NEW YORK STATE OF OPPORTUNITY.
Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

August 17, 2018

Ann Marie T. Sullivan, M.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Dear Dr. Sullivan:

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people receiving services in facilities under its jurisdiction from abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews in order to identify risks to the health, safety and welfare of people receiving such services.

On June 29, 2018, the Justice Center issued a draft of our review entitled *Review of Crisis Management Protocols at New York City Health + Hospitals*.[1] The Justice Center received a response from the Office of Mental Health dated August 13, 2018, outlining actions your office has already taken in follow up to the review findings as well as plans for additional corrective measures to be implemented in the near future. The final review findings, including the response from the Office of Mental Health, is attached.

This review was conducted by the Justice Center and would not have been possible without the cooperation and professionalism that staff from the New York City Health and Hospitals facilities provided during the course of the review. We appreciate and join you in your continuing commitment to the care of vulnerable people in New York State.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

[1]This Review was performed pursuant to the Justice Center's authority as set forth in the Protection of People with Special Needs Act, Chapter 501 of the Laws of 2012.

cc: Suzanne Feeney, OMH
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NEW YORK
STATE OF
OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Prevention and Quality Improvement

Review of Crisis Management Protocols at New York City Health + Hospitals

August 2018

161 Delaware Avenue, Delmar, New York 12054
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www.justicecenter.ny.gov

The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

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Executive Summary

Purpose

This systemic review, conducted by the Justice Center for the Protection of People with Special Needs (Justice Center), was initiated in response to substantiated cases of abuse involving the deliberate, inappropriate use of restraints that occurred on inpatient psychiatric units and/or the Comprehensive Psychiatric Emergency Programs (CPEP) at the New York City Health + Hospitals network of hospitals. These incidents included the use of medications as restraints for the convenience of staff, and staff failure to intervene using less restrictive methods.

The purpose of this review is to identify factors that may be contributing to the incidents of abuse and neglect, and to offer recommendations and outline best practices to help prevent future incidents of this nature.

Program Description

The New York State Office of Mental Health (OMH) is one of six state agencies overseen by the Justice Center. OMH licenses the behavioral health units in the 11 hospitals operated by the New York City Health + Hospitals (NYC H+H). The NYC H+H hospitals provide a continuum of inpatient and outpatient services and are staffed by multidisciplinary teams of psychiatrists, licensed clinical psychologists, nurses, and social workers.

Key Findings

1. New York City Health + Hospitals facilities implemented proactive, preventative strategies to reduce the use of manual holds, mechanical restraints, and stat intramuscular injections (IM's).
2. Staff reported that people receiving services who had intellectual disabilities and/or dementia were difficult to both treat and find appropriate placement for when ready for discharge.
3. Patient Care Technicians (PCTs) and Behavioral Health Associates (BHAs) were not included as part of the treatment planning process.
4. Incident management policies pertaining to reporting requirements on the units licensed by the Office of Alcoholism and Substance Abuse Services contained inaccurate information.

