

Montana Mental Health  
Nursing Care Center,  
Lewistown

November 9,

2018

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Site Inspection of Montana Mental Health Nursing Care  
Center, Lewistown, Montana

Mental Disabilities  
Board of Visitors

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## **OVERVIEW**

### **Mental Health Facility reviewed:**

Montana Mental Health Nursing Care Center, Lewistown, Montana

Dianne Scotten, Superintendent

### **Authority for review:**

Montana Code Annotated, 53-21-104 et seq.

### **Purpose of review:**

- 1) To learn about services provided by Montana Mental Health Nursing Care Center, Lewistown.
- 2) To assess the degree to which the services provided are humane, consistent with professional standards, and incorporate Mental Disabilities Board of Visitors standards for services.
- 3) To recognize excellent services.
- 4) To make recommendations for improvement of services.
- 5) To report to the Governor regarding the status of services.

### **Site Review Team:**

#### **Board:**

Daniel Laughlin

Amy Tipton

Jeffrey Folsom

Melissa Ancell

Sicily Morris

#### **BOV Staff:**

Craig Fitch

LuWaana Johnson

### **Review process:**

- Interviews with staff and clients
- Observation of treatment activities
- Review written description of treatment programs
- Inspection of the physical plant
- Review treatment records, policies and procedures, organizational structure, allegations of abuse/neglect

## Introduction

The Montana Mental Health Nursing Care Center (the Center) is a licensed residential facility for the long-term care and treatment of persons who have mental disorders and who require a level of care not available in the community, but who cannot benefit from the intensive psychiatric treatment available at Montana State Hospital. Similar to Montana State Hospital, the Center can accept residents voluntarily, but the vast majority of people who reside at the Center are involuntarily committed by District Courts around the State.

On November 9, 2018, the Mental Disabilities Board of Visitors (BOV) conducted a single day site inspection of the Center (in part due to budget restraints). While a one-day inspection did not allow BOV to gather information about all the BOV standards, it did allow all the Board members to visit the facility.

The Center has four primary residential wings that allow for segregation based on the varying levels of the residents' safety and medical needs. All the wings are well-organized with individual touches on rooms that reduces the feeling of an institutional feeling. Consistent with BOV's previous visits, the Center was impressively clean and odor free.

The Board ate lunch with the residents which provided an opportunity to experience the process by which meals are served and to assess the quality of the food. The patients interviewed said the food was great and that they were happy with the staff. The residents interviewed seemed content and generally pleased with the services they are receiving. BOV left the site inspection with the impression that the residents have good reason to be pleased with the services they are receiving.

## Organizational Planning and Quality Improvement

A comprehensive, multi-year strategic plan appears to be in place and referred to in both the annual report and more regularly through the interdisciplinary team meeting process. The plan is broad and ambitious. If the plan involves input from clients/family members or direct line staff, the staff interviewed did not appear to be aware of this.

The Center appears to have worked very hard and diligently on quality improvement with a position dedicated to the process and a policy specific to the QI/QA process written in 2015 and updated yearly. The new long-term nursing care regulations have certainly forced everyone to reexamine the quality of care at the Center. Leadership does have two interdisciplinary meetings daily that directs quality of care on a daily basis. The gathering of data daily and compiling them

monthly is an added benefit to quality of care. The focus appears to be on falls and safety, including an internal staff reward system for months without falls.

## **Rights, Responsibilities, and Safety**

The Center defines individual rights and responsibilities. Social workers read the rights and responsibilities to each resident within 24 to 48 hours of arrival. Each resident will be given a copy of the rights and responsibilities if they want one and a copy is sent to each guardian.

The facility prominently displays contact information on available advocacy services, including BOV, on all bulletin boards in areas where residents congregate. This information can also be found in the Resident Handbook. In addition, the social workers remind residents about the advocacy services BOV provides during the Resident Council meeting that is held once a month. Resident Council is another opportunity for patients to express issues that might affect rights/grievance issues. At least one resident on the council was very proud of the position and the council, but was unable to describe the council's actual role or actions.

The facility has a written grievance policy and grievance forms are located on each wing and easily accessible to residents. If a resident is able to ask for help, any staff can assist him to fill out a grievance form. If the resident cannot vocalize for help, staff can fill out a grievance and turn it in for the resident. Grievances are reported to the social workers who serve as the resident rights advocate. The social worker completes a preliminary investigation and then forwards the information to the superintendent who talks to the resident to resolve the grievance within seven days. The superintendent writes a summary of the grievance which remains on file for three years.

