**Lakeview Plan of Corrective Action**

**to the**

**New Hampshire DHHS Licensing Report**



**February 9, 2015**

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**LETTER FROM THE LAKEVIEW LEADERSHIP**

Dear DHHS Licensing Body:

As the leadership of Lakeview, we would like to begin by emphasizing that we take the findings of the December 9, 2014 licensing report very seriously. We know that as an organization we must change our culture and transform the operations and clinical services of Lakeview. We have been actively involved in every element of the design of this Plan of Correction.

Our fundamental goal through this plan is to develop practices that promote a culture of safety and client integration into the community, systems that sustain those practices, and continuous quality improvement strategies that ensure the practices are achieving the intended goals.

We are working to ensure that, rather than being a series of “units,” Lakeview evolves into a “system”—a combination of processes, people, and other resources that are working together to achieve an end. We understand that if we are not working closely with our managers, clinicians and line staff, our goals are unlikely to be met.

We understand that the quality and safety of care provided by Lakeview depends on many factors including:

* A culture that fosters safety and quality;
* The planning and provision of services that meet the needs of program participants;
* The availability of resources—human, financial, physical, and information—for providing care;
* A sufficient number of competent staff and other care providers; and
* Ongoing evaluation and improvement of performance.

We know that, as leaders, we are responsible for allocating the resources, influence, and control to provide for these factors. We know that it is up to us to establish Lakeview’s culture through our words, our own actions, and our expectations for action. The past months have caused us to take a long, hard look at how we function and what we need to do to remain relevant and survive.

Based on our many communications with representatives of DHHS and other stakeholders, we clearly understand that we must address our staffing issues by, among other things, aggressively recruiting quality staff to ensure that the predictable “call outs” do not result in unsafe situations for our clients. We will ensure that Levels of Supervision–which are clinical decisions—are not modified based on staff availability. And, we must take sufficient measures to ensure staff are set up for success, that our staff are well trained, equipped to handle the acuity of the program participants we admit and are able to manage crises effectively and safely.

We will systematically measure and manage admissions to ensure that the acuity of the clients admitted both individually and in aggregate do not exceed our capability and resources. Treatment plans and behavioral interventions will be modified in real time—and based on contributions by a person-centered team including the person served, diverse staff, and family members. We will effectively use the reams of data we collect to inform and enhance practice through a comprehensive QAPI process. Finally, we understand that the communication –about every clinical aspect of the programming—needs to be significantly improved and, once improved, sustained, anchoring these changes in our corporate culture

We are absolutely clear that major, sustainable changes in the areas identified above are essential to Lakeview’s continued existence. We know that effective QAPI programs are critical to improving the quality of life, and quality of care and services delivered. And we will create the leadership development and integration necessary to institutionalize its vital role into every aspect of our systems and processes.

Some of our immediate responses to demonstrate how seriously we are taking these findings include:

* Significant structural and operational shifts to include changes in leadership, compensation, clinical programming and infrastructure—all focused on improving, safety, consistency, and outcomes.
* Hiring of Fedcap Rehabilitative Services, Inc. to assist us in the development of ongoing systems improvements and to serve as our consultant and internal monitor. Fedcap will provide real time feedback to all relevant parties, including the State.
* Retention of Durante Advantage Training to support our efforts to build the skills and professionalism of our direct care staff.

Additionally, we acknowledge the following as directives from NH DHHS, that:

• Lakeview is directed to schedule and provide additional supervisory and direct care staffing beyond the level required or presently scheduled to meet the day to day needs of clients in order to ensure that clients’ safety and well-being are being maintained during this period. Lakeview shall report weekly to DHHS an analysis of its staffing, including the base line that is necessary by shift, cabin and client, identifying by name the assigned staff. Lakeview shall also identify by name, which additional supervisory and direct care staff are being assigned to meet this directive, again, by shift, cabin and client. Lakeview shall also self-report weekly any shortages of required staffing, including the additional levels of staffing required by this directive.

• Lakeview shall reassess each resident to ensure that the levels of supervision are clinically appropriate. Levels of Supervision (LOS) will be reduced only based on documented clinical rationale and this will occur at the weekly clinical services meeting and shall not be in response to staffing shortages.

• Lakeview shall immediately begin assessment of the effectiveness and adequacy of its training programs, including by obtaining input from its direct care and other staff as to training needs. As soon as possible thereafter, Lakeview will implement its revised training program.

• Lakeview shall provide a root cause analysis to DHHS within 7 calendar days of a Level III or IV incident report, accompanied by the incident report. Additionally, for each such incident analysis report, indicate how the cause and/or response relates to the systems being addressed by the POC, such as staffing, training, supervision and quality assessment review.

• Lakeview shall report to the Health Facility Licensing Unit within one day any allegation of client abuse or neglect. Within five calendar days, Lakeview shall provide the Health Facility Licensing Unit a completed investigation and report of specific actions taken, if any, regarding the abuse or neglect allegation. These reports shall be in addition to all other mandatory reporting requirements contained in rule or statute.

• Until such time as Lakeview has a sufficient number of adequately trained staff it needs to reduce the overall acuity of the resident population. Lakeview shall report every two weeks to the Department its progress on discharging these high acuity clients.

* Lakeview shall retain Fedcap Rehabilitative Services (as proposed by Lakeview), or similar qualified organization approved by the Department, to serve as Third Party Independent Monitor (TPIM) until such time as Lakeview achieves full compliance and implementation of the Plan of Correction (POC). The TPIM shall be responsible to report on a monthly basis to Lakeview and to the State on the progress of Lakeview in its implementation of all aspects of the POC. Reporting shall include, but not be limited to, steps to carry out and maintain the immediate actions directed by the Department in its letter dated January 14, 2015, as well as Lakeview’s development of ongoing systems improvements and to whether such improvements have been properly implemented, sustained and institutionalized within Lakeview. The TPIM shall develop, in consultation with Lakeview and the State, measurables and reports that will demonstrate the progress in implementation of the POC. Lakeview will bear the entire expense of the TPIM and which shall be at no cost to the State.

We appreciate your assistance in identifying the improvements needed in our current operations as we establish a new operational framework and transform our organization by institutionalizing these initiatives into our day-to-day operations not just in NH, but at all of our locations across the country.

Sincerely,

Chris Slover, Chairman and CEO

Tina M. Trudel, PhD
Dr. Tina Trudel, President and COO

INTRODUCTION and APPROACH

We have structured our responses to the findings in the following way:

1) Findings of the State in each of the major categories as directly noted in the DHHS licensing report:

* Quality Assurance/Performance Improvement /QAPI (also woven throughout the entire document)\*\*\*
* Staffing
* Level of Supervision
* Incident Reporting
* Crisis Management
* Acuity Level of Participants
* Assessment, Treatment Planning, and Documentation
* Medical Records
* Communication
* Infection Surveillance, Prevention and Control
* Medication Management
* Life Safety Code
1. Our understanding of the importance of this area to participant safety and quality care.
2. Our Immediate Response
3. Our Longer Term Corrective Plan
4. QAPI Strategy
5. Responsible Party for overseeing implementation of the corrective plan and QAPI

\*\*\* Note: We intentionally began with the Quality Assurance/Performance Improvement (QAPI) Section of the Plan of Correction because our order of this document is intended to demonstrate that framework for ensuring improved practices and processes implemented through our Plan of Correction is our evolving approach to QAPI.

We also re-ordered some sections because they naturally followed one another such as incident reporting and crisis management.

# QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT

**He-P 807.14 Duties and Responsibilities of the licensee: (c) The licensee shall provide the following core services: (1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding: (c) personnel safety.**

**State DHHS Licensing Finding**

The organization needs to continue to develop its Quality Improvement Performance Improvement (QAPI) program. QAPI/ QI staff need to be leaders and role models in the utilization of accepted QAPI methodologies (, such as PDCA, LEAN and Six Sigma), utilizing recognized tools to facilitate full utilization of the diverse inputs, data, root cause and aggregate data analyses, planning processes, action steps and on-going review for continuous program improvement .

**State DHHS Licensing Finding**

The organization needs to have all key aspects of organizational functions, including but not limited to: medication management, infection control, safety, security, staff and resident perception of satisfaction and care, human resources, staff competencies, documentation, etc., need to be identified elements of the QAPI/ QI program to ensure a cultural shift to QAPI across all aspects of the organization.

**State DHHS Finding**

The organization needs to develop a comprehensive program of staff training, monitoring, evaluation, data aggregation and analysis regarding the incident report system through its Quality Improvement QAPI Function, and to implement root cause analyses for significant incidents to develop deeper understandings of inter-related systems not necessarily evident in aggregate data analysis.

**State DHHS Finding**

The organization needs to assure that the Electronic Record implementation will be closely linked to QAPI methodologies.

**Comments**

We understand the critical importance of infusing quality improvement into every aspect of our programming. We agree that we must have a formalized, institutionalized and systematic approach to continuous quality and performance improvement that seeks to prevent problems, address existing issues, and ensure that all improvements in the system are sustained. We are working to build a comprehensive QAPI system that will ensure that:

* Structures for managing change and performance improvements exist that foster the safety of participants and the quality of care, treatment, and services.
* We have a systematic and on-going approach to change and performance improvement.
* We understand what data is important to collect and analyze—and which data merely adds to the noise.
* We use the right data to continuously evaluate the effectiveness of processes for the management of change and performance improvement on an on-going basis.
* We increasingly utilize root cause analyses to better assess critical incidents as well as complex and systemic issues.
* Based on our analyses, agency leaders establish priorities and benchmarks for performance improvement.
* On an ongoing basis, agency leaders reprioritize performance improvement activities in response to changes in the internal or external environment.
* Information is shared with staff, stakeholders, and agency leaders as part of our continuous improvement process, to ensure that all staff understand how data is driving decision making and have an opportunity to provide feedback to the process.

Further, Lakeview leadership understands how critical an electronic record is to our clinical practice and ongoing QAPI. While this process has taken some time, we are making progress. An electronic record that includes all demographic and clinical information is critical to advancing our clinical practice. When staff are trained on accurate and timely data entry, we will be able to capture and aggregate data for identified reports in real time, and Lakeview will have the ability to create custom reports internally which will also support the capacity for real time analytics. We anticipate the electronic health record (EHR) implementation and QAPI reporting features will be operational by the end of the second quarter, 2015 (June 30, 2015).