Key Recommendations

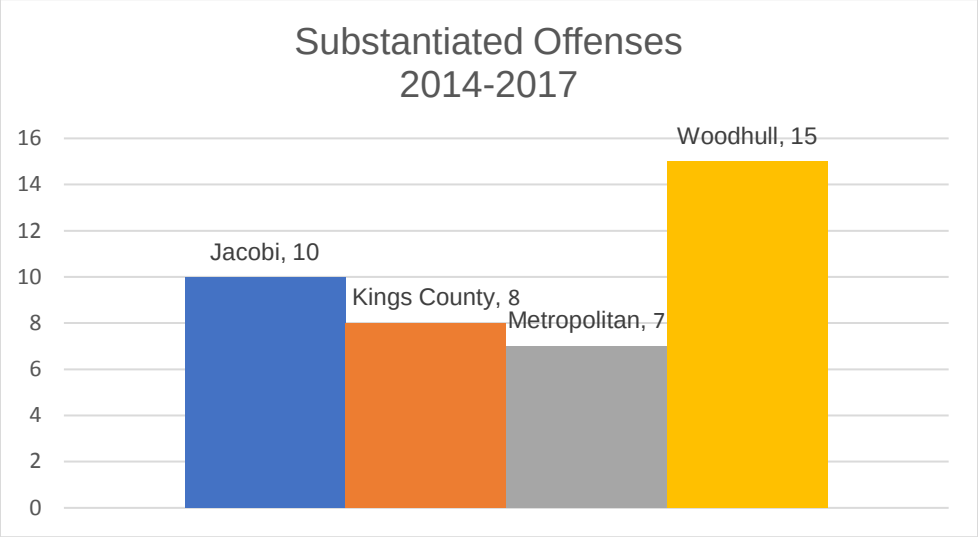
1. Continue efforts to reduce the use of restraints and to promote a safe environment for both people in care and staff providing services.
2. Train staff on serving people with developmental disabilities and dementia and work to identify new discharge solutions to ensure appropriate follow up care.
3. Include staff members from all disciplines as part of the treatment planning process.
4. Revise incident management policies to differentiate between reporting requirements for OMH-licensed and OASAS-licensed units of the hospitals. Ensure staff are trained on the new policies.

Review Findings

Background

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people in the care of hospitals under its jurisdiction against abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. The Justice Center conducts systemic reviews to identify, and make recommendations to reduce risks to the health, safety and welfare of people receiving such services.

The prevention and quality improvement unit (PQI) received referrals from internal business units at the Justice Center regarding the use of stat IM's at some NYC H+H facilities. A review of substantiated cases from January 2014-December 2017 at NYC H+H facilities revealed cases involving deliberate, inappropriate use of restraints and physical interventions. The hospitals chosen for further review were chosen based on the number of substantiated offenses at each hospital.



Scope and Methodology

The Justice Center conducted site visits at the four hospitals below:

1. Woodhull – July 13-14, 2017
2. Jacobi – August 29-30, 2017
3. Kings County – October 11-12, 2017
4. Metropolitan – January 9-10, 2018

The visits included a tour of the inpatient psychiatric units, and the Comprehensive Psychiatric Emergency Programs (CPEP) for the hospitals with CPEPs, as well as interviews with staff.[1] The Justice Center reviewed documentation for 20% of the census of people in care at the hospitals on the day of the visits.[2] These records were chosen based on the person in care's recent involvement in either a mechanical restraint, physical intervention, or use of a stat IM. The following documentation was reviewed:[3]

- Restraint documentation, including physician's order forms, restraint monitoring records, debriefing forms
- Personal Safety Plans
- Treatment planning documentation
- Progress notes
- Medication lists

Agency policies on incident management and crisis management were also reviewed. Several other types of documents specific to each facility and related to the reduction of restraints, physical interventions, and stat IM's were provided.[4]

