EXECUTIVE SUMMARY
Ombudsman Investigation – Alaska Psychiatric Institute, DHSS
J2018-0134
March 18, 2019

Introduction

Alaska Psychiatric Institute (API) is the only state psychiatric hospital in Alaska. API does not determine which patients it admits. Patients are committed to API by the Alaska Court System because they are suicidal, homicidal, violent, assaultive, psychotic, delusional, or so gravely disabled by their mental illness they cannot provide for their own basic needs. API serves the most acutely mentally ill patients – the patients who cannot be treated successfully in their home communities.

The Alaska State Ombudsman initiated an investigation of API pursuant to AS 24.55.120 on June 20, 2018. This investigation was based on a series of complaints about staff conduct toward patients. From January 1, 2015 to December 31, 2018, the Alaska State Ombudsman received 42 complaints specifically about API. Nearly one-third of these complaints were about patient abuse or neglect. In December, 2017, the Ombudsman received and investigated a specific allegation that a member of API staff assaulted a patient. In June, 2018 the Ombudsman received a complaint about pervasive staff misconduct involving patients, spurring this systemic investigation.

Based on the initial allegations and interviews with API staff and DHSS leadership in July 2018, the Ombudsman narrowed the scope of the investigation to three allegations:

1. Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients from use of force by API staff.
2. Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients due to violence by other patients.
3. Contrary to Law: API does not consistently comply with AS 47.30.825(d) or 42 CFR §482.13(e) in the use of seclusion and restraint.

The Ombudsman reviewed all relevant state and federal legal authority related to patient care, safety, seclusion, and restraint, as well as API policies and procedures. Evidence was collected from API, the Health Care Facilities Licensing and Certification section of Health Care Services, Adult Protective Services, and other agencies. The Ombudsman interviewed API staff from all clinical and service departments, from the chief executive officers to the psychiatric nursing assistants. The Ombudsman reviewed surveys and findings from the Centers from Medicare and Medicaid Services and the workplace safety report from attorney Bill Evans. The Ombudsman also interviewed Alaska health care practitioners working in other inpatient mental health settings, along with patients, advocates, and stakeholders in the mental health system.

Allegations of Violence Toward Patients

Allegation 1: Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients from use of force by API staff.

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not reasonably protect patients from excessive or unnecessary use of force by staff to be **justified**. DHSS did not provide any comment on the finding.

Investigation of the allegation that a Psychiatric Nursing Assistant (PNA) assaulted a patient in December 2017 showed that the assault did occur, and that none of the API staff who were present and witnessed the incident documented or reported the incident as required by law and API policy. While the PNA was terminated from employment, no disciplinary action was taken regarding the staff who witnessed and failed to report the patient abuse. API management did not follow hospital policy requiring that the assault be reported to law enforcement, nor did they provide the patient with any information about how they dealt with the staff misconduct (also required by API policy). Finally, API did not report the PNA's termination due to misconduct to the Board of Nursing, which is required by law.

The Ombudsman reviewed an incident on July 4, 2018, during which a patient's clavicle was broken. In the course of responding to a crisis on the unit, the patient was placed in a prohibited form of manual restraint against a door. The patient's clavicle was broken during the restraint – causing the patient to scream out in pain that his collarbone was broken. The patient did not receive immediate medical attention. Instead the patient was placed in seclusion until they were assessed for injury 30 minutes later, and then taken to the emergency room 30 minutes after that. None of the API staff involved in or witnessing the restraint, seclusion, or subsequent medical care made the required reports to API management or protective services.

How API responds to allegations of misuse of force by staff is a longstanding issue of concern. After a survey visit on July 19, 2018, CMS made findings that API failed to complete process reviews for two episodes of restraint in June 2018. After the August 31, 2017 survey, CMS made findings that API failed to adequately respond to a PNA's assault of a patient experiencing significant intellectual/developmental disabilities. CMS surveyors made similar findings related to the lack of response to possible patient maltreatment in 2016.

Allegation 2: Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients due to violence by other patients.

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not reasonably protect patients from violence by other patients to be **justified**. DHSS did not provide any comment on the finding.

After the May 30-31, 2018 survey visit, CMS made the finding that API failed to ensure that a patient received care in a safe setting and failed to follow its policies and procedure related to patient assaults. The Ombudsman reviewed video and documentary evidence related a specific incident in 2018, during which one patient raped another patient (under Alaska law, sexual penetration of another person known to be "mentally incapable" is sexual assault in the second degree – a class B felony[1]). The sexual assault occurred in a part of the unit that is in full view of

[1] AS 11.41.420(a)(3).

the nurses' counter and staff on the floor. However, the nurses' counter was left unattended and there were no staff on the floor (based on a 360 degree review of video surveillance of the unit at the time of the sexual assault).

How API staff responded to both the perpetrating patient and the victimized patient caused concern. The perpetrating patient was permitted to return to their room and shower, compromising evidence of the sexual assault. The victimized patient was left to sit, half-dressed and alone in full view of other patients and staff, for several minutes before being directed to dress and go to another room.

API did notify law enforcement, and the patients were interviewed by Anchorage Police Department. The victimized patient was taken for a forensic examination but received no additional treatment specific to the trauma of being raped from API providers. The perpetrating patient was discharged three days later.

The API staff responsible for staffing the nurses' counter and for performing "locater" duties – the roles critical to maintaining supervision of patients at all times – were not at their posts as required. This created the opportunity for one patient to sexually assault another, more vulnerable, patient. Neither staff member received any instruction or disciplinary action related to the incident.

In January, 2019 a patient sexually assaulted another patient – allegedly because staff failed to perform their duties of patient supervision. This assault was not reported internally as required by policy and was not reported to Adult Protective Services as required by law. It was eventually reported to law enforcement, and the perpetrating patient was charged.

The Ombudsman is also concerned that some API staff display a permissive attitude toward patient on patient assaults. This observation is corroborated by records API provided showing other incidents of patients being harmed by other patients with little to no response from staff. For example, on January 2, 2018, a patient assault was reported to staff. Staff observed injuries to the patient, and offered medical care. The assault occurred in the TV room (which is in full view of the nurses' counter), but there is no documentation that staff witnessed or acted upon the assault

when it occurred. The patient who had been assaulted could not identify their assailant, though another patient did. There is no documentation showing that the alleged aggressor was interviewed by API staff, or that any effort was taken to determine what triggered their behavior (so that it could be avoided in the future).

Allegation 3: Inappropriate Use of Seclusion and Restraint

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not consistently comply with AS 47.30.825(d) or 42 CFR §482.13(e) in the use of seclusion and restraint to be **justified**. DHSS did not provide any comment on the finding.

The Ombudsman reviewed documentation related to incidents of seclusion and restraint from January to September 2018, as well as data provided by API Quality Assurance. She also reviewed all the findings made by CMS from 2016 through July 2018. She reviewed video evidence and conducted interviews with staff regarding general and specific incidents of seclusion and/or restraint.