**Immediate Response**

We hired a new Director of QAPI [11/10/2014] who is an experienced health care professional possessing a Master’s degree in healthcare administration and hospital experience. She brings excellent role modeling, transformative and leadership qualities to the QAPI Department at Lakeview. She was hired because of her credentials AND because of her proven abilities to effectively communicate lessons learned during QAPI processes to direct care staff.

**Beginning on January 15th**, a Fedcap team member who is a CARF expert, Certified Rehab Counselor and skilled in CQI began working with the new Director of QAPI to design a comprehensive strategy that drives continuous quality improvement throughout the organization.

**In January 2015** we restructured the QAPI Committee and meeting process to ensure representative participation in the overall Committee and subcommittee functions. The overarching QAPI Committee has membership from the QAPI, Clinical Team, Direct Care, HR, EOC, Nursing, Case Management, Direct Care, Fiscal/ IT and Educational Departments/Services. The QAPI Committee will meet weekly in this configuration, with a rotating subcommittee structure to include monthly meetings of:

1) Environment of Care, Infection Control and Medication Management Subcommittee;

2) Safety and Workplace Violence Prevention Subcommittee;

3) Medical Records and EHR Subcommittee; and

4) Licensing, Accreditation and Policy & Procedure.

Each subcommittee will involve additional representative membership directly engaged with the subcommittee focus area. The QAPI Committee and subcommitees will also include relevant input from our diverse stakeholders including family, funder, area agency, surveyor, community advisory board, consultant, client and other sources of feedback for performance improvement.

**Longer Term Corrective Action Response**

Designing a QAPI strategy requires an understanding that action/ non-action has consequences. A culture of continuous quality improvement means that systems are in place to examine workplace anomalies through the lens of what occurred, why it occurred, what could have happened to change the outcome, what can we put in place to ensure that the outcomes changes next time. The QAPI strategy involves not only data driven aggregate analyses for trends and prediction, but also root cause analyses (RCA) for in depth learning and improvement of integrated complex systems and functions critical to successful operations.

The shift to QAPI culture includes utilizing data, analyses and diverse stakeholder inputs in order to predict and prevent issues across systems and to continually learn and improve as an organization. To appreciate the complex nature and interdependence of organizational functions, operations and systems, and to collectively recognize and understand program improvement opportunities from our unique and shared perspectives, is a cultural shift that this Plan of Correction serves to facilitate. Although not all QAPI initiatives are mentioned herein, key changes including improved multi-directional communication systems, facility rounds and walk-throughs, diversified committee/subcommittee membership, inclusion of stakeholders, frequent debriefing and dialogue, increased presence of clinicians and leadership across shifts and locations - are all steps and parts of supporting the QAPI cultural shift.

The chart below, for example, describes a QAPI process for incidents:



By **March 30, 2015** QAPI process such as the one described in the diagram above will be full defined and instituted throughout the agency. These QAPI processes will continue on and on-going basis, to be shared with relevant staff at all levels and with all applicable stakeholders.

By **March 30, 2015**, all staff will be trained on the QAPI process by the QAPI department and their designees. Shift Supervisors will have specialized training so that they understand their role in data collection from the moment any issue arises as well as proactive data collection that is used to identify potential, future issues. Tools and structure will be developed that everyone understands must be followed for successful identification and prevention of any and all factors that have the potential to detract from the quality of care. Conclusions leading to interventions and system change and subsequent on-going follow-up, will be disseminated to germane staff (leadership, clinical staff, educational staff) for further input, development of interventions and follow-up.

**By June 30th, 2015** this comprehensive cycle of tool and structure development, staff training to utilize the tools, review by QAPI and dissemination of findings leading to systems change and follow-up, has commenced, and will be fully functional across all programs and services.

The Director of QAPI, clinical staff and direct care staff are all working in conjunction with the EHR team to assure that critical data collection field and tools are embedded and that quality metrics are met within the system.

This process is already under way with anticipated 2nd quarter 2015 **'go live', by June 30, 2015.**

On March 30th we will provide our first report to all staff entitled “**Getting Better at What We Do!”** The report will be disseminated monthly for 6 months and then quarterly thereafter.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The leadership of Lakeview, in concert with our consultants, will conduct a weekly review of all processes and products implemented by the QAPI Department. The overall efficacy of efforts by the QAPI will be measured by the institutionalization of practices.

Specifically:

If specific QAPI processes are to be followed, are they followed? If not, why not? Is the process flawed? Does it need to be revised? If so, leadership will oversee revisions and hold the QAPI Department accountable for the institutionalization of the process.

If specific QAPI forms are to be used, are they used? If not, why not? Do they need revision? If so, leadership will oversee the revisions and hold the QAPI Department accountable for institutionalization of the use of the forms.

Do the QAPI Department and the Clinical Team work together to ensure that information is provided to staff in a way that is accessible? Are reports and analysis provided by the QAPI Department thorough? Do they provide information that supports best practice? If not, what needs to change?

The bi-annual staff survey will explore the staff understanding and usefulness of the QAPI process. We expect to see a growing understanding by staff and an appreciation for the data provided.

The QAPI Director, Clinical Director and Leadership Team will meet monthly with leadership to ensure that we are on track for developing a comprehensive QAPI culture.

QAPI Department will develop the Report: **Getting Better At What We Do!** that will describe our agency performance trends in the following areas:

* Incidents (type, location, time, LOS)
* Response Team Calls (frequency, location, time of day and relationship to LOS)
* Number of clients who move to community settings
* Results of Medical Record Audits
* Results of Staff and Other Satisfaction surveys
* Number of medication errors or adverse events involving medications
* Learning and trends from RCAs
* Other aggregate data analyses to improve practice as identified

**Responsible Party: QAPI Department, Clinical Director**

# STAFFING

**He-P 807.18 (a) Personnel: (a) The licensee shall ensure that sufficient number of qualified personnel are present in the RTRF to meet the needs of clients at all times.**

**State DHHS Licensing Finding**

The organization needs to increase its recruitment efforts, including salaries that are above market, to attract and retain qualified and competent direct care staff.

**Comments:** We acknowledge that we have not been successful in recruiting and retaining staff resources, and need to significantly increase our recruitment efforts and our staff retention. We also understand the critical importance that qualified and competent direct care staff has to client safety and will address this issue through short- and long-term strategies. We also appreciate that the work environment, clinical and management support, a culture of safety and creative recruitment and retention ideas are all a part of ensuring that the quantity and quality of personnel is a reliable, sustainable resource.

**Immediate Response:**

**Pay Increases**: The following announcement was sent out on January 7th to all direct care staff.

*We are pleased to announce that effective January 11, 2015, the starting salary for Rehabilitation Specialists and Education Aides has been increased from $10.00 an hour to $10.50 an hour. All Rehabilitation Specialists and Education Aides making less than $10.50 an hour will have their hourly rate brought up to the $10.50 starting rate.*

*These changes will be part of an overall training and development plan scheduled for implementation during the end of the first quarter of 2015. A comprehensive staff training development plan for new and existing direct care staff shall be implemented over the next three months and will include additional milestone bonus opportunities.*

*In addition, Shift Differentials are being increased effective January 11, 2015 for Rehabilitation Specialists, Ed Aides, Teacher Assistants and Nurses.*

 *B-shift: from $1.50/hour to $2.00/hour*

 *C-shift: from $1.50/hour to $2.50/hour*

 *W/E: including Friday C-shift: from $2.00/hour to $3.00/hour.*

*The Direct Care Staff working at Lakeview are highly valued and we appreciate the dedication and commitment provided to the program participants. These increases reflect our appreciation of your dedication and commitment, and are intended to enhance recruitment and retention initiatives for 2015.*

*We added a $1,000 referral bonus and $1,000 sign on bonus for January, 2015 to rapidly increase the recruitment pool for new hires.*

**Additional Staff**: We reassigned staff from the day shift to the 3-11 and weekend times to increase the staff-participant ratio during these shifts**.**

**Longer Term Corrective Action Response**

**Recruitment:** In the long-term, we clearly must over-recruit a pool of quality staff. We are working with our consultant to centralize aspects of our corporate HR functions and dedicate New Hampshire Human Resource staff to provide visible, dedicated assets to the recruitment and professional development of all staff with a strong focus on direct care staff. We have also identified a number of transitional housing options to assist us in recruiting from a broader geographic pool of applicants who may be willing to relocate to the region if provided with transitional housing.

Current HR staff continues to work aggressively on filling open direct care positions with qualified, competent staff. We have expanded our advertising/marketing strategies to include job fairs and we are working with our consultant to develop creative relationships with community colleges to serve as potential labor streams to our agency, such as through internships. We are also reframing our message –inviting staff to be part of a transformational process of clinical programming—emphasizing the important role that direct care staff will play in carrying out the treatment goals of each client.

We are also restructuring our Human Resource Department, ensuring an individual whose sole responsibility is the recruitment of new staff as well as a professional staff member providing support for recruitment at the professional staff level.

We know that typically, 2 direct care staff “call in” each day. As such we are recruiting enough new staff so that we can overstaff each shift by at least two direct care staff to mitigate for this reality and anticipate this staffing density will be achieved by March 30, 2015. We will also reach out to staff who have a pattern of calling out (more than 2x in a month) and provide specific training to them on the impact of the clinical programming and client safety when they do not show up to their assigned shift.

We are also expanding our pool of staff who are able to come in at any point in time to fill in when individuals call out. Currently we pay existing staff a $25.00 retainer to be on call. While this has served as a short-term solution for ensuring we are adequately staffed, we know that having staff work multiple shifts in a row is not a sustainable long term strategy. We are reaching out to other agencies to build our on-call pool.

**Retention**: Our data suggests that during years 0-2 of employment we have the highest rate of turnover. In response we are instituting a policy of over-hiring during this timeframe because we know that people drop off. We are instituting a model suggested by our consultant where during the first six months of employment, a new staff member will meet 3 times with human resources to explore their career options in the agency, become familiar with additional certifications that can result in salary increases and chart out their professional development plan as part of their on-boarding process. We anticipate all direct care staff to have a professional development plan in place by March 30, 2015 and Lakeview staff overall to have professional development plans in place by June 30, 2015.