Findings

Management of Crisis Situations

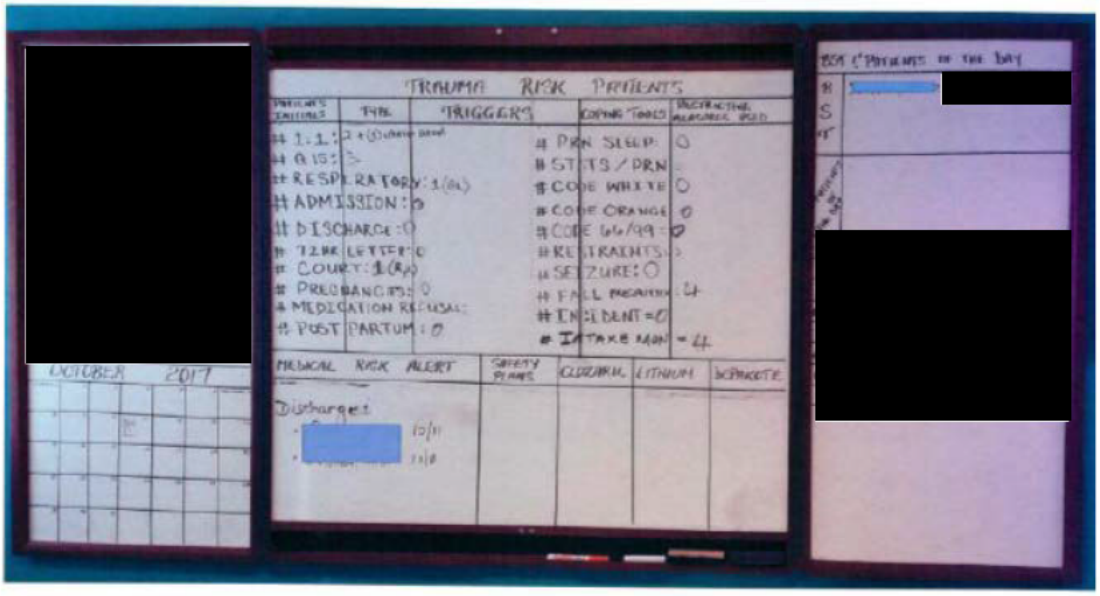
1. **The hospitals included in this Review had implemented proactive, preventative strategies to reduce the use of restraints, physical interventions, and psychotropic medications administered with stat intramuscular injections (IM).**

The Justice Center launched this review to identify trends related to managing crisis situations. The Justice Center found that each of the hospitals were already undertaking measures to prevent potential crisis situations from escalating to the point of needing to use a physical intervention, mechanical restraint, or stat IM. Agency administrators and unit staff from each facility described various actions already underway aimed at reducing the use of restraints, physical holds, and stat IM's during the site visits. Some of these efforts are described below and a full list of best practices aimed at reducing the use of restraints and physical interventions can be found in Appendix XX.

- All hospitals used white boards to communicate pertinent information related to the people in care. Information included new admissions, any high risk

[1] Woodhull, Jacobi, and Kings County had CPEPs.
[2] The total number of records reviewed was 61. Total for each facility is as follows: Woodhull-20; Jacobi-10; Kings County-17; Metropolitan-14.
[3] Each of the hospitals used slightly different terminology for these documents. Specific findings letters to each agency are included as appendices to this report and reference the language used at the corresponding facility.
[4] Documents describing promising practices are included as Appendices to this report.

medical or psychiatric needs for people in care and staff roles related to crisis management.



- Hospitals used various tools for measuring the effectiveness of the Preventing and Managing Crisis Situations (PMCS) training, to ensure employee retention of the information provided. These tools included pre- and post-tests, and the use of mock codes for preparing staff to handle a crisis before it reached the need for physical intervention.

Of the 61 patient charts reviewed across the four hospitals, the Justice Center identified 8 issues related to the use of mechanical restraints, physical interventions, and/or stat IM's. These concerns were communicated to the hospitals directly via the individual findings letters appended to this report. Notably, these concerns were largely related to documentation and not to the number of actual restraints or stat IM's given to the people in care in the sample.

2. All hospitals included in this Review adopted most of the components of the Preventing and Managing Crisis Situations (PMCS) curriculum to reduce the use of restraint and seclusion.

All four hospitals shared efforts undertaken to reduce the use of restraint and seclusion on their units. All hospitals adopted most of the components of the Preventing and Managing Crisis Situations (PMCS) as their crisis management program. PMCS is designed to strengthen staff competencies and build on those developed in core training by providing specific skills for preventing, deescalating or managing aggressive behavior. The PMCS curriculum teaches a preventative, 4-step process for managing crisis situations. It requires the use of an "Individual Crisis

Prevention Plan" to identify and outline triggers, warning signs, coping strategies, and preferences for people receiving services.

Individual Crisis Prevention Plans are designed to instruct staff on how to recognize escalating behavior as quickly as possible, so that they can intervene early and prevent the use of more restrictive interventions like restraint or seclusion.