The Center has an abuse/neglect policy in place and administration understands MCA 53-21-107 and that all abuse/neglect cases must be reported to DPHHS and BOV. All staff, from the housekeepers on up, are required to watch for and report any incidents of abuse or neglect. Direct care staff report abuse/neglect to his immediate supervisor or the nurse in charge who would then report to his supervisor or the superintendent. The social worker assists in investigations with the superintendent and director of nurses in all alleged abuse incidents and drafts a report that is given to the superintendent.

MANDT training is given to all new staff and a refresher is given yearly. MANDT training ensures that all staff understand and recognize the importance of using de-escalating techniques to resolve behavioral problems early on, before the problem escalates. When a resident becomes verbally or physically aggressive, all staff ensure that other residents in the area are safe and

removed from the immediate vicinity and the aggressor is helped to calm down. All incidents are written up and discussed during staff meetings. The Center has no seclusion room and the only restraint used is a one-piece clothing restraint used for residents who pose a risk to themselves or others due to use/misuse of bodily emissions.

## **Staff Competence, Training, Supervision and Relationships with Individuals**

Each new employee has two New Employee Orientations. Orientations can take from two weeks to six weeks to complete, depending on which department they work in (all departments are different).

A New Hire Packet is given to each new employee along with an explanation of the facility and department they will work in, an Employee Handbook, and information needed to give each new employee a good baseline to start work. They are also given an Orientation Checklist and a Duties Checklist to complete within thirty days and are assigned to work alongside a mentor for the first week to learn the duties of the job. After the first week the new employee can decide if he would like more hands-on training. Each new employee has a six-month probation period but is evaluated after three months employment. At that time, if necessary, further formal training is done.

A formal one-day orientation training is given within ninety days of hire. This orientation is not given until a sufficient number of new staff are on-board. In addition, MANDT training is required of each new employee (refresher given every year thereafter). The training may not take place within the first week, but a class is given whenever a few new staff start, usually within two weeks. Staff interviewed described extensive trainings that they had attended. In fact, one staff had a list of over fifteen trainings that she was involved in during the last year.

Supervisors interviewed demonstrated good management skills and all had a solid understanding of the processes for grievances and abuse and neglect of patients. Staff interviewed stated supervisors are regularly on the units monitoring interactions with patients, talking with staff and residents, and generally making their presence felt. Observed staff/patient interactions were respectful, positive and calm. Residents were plenty comfortable interacting with BOV staff and engaging in discussions regarding their stay at the facility.

## Treatment and Support

### General Treatment Planning:

A multi-disciplinary team creates a care plan for each resident at the time of admission. Also, a social history is completed by a social worker within thirty days of admission, the Resident's Care Plan Review is conducted within twenty-one days of admission, and quarterly reviews are completed with specific criteria being discussed. In addition, discharge planning begins at the time of admission with the participation of the resident and an identified family member / guardian to ensure the resident's needs are being met and that an adequate continuing care plan is being devised. This plan is also reviewed quarterly. It was discussed that all plans are adjusted throughout a resident's stay to meet his needs, and all parties are notified. A resident has access to his documentation at any time and can request copies.

### Trauma Informed Care - Evidence-Based Services

Medical, mental health, and certified nursing assistant staff are informed of accommodations needed for residents who have experienced trauma in their life. This information is shared on the resident's face sheet, and pertinent information or events is shared with staff at shift change to promote proactive communication and better care for residents. However, trauma training for staff was implemented in 2018 and currently includes a video on ACEs, the facility's on-line training program. Trauma informed care is scheduled to become more of a focus in future treatment planning during 2019 as the multi-disciplinary team will be adding specific issues into individual resident's plan of care.

- An example was provided of a resident who would hoard food, and this caused issues. Staff learned that this individual had a traumatic history involving food, so they provided a snack box for this person to create a sense of safety for him.

### Co-Occurring Psychiatric and Substance Use Disorders:

Inside the facility residents may attend Alcoholic Anonymous meetings and receive 1:1 therapy. The psychology specialist evaluates each resident upon arrival to determine whether the resident needs further evaluation or treatment. If further evaluation/treatment is recommended, the resident's doctor will refer the resident to a treatment center rather than have a licensed addiction counselor come in to complete an assessment. Individual resident care plans include resources that may be useful to the resident for substance use disorders and mental health disorders outside of the facility.