We are also trying to better understand why people leave the agency through a more comprehensive exit interview process which has already commenced. We further believe that enhanced communication with clinical and management staff during each shift will improve morale and potentially impact retention.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

We will track staffing patterns for each shift identifying the number of staff required based on LOS and number of staff on duty.

We will continue to track the number of staff that call out and follow-up with specific staff who demonstrate a problem pattern of repeat call outs to assess the best path forward for the employee and organization, for example, switching to per diem status or changing shifts..

We will carefully analyze data to determine by shift, if overstaffing by 2 direct care staff for each shift is functioning as an effective strategy for improving staffing patterns after one week of implementation. This will be reviewed in the shift-by-shift debriefings each day and then assessed in aggregate by week for each shift.

If we determine through our shift-by-shift review through debriefing that we need to increase the number of direct care overstaffing, we will do so immediately. This change in staffing based on shift-by-shift debriefing will also inform our aggregate review.

We will measure the effectiveness of each recruitment strategy by tracking how many new candidates resulted from each new market. The sign-on bonus and referral bonus plan has resulted in a new orientee class of 10 commencing 01/19/2015, our largest incoming class in months.

We will feed the information from the exit interviews into staff communications, assess for trends and provide opportunities for on-going dialogue to generate program improvement solicit ideas leading to new staff retention initiatives.

**Responsible Party: HR Director**

**State DHHS Licensing Finding**

The organization needs to administer the staff satisfaction survey on a semi-annual basis to use the data and help yield insights into the effect of staffing increases on morale and retention.

**Comments**

We agree that by more fully understanding the perspectives of staff, and more frequently obtaining their feedback, we can do a better job of recruitment, retention, building a culture of safety and improving staff morale. The semi-annual survey is part of a larger effort to engage staff and ensure that we have strong feedback mechanisms. We are increasing leadership and senior level management presence on the weekends and evenings, so that if staff has a concern they can share it. We are also increasing the number and format for all-staff town meetings—making certain that we create a safe environment for staff to talk to us. We are also refining our employee electronic newsletter, adding content and improving its utility as a communication vehicle.

**Immediate Action**

We have instituted **monthly (or more frequent) all-staff town meetings** (we are scheduling them one week out to ensure that staff have adequate notice) and hold these meetings at various times of the day (before B shift, after A shift and after C shift) to ensure all staff can participate. Commencing February, 2015, summary minutes of the Town Meetings will be shared with all staff via company all systems email and the company newsletter. Initially, we intend to communicate the findings of the licensing agreement and the components of the Plan of Correction and listen to staff ideas for system improvements. While not all ideas will be implemented, we want staff to know that we value the dialogue and their perspectives. We believe that often the simple act of asking staff for their opinion and really listening can stabilize morale while providing new perspectives on organizational change and improvement.

**Longer Term Corrective Action Response**

The organization will administer the staff satisfaction/feedback survey on a semi-annual basis, with the next survey to be administered in **March of 2015.**

Lakeview is currently working with our consultants to supplement our staff satisfaction survey, drilling deeper into day-to-day practice, clinical communications and ongoing training needs. Information from the staff survey will go directly to organizational leadership bi-annually, and findings will be integrated into communications, training and staff discussions.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

We have the information compiled from the initial staff survey—including the kinds of responses for each question. Using this as a baseline, we will compile information from the next survey and compare responses identifying successes and areas for improvement.

After the March, 2015 survey, we will administer our next survey in September of 2015 and every six months thereafter trending the responses to determine progress in overall staff satisfaction. Communication regarding findings will be disseminated to all staff within 3 weeks of survey.

In areas where staff express concern, leadership will meet with managers and Shift Supervisors to determine specific changes required, and will ensure implementation of changes within 60 days of survey completion, allowing for a full 90 days of implementation prior to re-survey. Staff will also be re-surveyed through the all-staff town meeting immediately following any new implementation, in order to gauge initial reactions to the changes and receive further inputs from a broad representation of staff.

For areas in which staff-expressed concerns do not improve after 2 months of effort, leadership will be held accountable to put together an immediate plan of action, to include focus groups of diverse, representative staff proposing alternative solutions to be implemented within 30 days of the focus group. Within the 2 month timeframe, staff will be kept apprised of efforts to address said area, through town meetings, newsletter and leadership communications.

All agency leadership will be trained on how to use information from the staff surveys to advance their supervisory and clinical efforts with direct care staff.

We will add new questions in the survey, each time, drilling deeper into the satisfaction of our staff, while retaining previous key questions to ensure benchmarking and trending.

**Responsible Party: HR Director**

# LEVEL OF SUPERVISON

**He-P 807.14 Duties and Responsibilities of the licensee: (c) The licensee shall provide the following core services: (1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding: (c) personnel safety.**

**State DHHS Licensing Finding**

The organization needs to assure that the level of supervision (LOS) of participants is not decreased due to staffing shortages.

**State DHHS Licensing Finding**

The program needs to immediately implement a policy that levels of supervision (LOS) are never to be lowered based on lack of sufficient staffing.

**State DHHS Licensing Finding**

The organization needs to develop mechanisms to clearly articulate and communicate levels of supervision (LOS) across shifts and between program components and treatment venues.

**Comment**

Levels of Supervision are the driving force within which clinical staff determine the frequency of visual contact (constant, every 15 minutes, every 60 minutes) defined by setting, including school, general campus, residence and community. We understand that all staff must understand the required levels of supervision thoroughly so that they can maintain the level, and provide a safe and secure environment for all participants and staff. Understanding Level of Supervision required is both a clinical issue and a communication issue. We also understand that we must find ways to more effectively communicate LOS to all staff. Further, we concur that LOS should not be changed due to staff shortages. Finally, we understand that our policy may not have been sufficiently clear, and as such we are revising our policy to ensure that expectations are explicit.

**Immediate Response**

**In December of 2014**, we reviewed the LOS of every program participant to ensure that our clinical determinations were current and correct. Our review resulted in a modification of several Levels of Supervision—some increased based on recent behavior and some decreased secondary to progress and reduced risk. LOS of every program participant is now being reviewed weekly at the Risk Management meeting. The Risk Management meeting has been revamped to include more diverse participation and review of all root cause analyses (RCAs) that may have occurred in the prior week to memorialize and disseminate organizational learning to assist in predication and prevention of future incidents as part of QAPI.

**Longer Term Corrective Action Response**

In order to ensure that LOS is based on clinical criteria and is unaffected by fluctuations in staff deployment, we will over-schedule staff to cover for the staff who call out.

Next, we will implement the on-call system (described earlier). It is the responsibility of the Shift Supervisor to meet with on-call staff, provide an overview of the LOS and needs of each program participant and to provide high levels of support to these additional staff. (See below)

Additionally, we are modifying our clinical program, bringing clinical staff and management (that typically worked the day shift) onto the 3-11 and weekend shifts. Some of these staff will be counted as part of the direct care staff numbers, thereby increasing the number of staff available to support required participant LOS. The Directors of both our Youth and Adult Programs, our Clinical Director and our Director of Residential Resources will now schedule their time to cover hours during the day, evening and weekend shifts to ensure consistency and continuity of program implementation over a 24/7 clinical model. This significantly increases the level of staff expertise and communication during the 3-11 shift and on weekends. While overnight (sleep) shift staff do not carry the same burden of active programming, daily shift debriefings, as well as periodic training and communication with clinical and leadership staff present is occurring, and will continue on at least a quarterly basis. Further, clinical and leadership staff are having contact across programs and services, thus providing an additional perspective to offer input and ideas to colleagues and QAPI for program improvement.

Communication of the changing needs of clients is paramount to effective clinical efforts. A master Levels of Supervision (LOS) sheet, which documents each participant's current LOS, is maintained by our clinical staff and is updated weekly during Risk Management Committee meetings, at which time change in overall risk status of each participant is considered with the input of the entire clinical team including supervising professionals. We will add direct care staff to this team to enhance the quality of the discussion and generate more diverse ideas for program improvement.

Changes to LOS made during the meeting will be communicated in written form (via the LOS sheet) which is distributed to all locations immediately following revision, and is also available electronically on the facility's shared drive. It is the responsibility of each Shift Supervisor and each Senior Rehabilitation Specialist to review the LOS assignments and to communicate any changes to the staff during shift change. Again, because the Directors of our Youth and Adult Programs and our Clinical Director will be part of the 3-11 shift and weekends on a much more regular basis, they will be able to immediately assist in clarifying LOS to direct care staff, and receive real time feedback regarding the program plan and resources. Auditing of availability and accuracy of LOS will be verified by Shift Supervisors and reviewed in the debriefing of **each shift**. Any missing LOS sheet will be downloaded and replaced by the Shift Supervisor during their shift.

**By March 30th**, all staff will be trained on use of the unit computer and location of current electronic LOS sheet. We will also carefully train new staff all new staff during unit orientation. **Each week** the electronic system LOS accuracy will be reviewed and corrected by the Risk Management committee in real time as a standing part of their meeting agenda.

Emergent changes which occur between Risk Management Committee meetings are communicated via shift supervisors and Senior Rehabilitation Specialists to direct care staff. A shift change log will be updated daily (or more frequently as required) to maintain and document active communications regarding LOS, and the LOS master sheet which is updated in real time and maintained on the shared drive which is accessible from all unit computers.

Lakeview’s Levels of Supervision Policy has been updated (currently in draft form for submission to the leadership) to provide the needed flexibility in the assignment and implementation of LOS for each participant. Once the policy is finalized, all staff, including supervisors and clinicians shall be trained on the new LOS policy with a competency post-test. **Monthly**, LOS re-review will occur via Shift Supervisors through the 2nd quarter, 2015 to ensure culture shift, and LOS review will continue to be part of orientation and annual re-certification thereafter. The new policy reads as follows:

The new LOS policy states:

*A staff member may not lower LOS for any participant without approval of a licensed clinician. Changes to a lower level of supervision may only be made for clinical reasons. Insufficient staff level is not considered a clinical reason. In general, these changes will be made following consultation with the clinical team and will be decided upon at the weekly Risk Management Committee meeting. Should a change to a lower level of supervision occur outside the weekly Risk Management Committee meeting, a licensed practitioner must document the change and the reason for the change in the participant’s medical record and document the outcome and any follow-up needed (for example, a time-limited LOS change to facilitate a family visit)*

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

**Starting in January, 2015** all staff will be trained on the new LOS policy. The post-test following the training will assess staff understanding of the policy. Results will be analyzed to identify trends indicating any areas of confusion or need for retraining. All initial LOS training will be completed by February, 2015, with monthly refreshers and spot checks through the end of the second quarter, 2015.