Individual Crisis Prevention Plans

Three of the four hospitals referred to the Individual Crisis Prevention Plan (ICPP) as a Personal Safety Plan; one hospital referred to the document as the Individual Crisis Plan.[5] The information contained within each document was similar. The PMCS curriculum calls for four components of the Individual Crisis Prevention Plan – Triggers, Warning Signs, Coping Strategies, and Preferences. While all the forms used by the hospitals contained most of this information, three out of four hospitals were missing a section for preferences related to the use of medication, restraint, seclusion, and the route of medication during crisis situations.

Similarly, ICPP's were not available or were incomplete for several people in care. During interviews, staff indicated that the ICPP is completed during the admissions process. People in care may be resistant to treatment, in an acute crisis at the time of admission, or have active symptoms, which could lead to difficulty with the completion of the document. Of the 61 records reviewed, 22 records had incomplete or missing ICPP's. Recognizing the difficulty of attempting to obtain this information upon admission, all the hospitals used other methods and documents to gather pertinent details about helping to manage a crisis for people in care. For example, at one facility, a "Getting to Know Me" card was completed upon admission to the unit, which solicited information regarding a person in care's triggers and calming techniques.

Treatment of People in Care

3. Staff at all hospitals expressed concerns regarding providing adequate treatment to people with dementia or other cognitive functioning deficits.

During entrance interviews with leadership staff at each facility, a common concern was the difficulty treating people who suffered from dementia or an intellectual disability. Furthermore, leadership staff expressed the challenges they faced regarding the lack of appropriate placements for these people receiving services upon discharge. At one facility, it was reported that a person with an intellectual disability had been there for several months because his family dropped him off at the facility and indicated they no longer wanted to be involved in his care. At another facility, two people with intellectual disabilities received care in the CPEP for months because the facility had been unable to locate appropriate aftercare services.

[5] These terms will be used interchangeably throughout this document.

A review of documentation supports a need for training on working with these populations as well. At one facility, there were two geriatric people in care who staff reported difficulty working with due to their display of early signs of dementia. Progress notes at another facility used outdated terms like “mute” and “mentally challenged” when describing a person in care who was also diagnosed with Autism.

4. Treatment plans did not include input from all members of the multidisciplinary team.

All four hospitals used treatment teams to create individual plans catered to the needs of each person in care. These teams were generally comprised of an attending physician, resident physician, nurse, psychologist, social worker, and a creative arts therapist.

Treatment plans did not include input from patient care technicians (PCTs) or behavioral health associates (BHAs). PCTs and BHAs both play critical roles in the daily operations of the units and their feedback regarding a person’s care is relevant. PCTs and BHAs are responsible for maintaining the safety and therapeutic milieu of the unit by interacting with people in care on the unit and intervening during a crisis. As such, PCTs and BHAs may have information about a person in care’s triggers and calming techniques that may not be known to clinical staff.

Incident Management

5. Incident management policies contained inaccurate information regarding incident reporting requirements for the inpatient substance abuse units.

The incident management policy at three of the four hospitals did not delineate differences in reporting requirements for their programs licensed by the Office of Mental Health from those licensed by the Office of Alcoholism and Substance Abuse Services. Specifically, the definitions for significant incidents listed are pursuant to OMH reporting requirements only. Reporting requirements for OASAS services are similar to those required by OMH, but they differ in terms of reporting certain significant incidents. For example, OMH only requires fights between people receiving services to be reported when the altercation results in serious injury or harm. OASAS considers all physical altercations between people in care as reportable incidents.[6]

6. An allegation of abuse/neglect was not reported to the Justice Center.

Staff were generally knowledgeable about the Justice Center and their requirements as a mandated reporter. Staff could list events that would constitute reportable

[6] Refer to 14 NYCRR 836.4(d)

incidents and how they would handle them. However, at one facility, an allegation of abuse/neglect was not reported to the Justice Center.[7]

Recommendations

The Justice Center's specific recommendations are detailed below. While this review focused on these four hospitals, the Justice Center recommends New York City Health + Hospitals assess all hospitals with attention to these findings and apply the recommendations across all programs, as appropriate.

