going into the youth’s room. Staff also described an occurrence when needed observations were missed for a prolonged period of time (overnight) for a youth. 15 minute checks are recorded on one combined sheet for all the youth on the unit. The sheets only check the location of the youth, not their observed behaviors. These are not filed individually in the youth’s clinical record.

#### **Recommendations:**

- Conduct additional training in levels of observation, and the performance of required checks.
  - Assign management staff to randomly audit their completion.
  - Change your 15 minute check sheets so there is one youth on one sheet. Add observed behaviors to the check sheet, instead of only documenting location.
  - Make sure RN’s spot check the completion of the rounds.
- 2) The review of patient flow from screening to admission focused on admission decisions, and the use of the Columbia Suicide Severity Rating Scale (CSSRS). The tool is to be used at admission by the MD during their admission evaluation, by the RN during their admission assessment, and when a youth demonstrates or verbalizes behaviors or statements that indicate dysregulation/self harm. Upon review of two records, two of the screens were not found (one admission screen by the MD, and one admission screen by the RN). Staff stated many do not like the tool, and raised concern that the screen is being used as a questionnaire, rather than an open ended discussion with the youth. During the competence assessment session, staff could not accurately

demonstrate that all of the staff who need to use the tool received training in its use, and some of the training took place months prior to its implementation at the PRTF.

Another change in practice is for RN's to do a risk assessment for SI/harm to self and others each shift. This is done in a progress note, and compliance with the records audited was 100%.

**Recommendations:**

- Determine who has been trained in the tool, and ensure all staff who are required to use the tool demonstrate competency in its use.
- Conduct a 100% concurrent audit of admission documentation.

The Policy "Referral, Waitlist and Admission Procedures", describes the process to screen and admit a youth to the facility. One section (page 150) of the policy states "After considering all the relevant features of the referral, the Intake Coordinator and the assigned manager over clinical services may: Review referrals in a weekly triage meeting or Recommend admission and schedule a pre-admission and admission date as quickly as possible.

**Recommendation:**

The policy should be amended to include oversight of the admission process by the Superintendent and the Medical Director.

3) Two discharge records were reviewed for completeness. Additional record reviews should be performed by the IC at a later date. Findings from the two audits include: missing data on restraint documentation for an episode on 4/12/18 for a youth, including criteria for discontinuing restraints, the name of the MD providing the order, and problem numbers missing on treatment plans.

**Recommendation:**

Conduct an immediate review of all documentation related to restraint by supervisory staff following each episode.

4-5)

A review of the proactive environmental risk assessment for the Lakota unit and environmental rounds of the three residential units occurred.

The written risk assessment contained both completed and work in progress. It did not include what mitigation strategies are in place at the current time to ensure youth safety while ligature risks remain on the units. During the unit tours additional risks were identified that should be added to the assessment

**Recommendation:**

Enhance your risk assessment to include both short term and long term strategies you plan to conduct in order to ensure environmental safety on the units.

**Environmental Risk Assessment:**

A preliminary environmental risk assessment was conducted of all three units. Most of the findings below appeared in all three units:

- HVAC units have loopable parts. Some have been mitigated, but others remain loopable. These are in spaces where staff is providing supervision (main room) and areas where the youth are unobserved (bathrooms, bedrooms).
- Beds can serve as anchor points at the point of attachment to the floor.
- Several bedrooms in Lakota have a grid ceiling.
- Some closets still have doors.
- All bedrooms do not have ligature resistant door handles and continuous hinges.
- The small side rooms in the entrance Kiwani and Quinnipiac have loopable cords, door handles, hinges, conduit, TV, furniture, and other hardware. When the door is closed, there is a significant blind spot. Youth can be in the room alone.
- There are several rooms (kitchen, staff office, laundry, janitor's closet, etc.) that contain ligature risks. Staff state youth are never alone in the rooms. These rooms should self-closing/self-locking door mechanisms so that "human error" is taken out of the operation. On Lakota, the consultant observed the staff office unoccupied and open. The room contained sharps, cords and other hazards.
- Corridor ceilings in Kiwani and Quinnipiac are accessible, and dropped grid type. The grids are not secured. Staff state they can observe the corridors. However, there appear to be areas in the corridor that are unobservable, and if staff are engaged in other milieu

activities these areas are a risk. In addition to the grids, there are exit signs, sensors to monitor the environment, door closures, handles and hinges that are loopable.