**In February 2015** and on-going, Shift Supervisors will provide Senior Rehab Specialists and Behaviorists training on communication and documentation of LOS during each shift change including the new shift change logs and LOS documentation tools. QAPI will randomly audit these tools to assess utilization, efficacy and opportunities for improvement.

We have developed a system that tracks the actual staff as compared to the required staff plan for each shift. **This data will be reviewed daily** by leadership and administrators as part of their shift debriefing. If it is determined that at any time the staffing plan was not sufficiently resourced, this suggests that either the over-scheduling or the on-call staffing plans (or both) are not working and a new strategy for ensuring adequate staffing levels needs to be employed, up to and including further redistribution of clinical and management resources. Staffing resource management will be reviewed with leadership every shift through debriefing, weekly with the Administrator and Human Resources Department, and in aggregate monthly via QAPI performance markers to assess and analyze trends by day, time and other factors as identified. This will allow for rapid review of trends, effectiveness of initiatives and planning for staff resources on a daily, weekly and sustained basis.

Initially, LOS changes will be reviewedbyleadership with Shift Supervisors for verification at each shift debriefing for the 24 hour cycle following the change, and further documented on the shift debriefing sheet.

The **first week of each month commencing March 2015,** The QAPI Department will perform a randomized sampling of shift change logs to assure that the LOS changes are communicated. Results of this LOS/shift change QAPI process will be communicated monthly to the direct care staff, leadership and agency leadership. Critical is our addition of direct care staff into the feedback loop—so that they have an opportunity to voice their perspectives on the efficacy of clinical processes. We are assessing the viability of computerizing this process to require staff sign-in and review in real time through our on-line LOS system.

**During the month of April, 2015**, the QAPI staff will further review the new LOS documentation forms that were developed in conjunction with staff and stakeholders, piloted in September, 2014 and implemented 4th Quarter, 2014, to assess their efficacy as a documentation and management tool. If they are not effective the tools will be modified. This process will occur until we see staff consistently and accurately using the forms.

QAPI staff and their designees will randomly (**at least once a week per shift, rotating across units**) attend shift change to ensure the quality of the information exchange. They will document their findings on a Shift Change Observation Form. This information will be compiled and included in the results of the randomized sampling of shift change logs. The information will be shared across programs to identify opportunities for improvement. Interventions will be monitored by QAPI and identified as successful or not, based on month-to- month comparative data. Effective and/or efficient practices will be formalized and disseminated across the organization to improve standardized approaches, particularly as opportunities for implementation of new tools through IT and our new EHR evolve.

Initially LOS review will be occurring on a shift by shift debriefing basis with the Shift Supervisor and the re-verified through an analysis of LOS information by QAPI **monthly**.

If the identified tools are not being used correctly additional training will be provided to staff. If the information suggests that Shift Supervisors or Senior Rehab Specialists are not communicating LOS properly, additional training will be provided. The quality of communication during shift change will be embedded into performance evaluations.

**Responsible Parties: Shift Supervisor will lead this process supported by HR Director, Clinical Director and Training Staff**

# CRISIS MANAGEMENT

**He-P 807.14 Duties and Responsibilities of the licensee: (c) The licensee shall provide the following core services: (1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding: (c) personnel safety**

**He-P 807.14(c) Duties and responsibilities of the Licensee: (2) Emergency response and crisis intervention.**

**State DHHS Licensing Finding**

The organization needs to comprehensively analyze crisis management training.

**State DHHS Licensing Finding**

The organization needs to comprehensively analyze crisis management training and response to events to identify problem areas and inform the development of alternative strategies.

**Comment**

Lakeview understands that we need to revamp the way in which our crisis intervention training is taught and the way that ongoing application of Mandt techniques is supported. We believe that in order for staff to effectively create a safe environment, they need to be confident in their skills in both preventing crisis from occurring through effective programming and in being able to de-escalate situations as crises occur. While we implemented the Mandt System in 2011, we understand the need to provide consistent refresher training to ensure staff competency in crisis management and their ability to utilize an array of strategies to de-escalate crisis. As an agency we understand the need to analyze data and study our patterns of response to events, and proactively provide training to improve these patterns. We also value input from all stakeholders to assist us in improving our crisis management systems.

**Immediate Response**

**In December of 2014**, we hired Durante Advantage Training, a reputable training entity certified in Mandt, to assist in providing training to all staff and to support the development of a training program. Trainers are providing both classroom training and hands-on training during day, evening and overnight shifts. Additionally, Lakeview has contracted with Relias Learning, a national web-based training company, to provide in depth and diverse training and multiple topics directly relevant to the provision of care through their electronic platform.

Durante Advantage Training and the Fedcap QAPI consultant are reviewing the past year of incident reports. Information is being used to revise Mandt Training and to develop a Train the Trainers for Lakeview Mandt Trainers.

Following a careful review of the process in concert with Fedcap, the Risk Management Committee has been restructured to include a more comprehensive review of information—building on the biopsychosocial assessment and inclusion of direct care staff into the discussion. The Risk Management meeting is held weekly and reviews all program participants, addressing identified risks and LOS in home, community and sleep settings. With a more robust review process and comprehensive representation within the Risk Committee, opportunities to predict and prevent risks will be improved, documented and disseminated as part of a continuous QAPI culture.

**As of January 30, 2015**, all Lakeview personnel files were screened for any employees with disciplinary action suggesting a misuse of Mandt or a potential need for training to maintain clinically indicated levels of supervision and care. This list was forwarded to QAPI and the training staff.

**By March 30th** **2015**, all identified employees on the personnel file screening list will meet in person with the training consultant or Lakeview trainer, to identify and implement any further training or supports needed to ensure their successful functioning in a direct care role. This process will be documented in each identified employee’s personnel file.

**Longer Term Corrective Action Response**

We are working with our new training contractor to establish competencies for all Mandt trainers and are adding additional trainers to the staff in the First Quarter of 2015.

**Beginning March 30th 2015**, once these new trainers are certified (training occurs centrally via Mandt), and competencies established, we will test trainers on these competencies quarterly and document and retrain if needed. Leadership staff will sit in on the training to assess the quality of the training and the kinds of questions being posed by staff. All training and protocols developed will be transferable to work in community based settings.

In addition to direct care staff readiness, we will establish competencies for Response Team members and test these competencies monthly for the second quarter of 2015, and then on a quarterly basis on-going. Any new response team members will also undergo competency checks weekly during the first four weeks, followed by three monthly competency assessments before transitioning to a quarterly competency assessment.

Further, the organization will institute a continuous learning culture, where direct care staff are supervised (in real time) by Mandt trainers in using crisis response techniques. Every crisis that occurs will be debriefed by clinical or leadership staff prior to shift change after every shift – days, evening and nights. Staff will be encouraged to share their feelings during these debriefs, to ensure that they have the opportunity to work through emotions such as fear, anger, frustration, etc. They will also be asked to identify what they might have done differently to de-escalate the situation. We are in the process of developing a structure for this process, ensuring that it is sustained over time. Debriefings after every shift are documented on the shift debriefing sheet by the shift supervisor and address any incident involving:

* Use of physical intervention
* Unauthorized absence off of campus or resulting in unsafe exposure to the elements
* Missing persons
* Intruder or member of public issue
* Environment of Care Emergency (i.e., power outage, flooding)
* Injuries to clients or staff requiring more than first-aid
* Any injury that is the result of aggression, physical intervention or self-injury
* Emergency Department visits or hospital discharge
* Contact with law enforcement, Fish & Game or Poison Control
* Illegal drugs or alcohol on campus
* Sexual encounter involving a participant and another person

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

**In January of 2015**, the QAPI Department designed and implemented tools to track all calls for assistance on campus and continues to refine the data management process.

**Each week** **commencing in February, 2015**, data will be analyzed at Treatment Team Meetings which include clinical staff and direct care staff, as well as with QAPI staff at weekly Risk Management. Additionally, RCAs and specific corrective action plans may be developed and reviewed via the Risk Management Committee.

**Weekly**, the Risk Management Committee will review QAPI data and RCAs to assess response team efficacy and trends such as by shift, by unit, by staff, by time off day, etc.

Our QAPI efforts are designed to continually assess if our Mandt Training is achieving the desired staff skills and competencies and as a result decreasing the number of incidents and the staff sense of confidence in their ability to manage crisis that do arise. In our review of the incidents over this past year, we have discovered very specific moments where different kinds of conversations, actions, reactions could have changed the results. As such, we are refining our crisis management process to include the following:

* Staff ensure that other participants are removed from the area;
* If Leadership staff is in the area, they immediately offer assistance in calming the client—they do not leave the staff member/client who are in crisis.
* If no leadership staff in the area, or more assistance is needed, immediately call for Response Team to support calming the client and de-escalating the situation;
* Provide immediate attention to calm the client and attend to his/her needs (soothing, medical care, re-direction, etc.)
* Staff member and shift supervisor discuss the incident, determine staff’s current stress and well-being, and if they should be removed immediately from the floor, change assignments, be suspended, see the nurse, etc.
* Staff member goes to area away from all clients and documents what occurred as soon as possible;
* Further conversation occurs with shift supervisor and staff supervisor to determine if staff members who exhibit stress or reactivity should be referred to EAP;
* Notifications to family/guardian, state agencies, funder and all other identified parties occur with the initial 24 hour window.
* Further interviews and information compilation occur within a short time window (72 hours target).
* Review of information by QAPI Department commences as soon as possible to allow for additional information requests.
* Gathering of the team, including all staff involved in the incident to make specific recommendations on training, supervision requirements (organization specific and person specific), and use of RCAs for any critical incidents.
* Determination of HR action and follow-up tracking for completion and efficacy.
* Report by QAPI as mandated to appropriate agencies.

We will collect information regarding every critical incident, in addition to staff (self-reported) confidence during incidents, staff requests for additional training, etc. Fedcap Team member is meeting with Director of QAPI to develop tools to track staff levels of proficiency and confidence.

**Each week** we will review this aggregate information during the Risk Management and Treatment Team Meetings. This information will be used to inform our decisions regarding additional training and shared with staff in a variety of ways including all-staff town meeting discussions, written reports and unit discussions.