CMS made many findings related to failure to follow legal and policy requirements for restraint and/or seclusion of patients during the surveys in 2016-2018. CMS noted several episodes of seclusion where there was no evidence of an immediate risk of harm to the patient or others, which violates 42 CFR §482.13(e), which provides: "All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff."

The Ombudsman identified an episode of what appears to be unlawful chemical restraint. Chemical restraint is expressly prohibited by API policy. Even so, in this instance API staff subjected an adolescent patient to involuntary IM medications rather than permitting the patient to voluntarily take oral crisis medication or attempting seclusion without medication.

The Ombudsman reviewed video of this incident. The patient was agitated, cussing at peers on the unit, and threatening someone. Documentation provided by API states that verbal interventions and redirection were attempted. Video and audio recording does not reflect how staff were using less restrictive means (required by law and policy) to help the patient regulate their behavior. The patient was placed in a vertical hold (which is a prohibited form of restraint) against the wall.

Staff walked the patient to the seclusion room, where video shows the patient entering the room willingly and sitting on the bed. A nurse said to the patient that they needed to lay down so the nurse could administer intramuscular (IM) injectible crisis medication. The patient responded "I'm calm," and "I'll take the medication," indicating they would take crisis medication by mouth. An unidentified API staff responded: "Because you attacked someone, you have to take the shots." API staff unequivocally connected the IM medications as a consequence for the patient's behavior, rather than a therapeutic intervention.

The patient stated "The shots hurt. You don't know what it feels like." The patient was visibly upset but remained on the bed and physically calm. A PNA then put his hands on the patient and three other three male staff joined the restraint at the shoulders and legs. The nurse administered the IM medications. API staff then left the patient on the bed, crying and alone. A few minutes later, staff return and take the patient back to the unit.

In this instance, API imposed a physical restraint upon a patient clearly not posing a risk to his own safety or the safety of others in order to administer involuntary IM medications as a consequence for earlier behavior. There is no clear therapeutic value to API's actions, and a clearly observable negative consequence – and trauma – to the patient. Thus, the Ombudsman finds that the actions of API staff in this incident violated federal regulation and API policy, both of which define "chemical restraint" as "a drug or medication when it is used as a restriction to manage the patient's behavior . . .and is not a standard treatment or dosage for the patient's condition."[2] API

[2] 42 CFR §482.13(e)(1)(i)(B)

policy further holds that "chemical restraint is considered an inappropriate method of controlling behavior and is not the practice of API."[3]

API Performance Improvement Data, 2017-2018

API provided data on the use of restraint and seclusion in 2017. The rate of patient restraint remained consistently low (.87-4.4/1,000 inpatient days). The rate of manual holds ranged from 15.81/1,000 inpatient days to 56.31/1,000 inpatient days. The rate of seclusion ranged from 2.79/1,000 inpatient days to 15.99/1,000 inpatient days.

API also quantified use of seclusion and restraint by percentage of patients affected. Between 8.85% and 17.09% of patients were subject to a manual hold in any given month in 2017. Between .05% and 2.87% of patients were restrained each month. In 2017, between 2.31% and 7.32% of patients were subject to seclusion each month.

In the first six months of 2018, between 11.9% and **22.1%** of patients were subject to manual holds. **One in five patients were subject to manual hold in May and June 2018.** The average percentage of patients restrained in the first six months of 2018 was 62% higher than the preceding six months (2.6% compared to 1.6%). **The average percentage of patients subject to seclusion in the first six months of 2018 was 75% higher than the preceding six months (9.6% compared to 5.46%).** API data shows that, in FY 18, the duration rate for seclusions exceeded 1 hour in five (5) of the twelve months – exceeding 2 hours in November 2017 and 3 hours March 2018.

Given the variability in the rates of patient hours in restraint and seclusion, the Ombudsman reviewed additional data sets provided by API to identify contributing factors. This included hospital census data for 2017. According to API, the adult acute units (Katmai and Susitna) were at or above 90% capacity for at least 83% of days each month in 2017. The entire hospital was at or above 90% capacity for at least 89% of days each month in 2017. There is not a clear correlation

[3] SC-030-02.01b.

between the months when API was at or above 90% capacity for the highest number of days and the utilization of seclusion and restraint. In fact, the months when API had the most patients (February, April, August, and September) were months with lower utilization of manual holds, restraint and seclusion.

Census pressures continued in FY18 (July 2017-June 2018), with the entire hospital running at or above 90% capacity for ten (10) months of the year. API was completely full (100% occupancy) in August 2017, April 2018, and May 2018. It was 90-99% full for four (4) other months in FY18. A series of unit closures occurred in FY18 as API addressed structural safety concerns and staffing shortages, so this data is adjusted to reflect actual capacity (rather than 80 beds).

The Ombudsman also reviewed treatment participation data for 2016-2018. **According to API, the average number of treatment groups dropped from 11.8 per day in February 2016 to 2.9 groups per day in June 2018.** Adolescent patients participated in therapeutic programming at lower levels in 2017 than in 2016. The same trend occurred for forensic patients and acute adult patients during that time. Total patient participation in therapeutic programs at API declined 76% between February 2016 and June 2018. This can be attributed in part to the 75% reduction in therapeutic groups offered.

API provided data from 2017-2018 that show that less than 70% of patient treatment plans documented patient involvement (which is required by federal regulation and API policy). Less than 70% of treatment plans were reviewed according to schedule in 2017. That rate improved somewhat in the first half of 2018, with over 70% of treatment plans being reviewed on schedule in three of those six months.

Patients are less likely to engage in treatment without some buy-in or investment in the process. Treatment regimens are less likely to be effective when they are not updated or modified based on patients' progress (or lack thereof). This increases the likelihood that patients will experience symptoms or demonstrate behaviors that require restraint or seclusion, and thus contributes to the utilization rates.

Close supervision of patients, with a goal of intervening earlier when patient behaviors begin to escalate and supporting patients to self-regulate, can help reduce the need for restraint or seclusion. Close observation is required whenever API determined a patient "requires additional observation and monitoring due to potential harm to that patient or others."[4] The close observation status scale (COSS) includes first degree, where the patient is checked every 15 minutes and their status is noted by "locater" staff. Second degree COSS is 1:1 observation, with staff (a PNA) in the same room with the patient, usually within arm's length, and maintaining continuous visual focus on the patient. Third degree COSS is the highest level of observation, with 2:1 staffing within arm's length of the patient and continuous visual monitoring.

API staff must remain focused and engaged (as appropriate) with the COSS patient to whom they are assigned. They may not eat, read, or engage in other distractions while assigned to a COSS patient.[5] Given the intensity of COSS, staff may not be assigned to 1:1 observation of a patient for more than two (2) hours at a time, and may not be assigned to 2:1 observation for more than one (1) hour at a time.[6]

This level of patient care requires additional staff. In FY17, there were more than 150 1:1 COSS patient days in six out of the 12 months. That year, 1,879 additional staff days were required to cover the needs of 1:1 and 2:1 patient observation. In FY18, the number of patient days per month of 1:1 COSS observation ranged from 125-226. The number of patient days per month of 2:1 COSS observation ranged from 0-31. The acuity of these patients resulted in API needing 2,327 additional staff days in FY18 to meet the demand for close observation.