### **Medications:**

There are three psychiatrists/doctors who share medication prescriptions at the Center: Dr. McMahon, Dr. Whitworth, and Dr. Cunningham. Dr. McMahon and Dr. Cunningham rotate their schedules while Dr. Whitworth visits every 3 weeks. Dr. McMahon and Dr. Cunningham are always available for after hour emergency phone calls. Medications are reviewed prior to admission of potential residents by one of the facility doctors. Prior to admission, there has to be an accepting doctor who is willing to add the potential resident to his caseload. The psychiatrist does a two-hour evaluation upon admission to the Center. Each resident visits the facility doctor for medical needs each month and they visit the facility doctor for psychiatric needs within thirty days after arrival and initial admission, followed by a visit every three months unless there is a medication change. If there is a medication change, the psychiatrist will follow-up with the resident three weeks after medication changes.

RN's, LPN's, and Medication Aide II's administer medications at the Center. In accordance with the Centers for Medicare and Medicaid Services (CMS), the medication prescription protocol is evidence-based and reflects internationally accepted medical standards. Medications are always stored in locked cabinets; narcotics are locked in a double-locked cabinet. There is an in-house pharmacy that includes a full-time pharmacist and a part-time pharmacist. A pharmacist is on campus five days a week and they audit medications every week and conduct medication reviews. Residents, their conservator, guardian, wards of the state, and power of attorney are provided with information about medications given along with a treatment plan. Residents can request a different provider as there are two available at the facility and one who comes 2-3 times per month. If a resident does not like one provider, he may request another.

Medication errors are documented in two different locations at the facility. There is an *Adverse Drug Event Form* and *self-report* methods. Quality improvement (QI) keeps track of medication errors and that information is given to a review committee where the error is discussed and plans made on how to avoid a repeated error.

In accordance with CMS new rulings, (2016-2019) the facility is required to attempt gradual dose reductions on all psychotropic drugs prescribed to those residing in the facility. The new requirements also added stricter criteria for using PRN (pro re nata, as needed) psychotropics which include face-to-face evaluations by an M.D. CMS also requires a minimum of twelve hours of dementia training for direct-care staff working on the Memory Care Wing.

## Post Report Observations, Suggestions, and Recommendations

After assembling all the information from the site inspection and the written materials, it is clear to BOV that the Center has been very active in adding/improving services for the staff and residents since the BOV's last site inspection. Just one example is in the new positions the Center was able to create in order to improve the quality of care. One position included a designated Quality Improvement Coordinator (which has been filled since 2016) and one position included a full-time psychiatric practitioner (unfilled).

- **Suggestion:** Even though the Center's mission does not include intensive psychiatric care for residents, it appeared to the BOV team that the Center would benefit from a full-time or half-time on-site psychiatric provider – especially given the new CMS rules requiring the documented effort at reducing psychiatric meds for all residents. The decision to increase the visitation times for the primary psychiatrist to every three weeks instead of every four weeks is a positive step, but BOV would encourage the Center to continue looking for an on-site licensed independent practitioner (LIP).

Despite the fact that the BOV team was impressed with many aspects of the site inspection, some members of the BOV team encountered evidence of low staff morale, in part due to the lingering effect of the bad press over the CMS survey, but also in part due to incidents that “can occur on a daily basis.” The BOV team offers two recommendations in reference to this issue:

- **Recommendation (1):** Create an FTE position(s) for on-campus security to assist with critical incidents, on campus safety concerns from residents and visitors, and with elopement risks.
- **Recommendation (2):** Consider adding a Critical Incident/Event Review process to the Q.A. department that can debrief staff and patients after incidents which might trigger trauma. Such incidents could include seclusion/restraint events, physical assaults, or resident/staff colleague deaths.

**Recommendation (3):** The Department of Public Health and Human Services needs to move to an electronic medication record system for all its facilities, including the Center.

## Facility Response

**Response (1):** When the Infirmary on D-Wing closes, MMHNCC will be looking into the feasibility of an intermediate inpatient behavioral health unit. If we have the means and/or approval, it will be necessary to have security. For now, being licensed as a Long-Term Care Facility, incidents may be assisted by our police department in Fergus County.

**Response: (2):** The Interdisciplinary Team meets twice a day (the QI coordinator is a part of this team) for incidents which includes grievances and alleged abuse investigations along with behaviors that occur in the facilities with the residents, etc. It would be appropriate to use the members along with those involved in those critical incidents for a debriefing. This will be started immediately. Sue Stevens, Psychology Specialist will be involved in facilitating the debriefing.

**Response: (3):** A proposal to the leadership at DPHHS will be completed this fiscal year for an EMR. DPHHS leadership is in agreement that this needs to be scheduled and options will be researched.