**If after one month of training and on the floor support of direct care staff** (March 2015) we are not seeing reductions in the number of incidents, reduction in the calls for the crisis Response Team and increase in the staff self-reported confidence in managing crisis, we will do one of two things 1) retrain our internal trainers and/or change our internal trainers and if after two months this is not effective, 2) utilize external trainers who are held to a performance contract.

Through the shift-by-shift debriefing with leadership, all critical incidents and interventions will be monitored multiple times per day to ensure safety and provide opportunity for input, feedback and intervention.

**Responsible Party: Shift Supervisors, Director of QAPI**

**State DHHS Licensing Finding**

The organization's staffing levels need to make accommodation for a dedicated Response Team to assure that crisis management events do not impact on the required level of supervision of other residents.

**Comments**

First, we believe that if staff is well trained, and that staffing is reflective of LOS, we should not need to use the Response Team frequently. That said, we understand that the use of the Response Team must not impact required Levels of Supervision. Further, we understand that there are times when an influx of a new staff (Response Team) onto a unit can actually contribute to the confusion if not done precisely. As such we appreciate how critical it is to effectively utilize the Response Team asset. Thus, as noted above, the review of the Response Team information will occur via QAPI through the Risk Management meeting to assess for trends (for example, by unit, shift, responder, time of day, etc.) and also as part of reviewing all RCAs for critical incidents. The Risk Management Committee has representation from all Teams, thus providing a feedback loop regarding effectiveness of the Response Team based on analysis of both incidents and aggregate data.

**Immediate Response**

The two Shift Supervisors on awake shifts are not unit assigned and serve as primary responders. Other designated responder staff are identified on each team, and are assigned to the general milieu, not any 1:1 or visual supervision assignment. A minimum of three (overnights) and up to six responders are identified per shift.

We are also reviewing use of the Response Team and determining if there are units that use the team more frequently than others, thus implying need for further clinical review and support. If indicated, this RCA will result in additional training and staff supervision. Ongoing analysis will determine if training was effective or if additional staff supports are required.

**Longer Term Corrective Action Response**

This response ties to our plans to over-schedule staff to mitigate “call outs” that occur and ensure LOS requirements are met. It also ties to our plans to schedule more clinical staff during the afternoon shift—expanding our treatment day from 8:00 a.m.-8:00 p.m.

The staff persons who are serving as members of the Response Team will be trained by our training contractor on the role of response teams commencing in February and completed by March 30, 2015 with continued training on an on-going basis and for any new responders. Competencies are being established and all members of the response team will be tested against those competencies, initially weekly for the first month, then monthly, and then on a quarterly basis, commencing **March, 2015.**

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The QAPI Department will track and trend data for all calls for assistance on a daily basis to assure that there is no impact on staffing for 1:1 LOS. This commenced in **January, 2015** with on-going refinement of the tools and training for data collection. The system will continue to be upgraded throughout **February, 2015.**

**Each week**, data will be analyzed, trends identified and conclusions shared with staff as part of staff meetings, Risk Management Committee and with members of the Response Teams and leadership.

If we determine that the Response Team model is not effective in stabilizing crisis situations, or if at any time, Response Teams impact LOS, will we will work with our consultants to examine other crisis response strategies we could employ and intervene immediately through allocation of other resources or other means of providing resources necessary to manage the risk including potential discharge of individuals with extreme and persistent risk.

**Responsible Party: Clinical Director**

**State DHHS Licensing Finding**

The organization needs to fully implement the Workplace Violence Prevention Program (WPV) and evaluate its effectiveness.

**Comment**

Lakeview understands that the number of incidents that involve workplace violence must be reduced. We understand that workplace violence impacts recruitment, retention and staff morale. We understand and agree that Lakeview must be a safe place for both participants and staff.

**Longer Term Corrective Action Response**

Lakeview's workplace violence prevention program (approved and developed in collaboration with OSHA) is in the process of being implemented according to the agreed upon abatement plan attached.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

**In January of 2105,** the Human Resources department started work on establishing a structure to evaluate the effectiveness of this WPV program by tracking trends in the occurrence of work place violence and resulting injuries and loss of work.

Data compiled from this process will be reviewed **each week** as part of our review of critical incidents. We intend to compile data to help us understand the types of injuries, the time and location of the injuries and the participants involved.

The reviews will determine if additional staff training is needed, will cause a review of LOS for participants involved, and help us to understand if a particular staff needs hands on support.

WPV program inputs and rounds by the Employee Health Nurse and other WPV and Safety Squad participants will be used to identify further opportunities for performance improvement in health and safety such as modifications to environments of care, identification of protective equipment and better methods of orientation and training in relevant areas.

**Responsible Party: HR Director**

# INCIDENT REPORTING

**He-P 807.14 Duties and Responsibilities of the licensee: (c) The licensee shall provide the following core services: (1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding: (c) personnel safety.**

**State DHHS Finding**

The organization needs to develop a comprehensive program of staff training, monitoring, evaluation, data aggregation and analysis regarding the incident report system through its Quality Improvement Function.

**State DHHS Finding**

The organization needs to develop a quality plan to look at events and give insights to who, when, where, LOS staffing, etc., to inform program improvements.

**Comment**

The Lakeview leadership understands the importance of having a system in place that effectively uses information and analysis from aggregate reports of incidents to design a comprehensive program of staff training, supervision, and performance improvement. Incidents are a window into the culture of the agency. How we track them and learn from them is critical to our collective professional growth and development. We need to understand who was involved in incidents, when they occurred, where they occurred and their relationship to LOS. We have already commenced end-of-shift debriefing with leadership multiple times per day to have real-time discussion of incidents for enhanced organizational inputs and learning.

**Immediate Response:**

The Fedcap consulting team and Durante Advantage Training are currently working with the QAPI Department, reviewing incident reports for the past year, identifying patterns that indicate immediate programming, training and supervisory needs.

**By February 27, 2015**, they will prepare a report and recommendations for review and implementation by Lakeview leadership. Initial trends have already resulted in initiation of Mandt retraining commencing January, 2015.

**Longer Term Corrective Action Response**

We are currently developing a structure and process for aggregating all incident reports by the subtypes of the Joint Commission. We are also working with the EHR implementation team to ensure that all incident data required for a comprehensive, aggregate analysis is included in the system. We are also working to develop the reports QAPI Department will require from the system.

Our consultants are working with us to ensure that we are accurately identifying trends and translating them into training and supervisory needs of staff.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

**On a monthly basis**, the QAPI Department will analyze the data to ensure a comprehensive plan of aggregating incident reports and analyzing trends ensures ongoing performance improvement. The data will include the following:

* Type of event;
* People involved in the event;
* Where the event occurred;
* When the event occurred;
* LOS at time of the event as compared to required LOS;
* Initiation of RCA and identified corrective action for discrepant findings

The QAPI Department will utilize the incident reporting data to identify areas where overall agency performance must be improved. **Initially this will be provided through the weekly Leadership call,** Operations Meeting and Risk Management Committee meetings for follow up through management channels of the programs and services affected through the first quarter of 2015. Assuming satisfactory overall organizational performance improvement, it is anticipated that this overall QAPI review will occur on a monthly basis.

**Aggregate** data will be shared during staff meetings through the **Getting Better at What We Do!** communication and performance improvement process.

**In April 2015**, supervisors will be trained on how to present data to staff to generate discussions on what data tells the team about performance improvement needs.

**Responsible Party: Director of QAPI**

# ACUITY LEVEL OF PARTICIPANTS

**He-P 807.18 Personnel: (a) The licensee shall ensure that sufficient numbers of qualified personnel are present in the RTRF to meet the needs of clients at all times.**

**State DHHS Licensing Finding**

The organization needs to ensure that there is sufficient staffing resource as part of the determination to admit prospective program participants who have a history that would indicate the need for high levels of supervision.

The organization needs to have the Director of Human Resources or designee to be part of the admission determination.

**Comments**

Lakeview leadership understands the direct correlation between the acuity of patients served, and our struggles with maintaining required levels of staffing. Further, we understand that the financial pressures to admit new participants cannot supersede the safety of those we serve. While have a history of being available to those who have no place left to turn, and a long standing commitment to ensuring that those who need our level of service have access, we understand that until we have stabilized our programming, staffing and level of staff competence, we must reduce the acuity of those we serve—even if that means turning away referrals we normally would have served. Going forward, we understand that every admission must be balanced against its impact on current participant safety.

**Immediate Response**

**In December 2014**, the clinical staff reviewed the acuity level of each client and identified six individuals with high acuity who we are now in the process of discharging. We have already discharged a medically intensive male client to FINR in Florida, a female client with significant behavioral and supervision needs to Crotched Mountain, and we are in the final stages of discharging another female client from NH with significant behavioral and supervision needs to Florida International. Additional discharge planning efforts are in progress.

A report detailing discharges for **January, 2015** has been submitted to DHHS. A mid-month update and monthly summary will be submitted for **February and March, 2015**, with **monthly summaries** submitted thereafter until mutually agreed upon discontinuation of this reporting process.

A member of the Human Resource Department team, who is also a nurse and has a strong history and understanding of the population served, will also be working closely with the Admissions team to review resources. This experience will also facilitate targeted Human resources recruitment for any expertise gaps identified through the Admissions process.

**Longer Term Corrective Action Response**

The Chief Operating Officer, Clinical Director, QAPI Director and HR representative will be involved in a review of all potential admissions to the program, along with the Director of Nursing and respective Program Director. This team has nearly completed a new process and accompanying policy that more clearly defines criteria for acceptance and specifies a methodology for taking into account staffing availability and current population needs as a factor in the decision to accept a new participant to the program.

**The goal is to fully implement the new policy by March 1, 2015**. However, much of this policy is already in place, as of January, 2015, including the piloting of the biopsychosocial risk assessment tool. All admissions are receiving considerable scrutiny. One aspect of the policy will be the implementation of a comprehensive risk assessment (noted as presently being piloted) as part of the overall biopsychosocial assessment process that results in an identification of the level of resources needed to serve the consumer. This information will be compared to the Daily LOS requirements to determine if the resources required for admission exist. For the purpose of ongoing data collection and accountability, there will be a specific place on the admissions form to document that based on assessment of the needs of the current population and existing supports it was /was not determined that the admission could occur.