Staff and Patient Behaviors

At the heart of the allegations related to patient safety and utilization of restraint and seclusion are the behaviors of patients and API staff, and how they respond to each other. Patients admitted to API are in crisis and either pose a danger to themselves or others or are gravely disabled. They

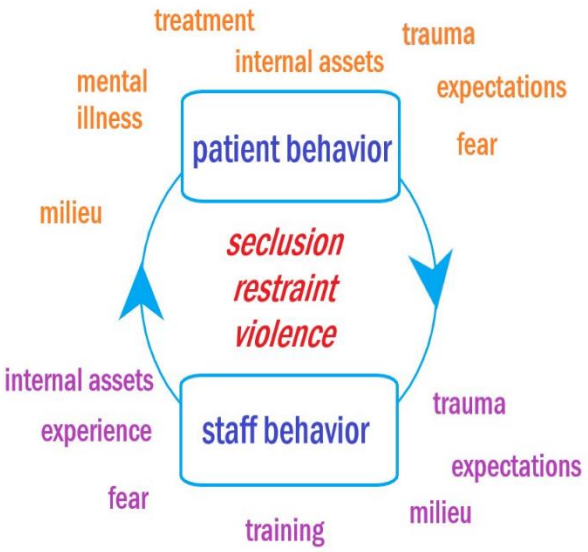
[4] API Policy and Procedure PC-060-14.
[5] *See id.* at section V.
[6] *Id.*

have no choice in their admission, and they cannot discharge themselves when they want. This sort of situation very reasonably creates fear, confusion, and anxiety for patients.

Consistent themes in interviews of staff, from PNA to CEO, included feelings of fear, distrust, conflict, and suspicion. Many staff described power and control dynamics in how API is managed and how hospital services are delivered. Perceptions of patients' actions as well as those of peers and managers were filtered through these lenses.

There is a feedback loop between patients and staff which contributes to the incidence of violence and utilization of seclusion and restraint at API. Patients bring with them their internal and external assets and deficits, the traumas they have experienced, and the symptoms and behaviors associated with their psychiatric disorders. Staff bring their own internal and external assets and deficits. They, too, have experienced trauma – whether inside or outside the hospital. Their behaviors are as important to this equation and those of the patients. Based on the Ombudsman's extensive interviews with API staff, as well as the inquiry made by Bill Evans related to workplace safety, this feedback loop is a significant contributor to the allegations investigated herein.

Diagram of Patient – Staff Feedback Loop



API staff described the hospital in which they want to work. It is a hospital that provides an environment that is supportive of healing: calm, safe, not crowded, permeated with the feeling that people are there to help and not to hurt. Staff are well trained, mentored, and offered continuing professional development. Hospital leadership are also well trained in the art of management. It is a hospital where there is open dialogue and respect for patients and staff. There are common expectations and consistent consequences for staff and for patients. It is a hospital that is recognized for the critical services it provides to Alaskans.

Recommendations

The Ombudsman recognizes that DHSS and API have tried to improve services and capacity at the hospital. Every CMS survey cited herein has resulted in a Plan of Correction with specific strategies and benchmarks for resolving the problems. Additional funding for nurses' salaries, bonuses, and positions was requested for FY19, and the Legislature appropriated those funds. API has attempted to address the acute needs of its I/DD and dementia patients by engaging a specialist and bringing on university students to augment therapeutic capacity. By June 2018, the API CEO and senior management were meeting every Thursday with Commissioner Valerie Davidson and DHSS leadership to identify, implement, and monitor ways to address admission waitlists, program and treatment deficiencies, ongoing oversight investigations, and personnel issues.

DHSS contracted with the Joint Commission Resources to provide technical assistance to help API achieve compliance with state and federal requirements. DHSS attempted to negotiate a System Improvement Agreement with CMS in August 2018, to provide API with time to resolve deficiencies. Governor Walker and Commissioner Davidson used their emergency powers to deploy resources and recruit community partners to resolve some of API's deficiencies through the DHSS Emergency Operations Center on October 13, 2018.

The Alaska Legislature appropriated an additional $3.1m in FY19 to expand nursing capacity at API. The Walker Administration approved creation of 82 additional clinical and support positions proposed by API (discussed below) in October 2018. Additional funding (an estimated $7.06m) for these positions, needed to resolve the deficiencies found during the CMS Surveys in 2017-2018, was not included in the FY19 supplemental budget proposal made by the Administration on January 28, 2019.

Leadership changes in quick succession in 2018-2019 have not resulted in immediate improvements, and deficiencies continue to be documented. On February 8, 2019, Commissioner Adam Crum announced that a private health care organization, Wellpath Recovery Solutions

(Wellpath), had been awarded a contract to "provide administrative leadership" of API "with continued oversight from the state."[7]

The Ombudsman seeks to make recommendations that will help API strengthen staff and patient assets to minimize challenging and violent behaviors, and thereby reduce incidents of violence toward patients and the need to use restraint and seclusion.

Recommendation 1: DHSS, if it continues to accept court ordered patients whose primary diagnosis is anything other than suicidality or a serious mental illness (i.e. a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities) should place those patients in an intermediate care facility for intellectual/developmental disabilities (ICF/IDD) or facility providing dementia care, and not API.

On April 20, 2018, the Director of the Division of Behavioral Health reported to the Ombudsman that API capacity was 58 beds. Of the patients at API on that day, six (6) were older than 65 and experiencing dementia and five (5) were adolescents experiencing intellectual/developmental disabilities. He explained that these 11 patients – 19% of the current hospital capacity – were only at API because there were no community services to which to discharge them. He also commented on the fact that these patients had much longer lengths of stay than patients committed for psychiatric crises.

On September 5, 2018, the Acting Director of Nursing reviewed the current patient census with the Ombudsman. Of patients admitted to API on that day, 20% did not have a primary diagnosis of serious mental illness. Some experienced significant and gravely disabling intellectual or developmental disabilities (I/DD) and some experienced dementia. In reality, API has even less capacity to treat patients experiencing psychiatric crises than the hospital bed count – because 20%

[7] February 8, 2019 Press Release from DHSS.

of the beds are being used for long-term residential care for patients needing ICF/IDD or dementia care services.

Based on staff interviews as well as the Ombudsman's review of seclusion and restraint records and UORs for 2018, I/DD and dementia patients accounted for a large proportion of incidents of violence toward self or others, and utilization of seclusion and restraint. These patients require higher levels of supervision (COSS, 1:1, etc.), putting strain on staff. These patients are also in need of specialized treatment and rehabilitative services outside the expertise and experience of API staff.