- Patient bathrooms contain stalls that are not ceiling to floor, and are loopable. The drain mechanisms on the tubs are loopable. One bathroom had a door stop that could be used as an anchor point. Some toilets still have exposed water lines. Toilets can be used as an anchor point where the tank connects to the seat.
- Phones used by patients are in an unobserved area. There were loopables including door handles, padlocks, and door hinges in these areas.
- Plastic trash bags are in use in the main area, and kitchen.
- The group rooms can also serve as emergency bedrooms. There were pull out couches in the rooms and a table which were loopable.

Other findings from environmental rounds:

- All of the units appear to have deferred maintenance and require a deep cleaning.
- Shower stalls in most bathrooms were dirty, and some appeared to have a significant amount of mold.
- Food storage is problematic. Refrigerators and freezers, and cabinets were dirty. Leftover food was not labelled according to policy.
- Kitchens contained stoves without “kill switches”. Staff relate no actual cooking occurs in the kitchen. Kitchen cabinets in Kiwani had items that could be used as weapons. These were in unsecured cabinets/drawers. The kitchen at Kiwani was dirty. The area was subsequently cleaned.
- Some doors were delaminating, and appeared to “stick” from humidity. On Kiwani the AC ceiling conduit was covered in condensation, and a large amount of water was on the floor of the day room.
- On Quinpiac, the small room at the entry had multiple dead bugs on the floor behind a couch.

The facility plans to close units sequentially, and address the ligature risks and maintenance issues. This approach will result in some of the units not having risks mitigated for an extended

amount of time. Additionally, some of the hardware needed (door closures, hinges, door knobs) are on back order. During the interim, increased staffing to ensure continuous observations of the unmitigated risks is advisable.

6-7) Report/findings deferred until additional information is obtained in subsequent visit.

8) During the discussion with staff responsible for staff education and training it appeared that the POC tasks related to staff education require remediation. There seemed to be a lack of a coordinated response to the needed actions from the POC, and a lack of a single point of accountability to ensure the actions were completed. Examples of this included: Multiple lists of staff who had/had not completed mandatory training such as C-SSRS, use of emergency medical equipment, etc. There wasn't consensus on how the lists were developed/who was on which, and who still required training. The training on the use of oxygen included a check off, and staff signature. The training on suction machine did not include a check off or signature attesting to staff competency. The training/update on the AED only included an update on the policy – indicating where the units were located. No staff competency assessment on this device was conducted (staff relate it's assessed every two years during CRP). For the C-SSRS, multiple lists were presented with the dates staff had training in its use. Staff commented that some people on the list didn't need the training, and others appeared to not have training at all.

**Recommendations:**

- Ensure that all staff who use the emergency equipment have a new demonstrated competency assessment for its use.
- Finalize training in the CSSRS. Determine if staff require additional training in the use of the tool, and conduct the same.

Other findings related to staff development:

Multiple staff are tracking different items related to HRM. This includes ongoing PSV of licenses, transcripts, attendance at trainings, etc. The facility uses the software "learning management system" which is deployed in many state agencies. Staff should explore with other DCF if there are ways in which this application can assist tracking trainings and other HRM functions.

9) Report/findings deferred until additional information is obtained in subsequent visit.

#### **IV. Other issues identified during the consultation:**

Staffing issues, in particular RN coverage, was a consistent theme throughout the consultation. The use of per diem staff or staff who “floated” from the hospital was described as problematic for nursing to have a leadership role on the unit, and to ensure continuity of care.

#### **V. Plan for Next On-Site Consultation:**

- Ongoing environmental risk assessment, and monitoring of completed remediation.
- Continued information gathering about quality assessment and the use of data
- Continued review of the actions associated with the POC.
- Continued policy and procedure review