Further, the admissions department will include required LOS on the Daily Projection. This Daily Projection will be updated every business day, and shared with Human Resources and all Program Directors, the Director of QAPI and Clinical and Administrative leadership on a daily basis. This ensures that all members of the leadership team understand our daily projected number of participants, the required staffing for those participants and the impact of a new admission.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

All staff will be trained on the new admissions policy **by March 1, 2015.**

All clinical staff will be trained on the new risk assessment tool and process by **March 1, 2015** with competencies assessed including inter-rater reliability checks**.**

All new admissions will be **reviewed weekly, compared to daily LOS sheets** to determine if the admission impacted adherence to LOS requirements. We will compare the LOS determinations made as a result of the risk assessment to the actual LOS requirements upon admission. If we see significant discrepancies, the tool will be revised to better guide the clinician and staff will be retrained.

**Responsible Party: Admissions Director, Clinical Director and Director of QAPI**

# ASSESSMENT, TREATMENT PLANNING AND DOCUMENTATION

**He-P 807.19 Client record: (a) The licensee shall maintain a legible, current and accurate record for each client based on services provided at the RTRF.**

**State DHHS Licensing Finding**

The organization needs to assure that Treatment and Behavioral Plans are modified in "real time," when there are significant changes in the individual's condition and behavior.

**Comments**

In order for Treatment and Behavioral Plans to be modified in “real time” there must be a seamless communication between direct care staff and the clinical team. Historically, there has been a disconnect between our clinical and direct care staff that we are absolutely committed to changing. We understand the importance of all staff operating from the most current treatment information available. Lakeview participants can have ebbs and flows in their progress that demand immediate attention and response. Any information that is important to the Treatment and Behavioral plans must be considered immediately and the course of treatment change as indicated.

**Immediate Response**

We have changed the schedules of clinical staff so that they are working the 3-11 shift and on the weekends. This infusion of clinical staff to the evening and weekend shifts ensures that new information (significant changes in a participant’s condition or behavior) can result in a real time modification of treatment and behavior plans.

Durante Advantage Training is assisting to observe staff –participant interaction and to determine how information is exchanged between direct care staff and clinical staff. This information is being used to inform the new training around documentation and communication between direct care and clinical staff.

**Longer Term Corrective Action Response**

***Refinement of Clinical Model:***  In partnership with our consultant we have changed the leadership, membership, content, flow and structure of the Risk Management Committee and developed a comprehensive Treatment Team that reviews data and clinical information through a lens of continuous quality improvement. We have crafted a clinical/practice model that will drive the work of the agency focused on 24/7 care in a continuous quality improvement environment.

The clinical model, depicted in the diagram below is in the process of being refined and elements of it are already implemented. Once finalized, it will be part of every staff training so that everyone understands how clinical goals drive practice. Of note, is our elongation of the treatment day –now occurring from 8:00 a.m. to 8:00 p.m. This shift is significantly impacting the clinical milieu of the campus.



***Enhanced Assessment*:** Our first step to enhancing our assessment is the introduction of a comprehensive biopsychosocial assessment rooted in best practices, that asks different questions and explores diverse areas of the consumer’s life to help plan for community based living. The assessment, developed with the consumer, community-based referral entities as well as guardians/parents when appropriate, drives transdisciplinary behavioral plans and clinical treatment and extends our work in the community. Assessments are typically completed within the first ten days of admission and the individual person-centered service plan is refined and adjusted over the first 30 days.

**Track One:** Following the biopsychosocial assessment, we will provide short-term (45 day) stabilization and a clinical treatment plan with the goal of rapid re-entry into the community within 60 days. We will send our clinical staff in vivo (within New England), or via technological interface (nationally) to meet with the sending party and identified discharge resources , working collaboratively to help prepare the discharge site / clinical team that will carry out the plan. The goal is to not duplicate available community services but instead to provide specific guidance and strategies to the intervention network servicing the client. Assessment and treatment will focus on the application of the interventions to the pre-identified community discharge site.

**Track Two:** Following the biopsychosocial assessment, the consumer receives a longer period of stabilization (up to 180 days)—using the clinical setting for medication trials, testing different behavioral interventions and re/habilitative treatment strategies to determine the most effective approach. The goal of this track is not to provide long-term placement, but to transition the consumer into the community as rapidly as possible following the development of transportable and transferable interventions.

**Track Three:** Completion of a biopsychosocial assessment for individuals who are referred with no long-term plan (except institutionalization) in place. Following this assessment we will provide the following:

* Similar to Track Two, we will have tested an array of behavioral approaches, re/habilitative interventions and community supports required for the individual to live safely in the community;
* Based on the plan and the community to which the consumer will return, we will identify the gaps in supports and will:
	+ Offer professional resources to our community partners on a fee-for- service basis to provide them with community-based capacity until such time as they can develop the required service array;
	+ Work with our community partners to help them build and deliver a wrap of services and clinical supports as required;
		- Offer Emergency Response capacity (SWAT TEAM approach) in the community designed to keep people from re-entering our facility.
* Offer short-term stabilization for individuals who have returned to the community.

**Connectivity Between Staff to Ensure Real Time Treatment Plan Modification**: Based on our improved biopsychosocial assessment process, a person-centered treatment plan will be enhanced to drive the content of the treatment/behavioral plan. We understand that a treatment plan is really a hypothesis of specific interventions that will best achieve desired client outcomes and that treatment/behavioral plans must change as soon as new information is uncovered. Currently reviews of client progress take place during weekly clinical meetings and more formally during monthly clinical team reviews. This process is not sufficient. Scheduling clinical staff in the later shifts provides a structure for new information that is relevant to treatment/behavioral planning to be integrated into the treatment plan/behavior plan immediately—and for the current information to drive practice.

When an individual shows two months of failure to progress toward behavioral treatment goals, or one month of regression on behavioral treatment goals, the Treatment Plan and Behavioral Plan will be modified. This process will be monitored via the upgraded Medical Chart review process, with trends identified to provide support to clinicians and teams in achieving these more rapid treatment plan modifications.

Lakeview will continue its best practice of changing one mode of intervention at a time to ensure integrity of the treatment model (behavior plan change versus pharmacological change, for example).

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

**By March 2015**, all clinical staff will be trained on new Biopsychosocial Assessment tools and process. Additional steps will occur in this regard, as some new tools rooted in best practices, will be built into the EHR.

**By March 2015**, all staff of the agency will be trained on our Clinical Model and the clinical model will be posted on walls and embedded into every training offered. All training will be tied back to advancing the integrity and consistency of the clinical model.

**Bi-Monthly,** the QAPI department with the Clinical Director will review a sampling of the Chart Notes, Treatment Plans and Behavior Plans for clients who had significant incidents or required Response Team intervention. We would anticipate that Clinical Notes, Treatment Plans/Behavioral Plans would reflect interventions and changes as a result of a pattern of significant incidents. If no interventions or modification of the treatment or behavioral plan occurred, the Treatment Team would meet to discuss the rationale. This will evolve into monthly reviews.

**Monthly** the QAPI Department with the Clinical Director will review a **random sampling** of participant Treatment Plans and Behavioral Plans. In cases where modifications were made to either, we will determine if the Shift Log and/or training documents reflected this conversation. If not, additional training will occur regarding Shift Log Documentation and staff training, as well as the critical communication that must occur during shift change.

**Responsible Party: Clinical Director**

# MEDICAL RECORDS

**State DHHS Licensing Finding**

The organization needs to have a more robust process for medical record audits at the point of care.

**Comments**

To date, our medical records department has focused on quantitative audit of our medical records. We understand the importance of shifting to a qualitative review and developing a chart review tool to ensure consistency of the audit process. We also see the importance of training and implementation of a robust system whereby any deficiency is identified and resolved quickly. The intended outcome through EHR conversion is to have real-time feedback and trending regarding documentation, thereby facilitating proactive solutions such as caseload review and documentation training.

**Immediate Response**

The medical record is being brought to all individual treatment planning meetings. The Case Manager is responsible for auditing the chart at this meeting and alerting the Program Director of any missing or substandard documentation. The Program Director, as the supervisor of the treatment team, is charged with follow-up and to ensure the allocation of resources to caseload needed to support the treatment and documentation process. This is further monitored through the Medical Record audit process, wherein QAPI may identify trends, patterns and recommendations through root cause analyses and corrective action plans. The current EHR in development features real time monitoring of documentation through a variety of standardized and customizable reports.

**Longer Term Corrective Action Response**

As a subcommittee of QAPI, the Medical Record Review committee will be reformulated with diverse clinical team representation, to review sample charts and assess trends and issues, as well as corrective follow-up for accurate, timely documentation. This process is beginning **March, 2015**, with the development of and training in the use of a new chart audit tool as previously noted.

The organization is in the midst of implementing an electronic health record (Care Logic by Qualifacts), **with 'go-live' planned for 2nd quarter of 2015**. The EHR implementation process includes identification and implementation of auditing and tracking procedures.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The QAPI Department, will institute a policy wherein the medical records staff will a**udit 5 charts per week** to assure accurate and timely documentation into the medical record (25% of charts per month). While random, the audits will intentionally represent clients with varying degrees of clinical need receiving services across different aspects of the program. The audit will include the following:

* accuracy of documentation;
* frequency of documentation:
* timeliness of documentation;
* thoroughness of documentation including identification of all individuals observing or contributing to notation.

The information will be analyzed and used to determine the need for additional training and supervision. Trends may warrant RCA to assess systems and resource issues and develop specific corrective action plans.

Training will be provided as part of agency QAPI plan. The expectation is that the audits discover more accurate and timely data entry.

Specific training will be provided to individual units, supervisors and staff as data analysis indicates. Caseloads and opportunities for staff redundancy, efficiencies and cross-training will be proactively reviewed to increase probability of timely and thorough documentation for performance improvement as part of the QAPI culture.

Reviews of our progress with documentation will be shared with staff during unit meetings and as part of **Getting Better at What We Do!** report.

**Responsible Party: Director QAPI**

**State DHHS Licensing Finding**

The organization needs to continue to show progress and support in moving forward with an electronic health record implementation.

**Comment**

Currently our medical record is in paper format and delivery of care can occur in one of several settings, often in different buildings. We understand that this presents significant challenges related to access to the physical record, for all care providers. We are very eager to implement our electronic medical record with a ‘go-live’ date scheduled by June 30, 2015. Weekly progress is occurring and documented through the implementation team, both by Qualifacts and our Project Manager.