API has attempted to complement internal professional capacity by working with an Applied Behavioral Analyst (ABA) and ABA students from the University of Alaska. These professionals and API staff report that these efforts have – with much time and effort – made a significant difference for the few patients receiving ABA services. However, this limited addition to API clinical capacity has not reduced the stress that serving this population puts on the hospital, nor does it address the legal ramifications of serving these populations in such a restrictive and clinically inappropriate setting.

API is a psychiatric hospital, not an ICF/IDD facility. API should not be serving patients who do not experience suicidality or a serious mental illness or psychiatric disorder. The current situation at API runs contrary to the ADA and the requirements laid out in *Olmstead v. L.C.* (1999) (*Olmstead*).

DHSS has attempted to expand community capacity to serve individuals with challenging behaviors resulting from I/DD and dementia. The Division of Behavioral Health partnered with HOPE Community Resources in Anchorage to create community placement for four (4) API patients diagnosed with dementia. However, there remain individuals who require facility-based care (as evident from the percentage of long-term patients at API who experience I/DD or dementia).

In the short term, DHSS should identify appropriate services (whether in-state or out-of-state) for API patients who do not have a psychiatric disorder that is responsive to the psychiatric treatment that API provides – and transfer those patients to the least restrictive clinically appropriate service setting. DHSS, with its counsel from the Department of Law, should convene the Court System and other stakeholders in the involuntary treatment legal process (i.e. Title 47), with the goal of reducing commitments of Alaskans experiencing intellectual/developmental disabilities, brain injuries, and dementias to API.

In the long-term, DHSS should convene providers, consumers and families, advocates, and other stakeholders in the systems serving Alaskans experiencing intellectual/developmental disabilities, brain injuries, and dementias to discuss how the State of Alaska will provide clinically appropriate and consumer-centered services in the least restrictive settings possible – while recognizing that there is a documented need for some sort of facility-based care staffed with appropriately credentialed and experienced clinicians and staff to provide services for patients with assaultive, aggressive, and challenging behaviors.

DHSS accepted this recommendation in part, responding:

> API will convene with the DHSS leadership to discuss the development of community-based less restrictive placement options for individuals with IDD/ dementia and related disorders, who currently do not experience an acute psychiatric crisis and do not carry a psychiatric diagnosis. API will request this collaboration to begin no later than June, 2019 and is a part of the implementation of the 1115 Waiver currently accepted by the Centers for Medicaid and Medicare Services (CMS) and in the planning stages.
>
> The importance of placing the aforementioned patients in the clinical setting, which promotes the therapeutic benefits of addressing the specific needs of these individuals, will constitute the focal point of the initiative. API will expeditiously review the Ombudsman recommended community-based treatment setting options with DHSS, and will seek the most clinically appropriate means to provide needed care to patients currently at API, while ensuring they are not at risk to self or others, and will arrange respective transfers of these patients.
>
> In addition to the 1115 Waiver mentioned above, the Department is also:
>
> > 1) establishing a higher level of capacity at the Alaska Pioneer Homes in order to serve elderly individuals in a more appropriate setting;

2) the Department has contracted with individual Assisted Living Homes (ALH) where appropriate to provide the least restrictive placement option; and

3) in July of 2019 the Department will be putting out a Request for Letters of Interest (RFLOI) to ALH providers who can provide care to high acuity patients and see what the level of interest and capacity is in the state that could be rolled into the second phase of the 1115 Waiver process to stand up that level of service. This last effort would include those populations mentioned in this recommendation, which typically have had little access to appropriate care within the state.[8]

Recommendation 2: API should identify and implement tools and resources to reduce the incidence of challenging patient behaviors and/or promote self-regulation.[9]

Research supports the observations of API staff that patients are often stressed and act out when there is nothing to occupy their attention – or nothing to help distract them from whatever is inciting their challenging behavior. Possible additions to the API toolbox, collected from staff and through review of evidence in the investigation include the following:

- Physical activities in the gym and outside yards, including organized and free play;
- Access to snacks, subsistence/traditional foods, and beverages;
- Life skills, cultural, art, and other activities;
- Sensory aids to help patients regulate the stimuli to which they are exposed;
- Behavioral plans; and
- Robust collection and analysis of quality assurance data and health metrics to improve milieu and hospital management.

[8] DHSS Response at 2.

[9] For additional research on preventing and mitigating patient aggression, *see e.g. Strategies to De-Escalate Aggressive Behavior in Psychiatric Patients*, RTI-UNC Evidence-Based Practice Center for the Agency for Healthcare Research and Quality (July 2016); *Predictors of Effective De-Escalation in Acute Inpatient Psychiatric Settings*, Lavelle, M. et al,. JOUR. OF CLINICAL NURSING 25, 2180-2188.; *Developing an Evidence-Based Practice for Psychiatric Nursing*, Buccheri, R. et al., USF Nursing and Health Professions Faculty Research and Publications (May 2010).

DHSS accepted this recommendation in part. DHSS committed to reviewing the API wellness program and re-examining programming modules "with the goal of enhancing patients' engagement and participation."[10] DHSS also explained that "the model being currently introduced by Wellpath includes six hours of active therapy a day per patient."[11] DHSS stated that API would "re-evaluate its processes" for providing snacks and subsistence foods for patients.[12]

DHSS agreed that "regularly scheduled recreational and occupational therapy activities" will benefit patients, and cited Wellpath's 6-hour active treatment model as an example of how API was addressing the lack of treatment services and activities for patients.[13] DHSS agreed to expand access to sensory aids for patients, and committed API leadership to "research the option of creating a 'Quiet Room.'"[14]

DHSS reported that API staff will receive training on the development and implementation of behavioral plans, and ensure a "clear understanding as to the plans' value and purpose" by April 5, 2019.[15] Further, "Human resources and Nursing Leadership will set clear expectations for staff regarding adherence to the policy and process" for using behavioral plans with patients.[16]

DHSS reported that it is currently revising its Quality Assurance/Performance Improvement Program, and will be incorporating "enhancement of data collection and reporting practices."[17]

Recommendation 3: API should place patients in units by acuity, and staff accordingly.

API has attempted to organize its patient populations so that services can be delivered more effectively, while also complying with appropriate laws and regulations. However, patients of varying diagnoses, symptomology, and acuity are housed together on the adult and adolescent units. This makes it difficult to tailor group active treatment options to the patients' needs. It also

[10] DHSS Response at 2.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*at 3.
[15] *Id.*
[16] *Id.*
[17] *Id.*

makes it difficult to staff the units with PNAs and nurses who have the training, skills, and aptitudes best suited to serving specific patients. This means that a large unit with many highly acute patients, or a small unit with even just one or two highly acute patients, can see higher incidence of violence and use of restraint and seclusion.

The current hospital structure would allow for placing patients based on immediate acute need versus the need for intermediate care. However, staff assigned to work high acuity units for long periods of time could experience greater burnout. There was also discussion of organizing therapeutic services off the units, so that patients could be included based on their treatment needs rather than unit assignment.