Management of Crisis Situations

1. Continue efforts to reduce the use of restraints and to promote a safe environment for both people in care and staff providing services. Review the "Best Practices" document appended to this report and consider implementing some of the tools across all hospitals in the New York City Health and Hospitals network.

2. Create a standardized Personal Safety Plan document that will be used by all hospitals that will include all elements of the plan as described in the PMCS curriculum.

Treatment of People in Care

3. Ensure that staff receive training on working with people with intellectual disabilities and other cognitive functioning deficits so that they are equipped to address each person's treatment needs. Develop a system to gather information from family members or other care providers to help NYC H+H staff work most effectively with people suffering from dementia or intellectual disabilities.

4. Include representation from all staff members who interact with people in care on a regular basis as part of the treatment team.

Incident Reporting

5. Revise incident management policies to include specific reporting requirements for units licensed by the Office of Alcoholism and Substance Abuse Services.

6. Train staff on incident reporting requirements and develop a process to ensure all reportable incidents are reported to the Justice Center.

[7] This incident was reported by Justice Center staff on January 24, 2018.

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

CHRISTOPHER TAVELLA, Ph.D.
Executive Deputy Commissioner

August 13, 2018

Denise M. Miranda, Esq.
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310

Dear Ms. Miranda:

Thank you for providing the draft report entitled *Review of Crisis Management Protocols at New York City Health + Hospitals*. We appreciate your partnership with the Office of Mental Health (OMH) and your commitment to supporting and protecting the health, safety and dignity of individuals in care in the mental health system.

OMH would like to issue a few points of clarification to the report and comments. Specifically:

1. As you know, a safe and therapeutic environment are the foundation of effective treatment. We share the value that Seclusion or Restraint should never be used for the convenience of staff. We agree that prevention is the best strategy and promote a focus on the creation and maintenance of an environment which empowers individuals in care.

2. The review of these issues in the Health + Hospitals System by the Justice Center is timely. We appreciate the focus. As a result of ongoing Clinical Risk Management and Licensing activities, OMH is working with leadership at Corporate Health + Hospitals on strengthening its efforts to minimize the use of Seclusion and Restraint in its system. This is an important and ongoing effort. We also agree that standardization of best practices and sharing helpful tools across the large and complex H+H system is important.

3. In addition to the promising practices that the Justice Center observed at some Health + Hospital sites, the Office of Mental Health would like to acknowledge information on a recommended evidenced-based approach to reducing Restraint and Seclusion. OMH has recommended using The National Association of State Mental Health Program Directors' Six Core Strategies for Reducing Seclusion and Restraint Use©. There are resources, tools and information on these evidence-based tools on the OMH website.

4. Regarding Key Recommendation 3, Page 8 regarding staff training on "working with people with intellectual disabilities and other cognitive functioning deficits," OMH is pleased to report that it is working very closely with OPWDD on a system redesign to

address the needs of recipients with IDD and behavioral health concerns which includes staff training and the establishment of a specialty inpatient unit licensed by OMH. OPWDD is implementing statewide START services, a nationally recognized best practice community-based crisis intervention service for recipients with IDD/MH. START will also assist in training mental health staff in how to provide person-centered, solutions focused approaches to reduce the need for inpatient care.

5. Regarding Key Recommendation 4, Page 8, which advises to Include staff members from all disciplines as part of the treatment planning process. Per 14 NYCRR Part 590, CPEPs do not have a comprehensive treatment planning requirement. The services provided are crisis intervention and short term in nature. Nonetheless we agree that all staff bring a value to the decision making about the course of treatment and that for those who are treated and released from a CPEP, all staff should be involved in the recommendations for a plan of care so as to reduce the likelihood for unnecessary CPEP repeat visits.

Again, thanks you for OMH the opportunity to comment on your draft report, *Review of Crisis Management Protocols at New York City Health + Hospitals.*

Sincerely,

Ann Marie T. Sullivan, M.D.
Commissioner