**Immediate Response**

We have committed to an electronic medical record product and have begun the process of full conversion to EHR. Our EHR project manager facilitates two meetings per week in keeping with the project schedule. In the interim, we have commenced review of paper charts as noted above.

**Longer Term Corrective Action Response**

The organization is currently working with Qualifacts - Care Logic in developing the EHR system for Lakeview and is working towards a 2nd Quarter, 2015 ‘go live’. Implementation is in progress, with weekly meetings involving stakeholders occurring as planned. We will work with our consultants to ensure that the design of the system and accompanying reporting will advance our clinical practice and ability to carefully track practice trends.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The Director of QAPI and/or EHR project manager will provide **weekly updates** to the Administrator regarding the status of our EHR adoption and when fully implemented, with adopt metrics to measure access, confidentiality, timeliness and quality of content as related to Joint Commission and CARF standards.

We are also in the process of developing a QAPI process for post implementation—to ensure that the EHR meets our auditing and QA requirements. We understand that the first months of implementation are critical for catching errors in design and making immediate corrections.

**Responsible Party: Director QAPI/Project Director IT**

# COMMUNICATION

**He-P 807.14 Duties and Responsibilities of the licensee: (c) The licensee shall provide the following core services: (1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding: (c) personnel safety.**

**State DHHS Licensing Finding**

The organization will enhance the staff communication to assure patient and staff safety.

The organization will continue to implement appropriate communication mechanisms to ensure that all staff, especially direct care staff, have access to critical clinical and behavioral/ functional information regarding program participants at a frequency that can guide the day-to- day operations.

**Comment**

Lakeview leadership recognizes the importance of communication as a vital thread that connects the work of the agency. We understand and agree that the more clinical, direct care, educational, HR, medical and QAPI staff communicate with one another, the more seamless and integrated our programming. Further, we concur that it is imperative that our care staff have immediate access to key information related to care, treatment and advancement of our program participants, and that we must utilize multiple mechanisms to ensure that information is shared effectively.

**Immediate Response**

We have suspended all administrative meetings between 3:00pm and 4:00pm to ensure that core supervisory and clinical leadership team members are present on the units and available for debriefings at shift change. We have also installed computers in every staff office in the cabins and provided all staff members with email and secure access.

**In January 2015**, we launched House Meetings on second shift with the purpose of addressing and solving problems, giving each participant a chance to express him/herself, and connecting the participants and staff as a group. Program participants, staff and members of the clinical team all participate in the House Meetings.

Some of the issues addressed during the house meetings include:

Conflicts and concerns within the house

* Is there anything that isn’t working as it should?
* How can we work together to problem solve things that aren’t going well?
* Does anyone need help from a peer or a staff member?

House needs:

* Do we have necessary supplies and equipment for programming?
* Does anything need to be repaired or replaced?
* Are there any improvements that could be made to make daily life more comfortable and enjoyable?

Highs and Lows for the day:

* What was your best moment today?
* What was the one that gave you the most difficulty, and how did you handle it?

Planning for the evening:

* What’s on the house schedule tonight?
* Who is participating?
* Who is going to a campus or community activity?
* What do we need to do to prepare?

We have already started to see a positive impact of these House Meetings on client attitude, morale and overall communication.

**Longer Term Corrective Action Response**

Communication between direct care and clinical staff are foundational to an effective program. As indicated earlier in this document, we are instituting mechanisms and structure to ensure that this communication exists including:

* Training direct care staff in how to utilize information on the treatment Plan and Behavioral Health Plan to inform day-to-day interactions with clients followed by involvement of direct care staff in the review of data to better understand trends and to assist in identification of solutions;
* Significant improvement in the structure and process of shift change to ensure quality and comprehensive information is shared;
* Observation and real time feedback on crisis management and incident reporting;
* Review of medical record audits to assist in improving quality, accuracy and timeliness of documentation;
* Enhancement of staff surveys to ensure the quality of the feedback process;
* Clinical staff and direct care staff working side-by-side during shifts, including day, evenings and weekends.

***Additional strategies to improve communication are discussed below:***

The Individual Service Plan and Behavioral Plans drive the day to day interaction with the client. Each participant living area has a copy of the Individual Service Plan and Behavior Plan of every client. It is the responsibility of the Senior Rehabilitation Specialist to assure that direct staff working with participants have detailed understanding of the treatment goals and strategies for each client, and that every interaction is driven by these plans. We will initiate a new series of trainings for the Senior Rehab Specialists to be completed by June 30, 2015, to ensure that they are effectively communicating: 1) the primary goals of the plan; 2) the specific interventions to be utilized to help manage behavior; 3) the expectations for behavioral change and how to communicate specific changes in the ISP and Behavioral Plans; and 4) the teaching approach with staff of how the ISP and Behavioral Plan drives day-to-day interactions with the client, informs activities and guides voice tone, conversation and interaction. These trainings will become part of the orientation for any new Senior Rehab Specialist to ensure continuity in expectations for the role.

Every living area also has a shift change log and 30 minute overlap process to assure proper communication between shifts/ staff for each participant. Leadership staff and trainers will “drop in” during shift time to observe the quality and comprehensive nature of the communication. Also, Lakeview communicates information via e-mail and maintains critical information on a shared drive. All living areas are equipped with computers that are accessible by all staff. The EHR shall be configured for real time access to records, which will greatly enhance immediate availability of relevant information.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The QAPI Department and their designees will perform a randomized sampling of shift change logs each month to assure the LOS and treatment plan changes are communicated effectively across all shift at all locations. This information will then be reviewed by the Clinical Director and Program Directors to target unit/shift improvements needed. As needs are identified, additional training and enhanced supervision will be provided. Trends and inputs will be identified for QAPI to proactively share generalized learning across units and programs for continuous quality improvement.

**Responsible Party: Clinical and Program (Youth, Adult) Directors**

# MEDICATION MANAGEMENT

**He-P 807.17 Medication Services: (a) All medications and treatment shall be administered in accordance with the orders of the licenses practitioner, except as allowed in (b) below.**

**State DHHS Licensing Finding**

The organization does a medication analysis on medication errors or adverse events.

**Comment**

We understand and agree with the importance of conducting an analysis on all medication errors or adverse events involving medications. We also understand that multiple reviews of these processes and repeated training to ensure consistency and salience of these processes is critical to ensure optimal medication services and maintain high standards among all nursing staff.

**Immediate Response**

The Director of Nursing conducted a review of all medication errors or adverse events involving medication in the past quarter and provided that information to the QAPI Department as part of agency performance improvement to establish baseline data and seek additional inputs and insights from the QAPI subcommittee. The nursing department is in the midst of retraining in vivo, and via Relias learning modules, to ensure high standards, constant monitoring and on-going performance improvement across the medication process.

**By March 2015,** the QAPI Department is reinstating the subcommittee which meets monthly to review medication management issues among a broader group. The QAPI subcommittee will complete a walk-through of the medication process and observe a medication pass quarterly in order to have greater insight and input that may assist in avoiding medication errors in the future.

**Longer Term Corrective Action Response**

The Director of Nursing will review all medication errors / adverse events, and analyzes the results for follow-up via monthly review with the Medical Director and Executive Leadership team, as well as the contract pharmacy where applicable. Nurse training and competence in the medication related processes will occur at orientation and annually thereafter through in vivo and Relias Learning modules. Information regarding medication management will also be reviewed with a more diverse group though the QAPI - Environment of Care, Infection Control and Medication Management subcommittee as noted above, to better identify opportunities for system wide improvements that may impact medication errors (for example, the design, lighting and tidiness of medication rooms).

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

The data from the review by the Director of Nursing will be shared with the QAPI Department and subcommittee to be used for identification of process improvement opportunities from diverse perspectives and to determine if there are further training needs and opportunities for those involved in the medication process.

Through ongoing analysis we expect to see a decrease in the number of medication errors.

If decreases or very low rates of medication errors do not occur we will evaluate trends, aggregate data, follow-up on recommendations, effectiveness of training and consider corrective action plans for medical personnel as indicated with a formal response developed by the QAPI subcommittee within 30 days of the end of the quarter.

Training and competence of nurses regarding medication services will be demonstrated through orientation and annually thereafter utilizing multiple training forums with competency assessment as noted.

**Responsible Party: Directors of Nursing and Director of QAPI**

**He-P 807.17 Medication Services: (ap) The licensee shall develop and implement a system for reporting any observed adverse reactions to medication and side effects, or medication errors such as incorrect medications, within 24 hours of the adverse reaction or medication error.**

**State DHHS Licensing Finding**

The organization creates a system by which all medication errors or adverse medication events are reported within 24 hours.

**Comment**

The agency leadership agrees and understands the importance of reporting all medication errors and/or adverse medication events within 24 hours. This is one of many systems we need to institutionalize, and to ensure continuous improvement through training and competence as noted above, along with the more formal relationship to the QAPI process through a focused subcommittee with diverse membership.

**Immediate Response**

Reviewed the current timeframe for reporting medication reviews to determine where the gap is in communication.

**By March 2015**, all nurse retraining regarding all medication processes will be completed. This training will be part of all new nurse orientation with competency assessed on an annual basis. Reporting timeframes, issues and systems will be reviewed with the QAPI subcommittee focused on this area in an effort to identify opportunities for further systems improvement and refinement.

**Longer Term Corrective Action Response**

The QAPI Department, upon receipt, will report medication errors or adverse medication events to State agencies within 24 hours following mandatory reporting procedures. We will work with our QAPI Department and Nursing Department to ensure that our policy for Medication Errors/Adverse Drug Reactions, developed in conjunction with Omnicare (Pharmacy), is fully implemented as follows:

Upon discovery of a medication error the following steps will be taken:

1. Individual who discovered the medication error reports immediately to a nurse;
2. Nurse immediately ensures safety and;
3. Nurse notifies the Director of Nursing or designee;
4. Pharmacy is notified if error is related to dispensing/packaging;
5. Nurse notifies the Provider and receives/implements instructions;
6. Individual who discovered the medication error completes an Incident Report;
7. The nurse who was notified completes the “Health Services Note” section of the Incident Report;
8. Notifications are made in accordance with the Incident Report requirements;
9. The incident Report is forwarded to QAPI per policy;
10. A Medication Occurrence Report for Licensed Nurses is completed and submitted to the Director of Nursing or designee for review;
11. The Primary Nurse is notified;
12. A nursing note is drafted in the client’s medical record.