In 2018, DHSS contracted with Anchorage architect Steve Fishback to provide options for expanding API, which lacks capacity to meet the psychiatric inpatient hospital demand of Alaska's current population. This provides an opportunity to explore ways to serve patients better by creating physical space that allows for placing patients in units by acuity. API staff observed that smaller units are usually less chaotic, and patients respond better to staff and programming in less crowded milieus.

DHSS accepted this recommendation:

> API leadership will pursue the Ombudsman's recommendation and along with the Clinical Leadership of the hospital, will re-evaluate the acuity level of all current patients with the goal of developing alternative appropriate treatment and housing milieu for each patient within the hospital as well as to be able to sustain this milieu for the newly admitted patients. Wellpath is assisting API in exploring better means of utilizing smaller spaces within the hospital or to develop a plan for a possible re-design of the existing spaces.[18]

Recommendation 4: API should revise its policies and practices regarding Unusual Occurrence Reports (UOR), and the associated medical chart documentation, to ensure that the information is effectively recorded and used to inform patient treatment plans; management,

[18] DHSS Response at 3.

coaching, and training of staff; milieu management; resource allocations; and broader hospital management decisions.

Having reviewed the UORs completed from January-September 2018, the Ombudsman has identified practice and policy areas warranting attention. UORs are often not completed by staff with first-hand knowledge of the facts of the incident. This limits the value of the information in the report. API should consider requiring the staff who took lead on the code, or who was directly involved in the incident, to complete the UOR. (This may not be appropriate if the staff was also a victim of violence by the patient.)

It was not infrequent that the Nursing Shift Supervisor (NSS) on duty completed the UOR and then conducted the supervisor review within minutes of the underlying incident report. This avoids third-party review of the incident, especially if the NSS leads (or simply fills out the form for) a staff debrief after the incident. API should require the NSS, or the NSS's supervisor if the NSS was the author of the UOR, to review the UOR and complete the supervisor review. API should consider that the supervisor review should occur after the staff debrief, to ensure that information is part of the record reviewed by the supervisor.

Documentation of the incident does not always align with the information in the UOR. Notes are usually, but not always, written by staff with first-hand knowledge of the event. The "less restrictive means" and interventions attempted prior to use of restraint or seclusion are consistently recorded as the same broad categories of "verbal intervention" or "redirection." While some staff take the time to describe the ways staff attempted to engage the patient to redirect or de-escalate prior to initiating a restraint, there are many UORs that do not clearly show active efforts to avoid restraint. It's possible that having staff with first-hand knowledge of what happened complete the documentation will allow for more detailed descriptions of active efforts to use less restrictive means. API should require that the supervisor reviewing the UOR check for detailed/descriptive information when they review the UOR and follow up with the author if necessary.

UOR documentation frequently did not clearly indicate the duration of a restraint or a seclusion. It could often be determined by reviewing the more extensive medical chart, but this reduces the value of UORs as a data and management tool. API should require that the supervisor reviewing the UOR check to ensure that duration is clearly included in the medical documentation.

The Ombudsman recognizes that the documentation required of health care practitioners – especially at API – is extremely burdensome. The time required to comply with documentation requirements is time taken away from patients. There could be opportunities to streamline the UOR documentation and reporting at API while at the same time improving the accuracy and value of the information collected.

DHSS accepted this recommendation. API staff began training on "proper and consistent processes of documenting the UORS accurately and timely" on March 4, 2019.[19] "This includes noting the timing of each seclusion and restraint event."[20] A new Nursing Shift Report was implemented March 4, 2019 and staff were trained on "the importance of ensuring the information from the UORs aligns with the Nursing Shift Report."[21] Nursing staff have been designated to resolve discrepancies between medical documentation, Nursing Shift Reports, and UORs.[22]

Recommendation 5: API should provide a clear explanation, in plain language, to all staff of the hospital restraint policy.

In his report on workplace safety and the environment at API, attorney Bill Evans stated:

> "The largest single issue impacting the overall work environment at API is the significant cultural divide that exists surrounding the issue of patient safety versus staff safety."[23]

[19] DHSS Response at 3-4.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] "Non-Confidential Public Report of Alaska Psychiatric Institute Investigation," Williams Evans, J.D. (September 7, 2018) at 4.

He explained that "a large segment of staff" at API believe that oversight and enforcement of regulations related to use of seclusion and restraint have the effect of "reducing staff's ability to maintain safe control of the units."[24] This "cultural divide . . . permeates nearly all aspects of the workplace," which contributes to safety concerns in the hospital.[25] The Ombudsman's investigation corroborates the findings made by Mr. Evans.

API policies and procedures, primarily SC-030.02.01, clearly prevent punitive use of restraint and limit use of restraint to situations posing "a clear and significant risk to the patient or others." However, staff interviews reflect a pervasive opinion that patients need to "submit" to staff authority, that patients are dangerous and need to be controlled, and that patients must experience consequences for failing to do as staff direct. Review of UORs related to use of restraint in 2018 showed that restraint is sometimes used as a consequence for negative behavior that does not rise to the required level of creating an immediate or imminent risk of physical harm to self or others. There were also instances documented where restraint was used as a behavior management tool.

API should work with all staff to establish a shared understanding of what 42 CFR §482.13(e) requires. Staff should have a shared understanding of what constitutes a risk to the "immediate physical safety of the patient, a staff member, or others" so that patients are treated equitably and consistently throughout the hospital (and not depending upon who is working in what unit).

The Ombudsman understands that many, if not all, staff at API have experienced trauma at work. It is reasonable that some staff may interpret patient behaviors differently, and that what may feel threatening or unsafe to one member of staff may not be interpreted the same way by others. API should empower and equip supervisors to make decisions about the immediacy of the risk of harm based on as objective criteria as possible – while still allowing for professional discretion to assess and respond to crisis situations.

API unit managers should also ensure that responses to frequent or repeated patient behavior are consistent across shifts (i.e. behavior that day shift ignores should not result in seclusion during

[24] *Id.*
[25] *Id.* at 6.

night shift). The disparities between day shift operations and night/weekend shift operations were highlighted by floor staff as well as management. Communication at shift change is compromised when staff leave early or arrive late. Some night and weekend shift report a lack of respect for their work, being treated as "babysitters" while day shift staff are health care providers.

The Ombudsman considered making a recommendation related to chemical restraint. However, API health care practitioners explained that even medications delivered properly in response to patient crisis could be considered "chemical restraint." Given the nuances and clinical ramifications of involuntary psychiatric medications, and the fact that involuntary medication is subject to judicial oversight, the Ombudsman believes that her concerns about the incident noted above can be addressed by API ensuring that all staff understand that no form of restraint – chemical or otherwise – can be used to punish a patient.

DHSS accepted this recommendation. DHSS reported that the restraint and seclusion policies had been reviewed, with revisions to be complete by March 15, 2019.[26] "Once the revised policy is approved and published, all staff will be trained and provided a detailed and clear explanation of the policy," by March 30, 2019.[27]

Recommendation 6: API should work collaboratively with staff to mitigate and prevent challenging staff behaviors. Staff behaviors directly contribute to the patient behaviors. When staff engage in rude, dismissive, fearful, or negative behavior, that creates a barrier to effective treatment and milieu management.

DHSS accepted this recommendation. DHSS reported that API policies governing staff conduct toward patients had been reviewed, with revisions to be complete by March 15, 2019.[28] "Once the revised policy is approved and published, all staff will be trained and provided a detailed and clear

[26] DHSS Response at 4.
[27] *Id.*
[28] *Id.*

explanation of the policy."[29] Training on the API Ethics Policy will be provided by March 30, 2019.[30]

Communication

API should prioritize open, direct, honest, and transparent communication with staff. All staff interviewed commented on the lack of trust in management because they felt that either information was being kept from them, or the information they received was incomplete or inaccurate. When implementing changes in practice or policy, API must provide information that is timely, accurate, and easily understood. API must also encourage and respond in good faith to feedback from staff. There is a pervasive lack of confidence that feedback will be received without retribution, or that any helpful action will be taken in response. It will take time, and the rebuilding of trust, to establish effective lines of communication between staff and management, but this is essential to change management and improving the efficacy of the mental health treatment provided.

DHSS responded that API hospital management and nursing leadership have developed a "plan of action" to improve the frequency and transparency of communications with staff.[31] DHSS committed to implement a significant change in how information is shared with API staff:

> Effective immediately, the facility leadership will communicate all issues related to survey outcomes and corrective action plans to nurse managers and staff I a timely manner and will work in close collaboration with the department staff to address any corrective actions/issue resolution, including requesting staff's input into the applicable process or policies revision.[32]

Equitable Treatment

Many staff reported a long history of favoritism in the way nursing staff were managed. API has made efforts to address that issue, and to treat staff more equitably. API should maintain its commitment to

[29] *Id.*
[30] *Id.*
[31] *Id.* at 4-5.
[32] *Id.* at 5.

fair dealing and consistent management of all staff, while also improving communication within the hospital.

DHSS responded that "API Leadership will adhere to the "open-door" policy to promote confidence in staff communications with supervisors.[33] DHSS provided no comments related to the recommendation to ensure fair dealing and consistent personnel management.

Perpetual Learning

Most direct care staff interviewed reported that education was a "punishment" for when staff made a mistake. None of the direct care staff interviewed commented positively about the continuing education or training received after their initial onboarding. It appeared, however, that this was less about the quality of the education and more because hospital education was seen as remedial rather than as professional development. API should consider working toward creating an attitude of perpetual learning in the hospital, building upon the Alaska Psychology Internship Consortium (AK-PIC) and University of Washington WWAMI multi-state medical education programs.

DHSS provided no comments related to changing the dynamics or attitudes related to training and continuing education for API staff.

Staff to Strengths

As with any organization, API has staff with particular skills and aptitudes that allow them to work more effectively with some types of patients, or in some kinds of settings, than in others. API should establish staffing practices that assign PNAs and nurses to units based on their strengths, rather than their availability. API should also be willing to reassign staff to maximize their strengths. This would enhance the consistency of care in each unit, by allowing staff to complement each other's skills and experience and to develop a team dynamic. Staffing according to PNAs' and nurses' strengths will

[33] *Id.*

also reduce the number of incidents where staff over-react to or exacerbate patients' behaviors, leading to episodes of violence and/or the need for restraint or seclusion.

DHSS committed to implementing this recommendation:

> API will adopt the strategy of staffing the units according to individual staff member's strengths rather than availability, to promote unit cohesiveness and a team dynamic. The Human Resources department will be tasked with initiating this process beginning 4/1/2019. Wellpath is currently evaluating this specific issue at API and will submit a plan in accordance with their contract.[34]

Immediate Accountability and Kudos

API clinical managers, Quality Assurance, Human Resources, and Hospital Education should work together to identify and respond to problematic staff behaviors as quickly as possible, and preferably before the behaviors become too challenging. By identifying early-on areas where a staff person is not following policy or best practice, and then offering coaching and education (rather than discipline), API is more likely to prevent bad habits from becoming ingrained.

API clinical managers, Quality Assurance, Human Resources, and Hospital Education should work together to identify and recognize when staff perform well, especially in difficult situations. This should also be done as quickly as possible. It not only reinforces the positive employee behavior but creates incentives for continued improvement by the staff at issue and their peers.

API should establish procedures for staff "kudos." Many staff spoke of how meaningful it was when the former medical director sent a handwritten note of appreciation to staff by mail to their home. Those notes, often accompanied by a pin or other token, were valued by PNAs and nurses and provided the support they needed when the days were especially hard.

DHSS committed to implementing this recommendation: "API will implement a hospital-wide Employee Recognition Program" that includes monthly, quarterly, and annual events to recognize

[34] *Id.* at 5.

"staff who perform well, especially in challenging situations."[35] The Ombudsman appreciates this response, while noting that the positive reinforcement that API staff reported was most effective was the personal and direct communication from leadership (rather than an employee-of-the-month type of recognition).

Recommendation 7: API should continue to recruit and retain high quality health care professionals, ensuring that the staffing at the hospital is sufficient to provide effective inpatient psychiatric care even when the hospital is at full capacity (80).

Recommendation 7.1: The API Human Resources Department should be autonomous, not subject to the centralized recruitment and hiring processes coordinated through the Department of Administration.

There are no dedicated resources at DHSS or the Department of Administration for the human resources needs of API. API currently shares an off-site human resources consultant at DHSS with the Alaska Pioneer Home. The human resources consultant is not supervised by or accountable to API management. API managers only have access to the consultant Monday-Thursday 8:00 a.m. - 4:30 p.m. While that may be reasonable for most state agencies, it does not meet the needs of a 24/7 acute psychiatric hospital.

Based on interviews with DHSS leadership in 2018 and API staff, it appears that the extensive recruitment and other human resources demands of the state psychiatric hospital have not been recognized by previous Administrations. API has been subject to hiring freezes and furlough requirements, even though it is required to provide critical hospital services to acutely ill patients all day, every day.

Funding for additional nursing positions at API was available July 1, 2018. Negotiations with the union and approval of the pay raises for nurses took several months, and recruitment for those positions could not begin until September 2018. The Ombudsman recognizes that some of the delays

[35] DHSS Response at 5.

in hiring the additional staff funded in FY19 were outside of API's control. Unlike some other critical service agencies, API did not receive a specific waiver from the hiring freeze during Governor Walker's Administration.[36] Negotiations with the Department of Administration and the labor union over pay raises and bonuses complicated the already sluggish state hiring process.