Upon discovery of an Adverse Drug Reaction the following steps will be taken:

1. Lakeview Policy # 6.22 Adverse Drug Reaction Reporting is replaced with Omnicare Policy #10.3 Adverse Drug Reactions.
2. Adverse Drug Reactions (ADRs) are classified as 1-4; Mild, Moderate, Severe, Lethal
3. In the event of a Minor ADR the following steps are taken:
	1. Individual who discovered the Minor ADR reports immediately to a nurse;
	2. Nurse immediately ensures safety;
	3. Nurse notifies the Director of Nursing or designee;
	4. Nurse notifies the Provider and receives/implements instructions;
	5. Pharmacy is notified if Minor ADR is related to dispensing/packaging;
	6. Individual who discovered the Minor ADR completes an Incident Report;
	7. The nurse who was notified completes the “Health Services Note” section of the Incident Report;
	8. Notifications are made in accordance with the Incident Report requirements;
		1. The incident Report is forwarded to QAPI per policy
	9. A Medication Occurrence Report for Licensed Nurses is completed and submitted to the Director of Nursing or designee for review
	10. The Primary Nurse is notified
	11. A nursing note is drafted in the resident’s medical record.

In the event of a Moderate (2), Severe (3) or Lethal (4) ADR the following steps are taken:

All steps as appropriate from mild ADR are implemented. Health and safety measures are imperative. In accordance with Omnicare Policy #10.3 Adverse Drug Reactions the facility will report the ADR to the FDA using the Medwatch Event Reporting System using the Medwatch form.

All ADR data is submitted to QAPI for secondary analysis and reviewed with the Board of Directors on a quarterly basis.

**Responsible Party: Directors of Nursing and Director of QAPI**

**State DHHS Licensing Finding**

The organization needs to develop a comprehensive system for the evaluation of medication management issues which utilizes its contracted pharmacy as a primary resource.

The organization needs to assure that the medication administration is following providers’ orders.

**Comment**

Lakeview agrees that we must develop a comprehensive system for evaluation of medication management issues –engaging our contracted pharmacy in the process. We also agree that our administration of medication must follow the exact orders of the providers. Our goal is to be a strong partner with our providers. As noted, previously, nurse training and competence is instrumental in ensuring continuous quality improvement. Additionally, the process will benefit from the focus of a diverse QAPI subcommittee charged with improving medication processes on an on-going basis.

**Immediate Response**

By the end of February 2015, a detailed, review of medication for each patient will be completed. Nurse retraining regarding medication processes has commenced and will be completed in the first quarter of 2015. QAPI has reconstituted the subcommittee which focuses on medication issues to provide an additional resource and accountability to improve all medication related processes. Omnicare will be invited to participate in this review process.

**Longer Term Corrective Action Response**

The medication management system at Lakeview has its policies defined by Omnicare as the contracted Pharmacy company. The policies follow all State/ Federal regulations. Omnicare provides assurance of all medication compliance through its own auditing functions.

The Lakeview Director of Nursing reviews all medication errors or adverse events and reviews the MAR's on a monthly basis. Lakeview Medication Administration #6.0 follows Omnicare policy on General Dosing Preparation and Medication Administration, in conjunction with Lakeview Administration policy #6.20 for all medication administration practices.

Nurse training and competence regarding medication management will be included within orientation and annually thereafter.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

Each medication administering nurse is required to complete a Med Nurse Daily Checklist form and submit this to the Director of Nursing or Designee at the end of his/her shift. This form requires confirmation that the MARs utilized by the nurse have been reviewed for accuracy and the completing of documentation.

*Audits of the MAR and medical record:*MARS are audited at least monthly by the Assistant Director of Nursing for accuracy and completion. The findings are reported and transcribed onto the QAPI spreadsheet. Any errors or trends identified are addressed through follow-up. Primary nurses are responsible for reviewing their residents’ MARS weekly for accuracy. Primary Nurses are also responsible for completing the second check of the MAR Recapitulation process monthly to ensure transcription of order accuracy. The C-Shift Nurse on duty is responsible for completing chart checks nightly which is captured in their C-Shift Report Tool. This Tool is submitted to the Director of Nursing or designee at the end of each shift. Random reviews of these various documentation and review processes will be reported to the QAPI subcommittee on a monthly basis to ensure that there is no drift in these processes and to provide opportunity for ideas of process improvement from a more diverse group.

*Medication Omissions/Refusals:*All medication omissions or refusals are drafted on the Medication Occurrence sheet and addressed as noted above.

Nurses will be trained and demonstrate competence regarding medication management through orientation and annually thereafter.

**Responsible Party: Director of Nursing**

# INFECTION SURVEILLANCE, PREVENTION AND CONTROL

**He-P 807.21 Infection control (a) The RTRF shall develop and implement an infection control program that educates and provides procedures for the prevention, control, and investigation of infections and communicable diseases.**

**State DHHS Finding**

The organization needs to have within its Infection control program a pro-active risk assessment and evaluation that involves all aspects of infection control throughout the program.

**Comment**

We recognize that while we have an established infection control program, the nature of infection control in the Lakeview environment can be enhanced through analyses and expansion to review all systems and potential vectors for infection.

**Immediate Response**

The Infection Control program will now have a monthly meeting as a subcommittee of QAPI to involve diverse organizational membership to better identify risks for infection and solutions throughout the environment of care, including the Director of Residential Resources (environment of care) housekeeping, dietary and direct care staff. An initial review of current data and potential risks across the program and development of improvement opportunities will be completed by the end of the first quarter, 2015, to include a facility-wide walk-through by staff members involved in the Infection Control program.

**Longer Term Corrective Action Response**

**In the last quarter of 2014** Lakeview established infection control program which describes the surveillance and monitoring of infections. This infection control program has an assessment and annual evaluation of the all infection control data. The infection control data and analyses will be presented for review to the Board of Directors on a quarterly basis. The additional on-going monthly forum to review and improve upon system-wide infection risk management involving diverse representation will report to QAPI as infection control improvements and initiatives are developed, implemented and assessed for on-going improvement.

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

*Surveillance and Monitoring of Infections:*The Infection Control process will expand to include review and analyses shared through a monthly meeting format of the QAPI subcommittee with diverse membership to include Environment of Care and Direct Care. The data and analyses will be shared and reviewed with representative staff, as well as with the medical personnel presently involved.

*Pro-active Risk Assessment and Evaluation:*The Infection Control Risk Assessment will be part of an on-going Infection Control process to include inputs from the Environment of Care, Housekeeping, Dietary, Direct Care as well as our Medical and Nursing staff, to ensure identification of infection risks and solutions across the program. This will be part of the QAPI process and reviewed though a diverse representation of staff in a monthly meeting format and will include initial and periodic facility walk-throughs.

**Responsible Party: Director of Nursing**

**State DHHS Finding**

The organization needs to incorporate Environment of Care and Safety issues into its Infection Control Program.

**Comment:**

We recognize that Lakeview’s Infection Control program has been more narrowly focused on traditional surveillance and data collection methodologies. A systemic and pro-active approach will be developed to include all aspects of the organization and address on-going identified infection risks and solutions through Infection Control rounds, training, data and incident review.

**Immediate Response:**

**Monthly,** the Infection Control program will meet as a subcommittee of QAPI to involve diverse organizational membership as noted above, to better identify risks for infection and solutions throughout the environment of care, to include the Director of Residential Resources (environment of care) housekeeping, dietary and direct care staff. An initial review of current data and potential risks across the program and development of improvement opportunities will be completed by the end of the first quarter, 2015, to include a facility-wide walk through by diverse staff members involved in the Infection Control program, with on-going quarterly rounds to provide pro-active infection control insights and opportunities.

**Longer Term Corrective Action Response**

Lakeview will incorporate the Environment of Care (EOC) and Safety issues into its infection control program by adding it into the comprehensive infection control program and including EOC elements in its infection control review to include housekeeping, sanitation and storage issues, among others. QA markers will be identified and implemented with stakeholder input to ensure the successful implementation of new policies and procedures as noted above. Information and best practices gleaned through the infection control process will be incorporated into the orientation and training of staff across all EOC departments.

**QAPI**

**REFINING AND INSTITUTONALIZING BEST PRACTICE THROUGH QAPI**

*EOC and Systems Approach to Infection Control:*The Infection Control process will expand to include review and analyses shared through a monthly meeting format that includes participation of diverse staff representing the Environment of Care, Housekeeping, Dietary, Direct Care as well as our Medical and Nursing staff, to ensure identification of infection risks and solutions across the program.

*EOC Infection Control Education and Training:*

Based on the issues identified through the Infection Control process, specific infection control orientation and training will be included in the orientation and on-going training across all EOC departments.

**Responsible Party: Director of Nursing and Director of Residential Resources**

LIFE SAFETY CODE NFPA 101 (2009 edition).

**Finding**

Main building observed 2 rooms could be lacking some sprinkler coverage the main living room on the first floor and the hallway to dining room.

**Corrective Action Response**

Lakeview had Life Safety Sprinkler company come out to view the sprinkler coverage and Life Safety determined coverage is adequate and no action is necessary. Life Safety will be writing a letter to Lakeview with these findings of supporting documents. Communication with sprinkler company attached.

**Date of completion: December 2014**

**Responsible Party: Administrator**

**Finding**

The Main building the main hallway door next to the ILS wing has damaged frame and needs to be fixed / changed to keep a smoke tight seal on the door.

**Corrective Action Response**

Door has been ordered and expected time of arrival is Middle of January 2015, so estimated completion date of new door to be in place is end of January 2015. Invoice attached.

**Date of completion: January 2015**

**Responsible Party: Administrator**

**Finding**

The Cambridge cabin has a crawl space below the 1st floor (furnace area) with some minor penetrations through the drywall that need to be sealed to prevent the potential passage of smoke.

**Corrective Action Response**

Lakeview has already corrected all the penetrations though the dry wall in Cambridge so the smoke barrier is now in place as of December 4, 2014. Photos attached.

**Date of completion: December 4, 2014**

**Responsible Party: Administrator**