Governor Walker and then Commissioner Valerie Davidson activated the Emergency Operations Center (EOC) to address the lack of treatment capacity at API on October 13, 2018. This EOC included a focus on staffing needs at the hospital. Pursuant to the EOC declaration, the Division of Behavioral Health assigned an additional 15 staff hours/week to API on November 5, 2018 to support hiring activities.[37] API anticipated hiring ten (10) new PNAs in November and December 2018.[38]

However, it appears that API's human resources demands are still not receiving the priority attention required. A classification study for the psychology positions at API was requested more than two (2) years ago but has not started. The PNA position classification study that the Department of Administration was to have completed by December 2018 has not been provided to API. The nursing position classification study was supposed to be completed by the end of February or early March 2019. The nursing salary review begun in FY18 is still not completed.

The Ombudsman understands that the Department of Administration does not have unlimited resources and must provide human resources services to many state agencies. For this reason, API should have an autonomous, on-site Human Resources Department that is directly accountable to the hospital CEO and the API governing body. At a minimum, API should have a Human Resources Director; a consultant focused on staff grievances and labor relations; a consultant focused on workplace injury, medical leave, etc.; two (2) consultants dedicated to performance improvement and disciplinary matters; two (2) recruitment and hiring staff; one (1) position dedicated to staff background checks, preparing human resources records for surveys and audits, and reporting to licensing boards; a payroll clerk; and an administrative assistant.

[36] *See* Memorandum from Chief of Staff Jim Whitaker to All Commissioners, August 24, 2016 re: Hiring Restrictions.
[37] *See* DHSS Incident Action Plan, November 9, 2018 at 4.
[38] *See* DHSS Incident Action Plan, November 9, 2018 at 4.

DHSS declined to implement this recommendation, but noted that "all vacant clinical positions are being recruited."[39] The Ombudsman maintains this recommendation, based upon inability of the current human resources structure to respond to the recruitment, retention, and performance management needs of API in a timely or comprehensive manner.

Recommendation 7.2: API should prioritize recruiting and maintaining the health care workforce needed to provide treatment to all patients committed to API.

API lacks the psychiatrists needed to provide care to 80 patients. There are only three (3) psychiatrists on staff currently. One physician serves as medical director and psychiatric director – and carries a patient load. This is not tenable in the long-term. Reliance on *locum tenens* (temporary, traveling) physicians is not cost-effective – and it reduces the continuity of care for API patients. API has three (3) physician assistants (all working under the medical director's supervision). API has two (2) experienced advanced nurse practitioners, and one nurse practitioner working under supervision. API also lacks sufficient forensic psychology staff to meet the demand for assessments for competency and restoration, which has created a months-long backlog.[40]

In August 2018, API determined what staff the hospital would need to correct the deficiencies identified by CMS surveys:

- 3 social workers
- 4 forensic psychologists
- 2 psychologists
- 1 advanced nurse practitioner
- 1 occupational therapist
- 5 recreational therapists
- 3 substance use disorder counselors
- 34 PNA II
- 14 PNA IV
- 9 maintenance/environmental services journey-level staff
- 1 accounting technician
- 1 administrative officer
- 2 office assistants

[39] DHSS Response at 6.
[40] The Ombudsman reserves the issue of seriously mentally ill criminally defendants spending months in Alaska's prisons while they wait for a competency and restoration assessment for future investigation.

The cost associated with expanding API's therapeutic and support staff to meet the needs of patients was estimated to be $7.056m per year.

DHSS's response to this recommendation is that it "concurs," but provided no comment related to whether and how the Department plans to secure the additional health care professionals and support staffing identified by API as necessary to meet the needs of patients and to address the deficiencies identified by HCFLC and the Ombudsman:

> The Department concurs and has prioritized recruitment and training for a safe work environment to increase staff retention. Training staff with tools that work and giving them confidence in their ability to appropriately modify patient behavior is key to retention. Wellpath has instituted a true Root Cause Analysis process for every incident and involves all staff in the process. This has proven to be immediately effective in engaging staff and giving them a new way to approach difficult situations.[41]

The Ombudsman maintains the recommendation that DHSS ensure that API has adequate psychiatrists, psychologists, therapists, nurses, and psychiatric nursing assistants to safely and effectively provide psychiatric treatment to patients.

Recommendation 7.3: API should commission a classification study, preferably by an expert in psychiatric inpatient hospital staffing, to ensure the PNA series accurately reflects the extensive expectations placed upon PNAs for the direct care and treatment of patients. The Ombudsman understands that the Department of Administration has undertaken a classification study of the PNA series, but it has not been provided to API as of the date of this writing.

Based on the investigation and many interviews with PNA and nursing staff, it is clear that **PNAs bear the greatest responsibility for patients' care,** and often spend the most time with patients while they are undergoing treatment at API. However, the skills and experience required for an entry level PNA are simply a high school diploma or GED. No knowledge or training related to mental health or health care is required.

[41] DHSS Response at 6.

Comments from some members of API management to the Ombudsman during the investigation indicated a lack of respect for the work PNAs do. This lack of respect is also reflected in the compensation afforded to PNAs. A PNA I is a range 9 – a starting salary of $2,678/month. A PNA IV is a range 14 – a starting salary of $3,644/month. A classification study by an expert in hospital staffing and management will provide the opportunity to align the work PNAs are asked to perform every day to the position description, requirements, and compensation.

DHSS declined to implement this recommendation, citing the pending classification studies at the Department of Administration.[42] Given the evidence that API's human resources needs have not been prioritized by the Department of Administration in the past, and that the PNAs provide a specialized health care service within a unique environment in the state system, the Ombudsman maintains the recommendation that the Department pursue reclassification by an organization with expertise in hospital management to better align the qualifications and compensation of the PNA series.

Recommendation 7.4: API should implement a mentoring program for new hires, matching new employees with experienced staff (who have demonstrated high levels of proficiency and adherence to best practices) for a meaningful period of time.

DHSS committed to implement this recommendation: "API Hospital Education and Human Resources . . . will ensure the formal mentorship and competency evaluation program for PNAs is implemented by May 1, 2019."[43]

Recommendation 7.5: API should expand the Recovery Support Services Department to provide adequate peer support, patient advocacy, and patient grievance services, including evenings and weekends.

The Recovery Support Services Department is currently staffed by one (1) manager and one (1) peer support specialist. The peer support specialist reports spending most of his time on patient grievances and administrative tasks, rather than providing peer support and advocacy to patients. There are no

[42] *See* DHSS Response at 6.
[43] *Id.*

peer support resources available to patients admitted on weekends or evenings, which means that nursing staff lack a critical resource for making admissions less traumatic for patients. Peer support and advocacy should be available to patients beyond just the usual Monday-Friday business day.

The volume of patient grievances is substantial, and API has been cited by CMS for failure to process and respond to grievances timely. Not only is it essential that API respond to these grievances according to law and policy – patient feedback is an invaluable source of information about the day-to-day effectiveness of the services API provides. Grievances are a valuable source of information to API as it seeks to resolve deficiencies and improve services. Thus, having at least one member of staff dedicated to processing and responding to patient grievances, and tracking them through the higher levels of resolution, is critical.

DHSS accepted this recommendation, responding that "API is committed to expanding its Recovery Support program services" and has the "goal of having services available to patients 7 days a week."[44] DHSS also responded that "the patient advocate will be appointed as the responsible party for addressing all patient grievances and complaints"[45] – which is already a responsibility of the two staff in the Recovery Support Services Department.

Recommendation 8: API should expand active treatment delivered to patients until a significant portion of the day, including weekends, involves evidence-based psychiatric and behavioral health care.

When the Ombudsman initiated the investigation, active treatment was not being delivered consistently every day on the units. While school/education services are provided on the Chilkat Unit during the school year, they are not offered in the summer – leaving long periods of unoccupied time for patients.

API has long had a treatment model of acute care and stabilization. However, API does not currently deliver the active treatment services needed to address the intensive needs of the most acutely

[44] *Id.*
[45] *Id.*

mentally ill. API should have staff on-site with the skills, experience, resources, and supplies needed to offer active treatment appropriate to address the specific symptoms and needs of patients Monday through Friday and on weekends. There should also be clinical staff (a psychologist or other mental health professional) available until 7:00 p.m. to support staff on the units when responding to challenging or crisis situations.

DHSS accepted this recommendation and committed to presenting a proposal for "a revised, more vigorous treatment module program" by May 1, 2019.[46] DHSS pointed to the active treatment model being introduced by Wellpath that includes "six hours of active therapy a day per patient."[47]

Recommendation 9: API should fully implement individualized treatment plans, developed by a multidisciplinary team in partnership with the patient, and should ensure that treatment plans are modified appropriately based on patient progress or lack of progress and the observations of all staff engaged in the patient's care.

API reportedly has an excellent treatment planning tool. However, too often patients are given "cookie cutter" treatment plans developed by one member of a treatment team with little input from the patient or the staff who engage most directly with the patient. API should define the multidisciplinary treatment team to specifically include the patient's primary care provider, psychiatrist, licensed psychologist, recreational or other rehabilitative therapist, licensed independent practitioner, social work discharge planner, and teacher (if an adolescent). Hospital Education should also have a representative at treatment team meetings, so that any training or continuing education resources needed can be identified and delivered.

DHSS accepted this recommendation and committed to providing training to API staff on individualized treatment planning in March 2019.[48] After the delivery of this training, API will review a sample of 20% of all treatment plans each month to ensure "they include the patient's perspective,

[46] *Id.* at 7.
[47] *Id.*
[48] DHSS Response at 7.

observations from staff who work with the patient, and indications regarding progress."[49] Treatment teams will receive additional training if their treatment plans do not meet expectations.[50]

Recommendation 9.1: API should require face-to-face meetings of the full multidisciplinary treatment team, with the patient, each week and whenever a significant change occurs in the patient's symptoms or behavior.

DHSS responded that "staff will be encouraged to increase the number of disciplines" who meet with patients to develop and update their treatment plans.[51]

Recommendation 9.2: API should require than a PNA IV familiar with the patient and their care and progress (and preferably who has established a rapport with the patient) to be part of the patient's multidisciplinary treatment team. The PNA IV should be included on all treatment team meetings. API reported that PNAs are now being included in treatment team meetings, which the Ombudsman appreciates. However, the Ombudsman notes that this recommendation was also made by the Alaska Mental Health Board in 1998 but wasn't implemented until 2000.[52] The practice fell away sometime after the current hospital opened. Thus, the Ombudsman has maintained the recommendation to ensure that recent inclusion of PNAs on treatment teams continues.

DHSS committed to include a PNA familiar with the patient at each treatment team meeting, and to confirm participation through review of treatment plans and documentation.[53]

Recommendation 10: API should make Hospital Education an independent department within the hospital, with the director becoming part of the senior management team and the addition of educator positions sufficient to onboard and support the large number of new hires needed in 2019-2020.

---

[49] *Id.*
[50] *See id.*
[51] *Id.*
[52] *See Alaska Psychiatric Institute, FY 2000 Review,* Alaska Mental Health Board Program Evaluation and Review Committee (February 16, 2000) at 25.
[53] *See* DHSS Response at 7.

Hospital Education is a crucial part of API, ensuring that staff have the education, training, and tools they need to effectively deliver services. In the past two years, Hospital Education has moved from the Nursing Department to Quality Assurance, only to be suddenly and without notice moved back to the Nursing Department in the summer of 2018. Hospital Education is responsible for significant duties related to Quality Assurance, even after being moved out of that department. This creates a conflict of interest between the goals of the Nursing Department and Hospital Education.

Hospital Education plays a pivotal role in the implementation not only of the Ombudsman's recommendations, but the changes identified by API in successive Plans of Correction. Hospital Education must have the authority and resources it needs to achieve API's goals for staff training and continuing education.

DHSS accepted this recommendation, reporting that the Hospital Education Department "was already transitioned to be independent from the Nursing Department in mid-February [2019]" and that a "Hospital Education representative" is participating on the senior management team, quality assurance committee, and safety "huddle."[54] DHSS did not provide comment on the need for additional educator resources in the Hospital Education Department, but did note that Wellpath has provided the opportunity for additional staff training.[55]

Recommendation 11: API should provide trauma-informed supervision, support, and on-site counseling for staff.

DHSS contracted with attorney Bill Evans to review issues related to staff safety at API, which is why this issue was not investigated by the Ombudsman. However, the fear and trauma reported by most if not all staff interviewed at length by the Ombudsman is a contributing factor to the episodes of violence, restraint, and seclusion at API – because staff are responding in ways affected by their own past traumatic experiences at API.

[54] *Id.*
[55] *See id.*

While there is a great deal of research and evaluation related to providing trauma-informed care, there are few resources available to supervisors who manage highly traumatized staff. API should work with Hospital Education to identify evidence- and practice-based resources for supervisors (or potentially develop resources with Alaskan experts) so that they can better manage and support staff before, during, and after crisis situations.

Staff expressed a desire for access to confidential resources, such as a trained chaplain or counselor, at API to help process stress and trauma experienced at work. This could potentially be done in partnership with CISM-trained[56] chaplains from the Alaska Police and Fire Chaplains, or the Anchorage area emergency responder chaplains, or the Employee Assistance Program offered to state employees to offer on-site debriefs and individual counseling.

DHSS did not accept this recommendation. DHSS responded that "API staff received training in trauma-informed care" but did not address the need to provide resources and training to supervisors of staff experiencing primary or secondary trauma.[57] DHSS also responded that "staff who experience stress and trauma at work will be referred to the Employee Assistance Program effective immediately."[58] This is the minimum response of an employer after a major critical incident (like a natural disaster) or a member of staff is harmed. DHSS offered that API staff needing support could also contact Dr. Kevin Ann Huckshorn, a consultant working for or with Wellpath.[59] The Ombudsman maintains the recommendation to have confidential on-site counseling and support resources available for staff experiencing stress and/or trauma.

Conclusion

The Ombudsman is grateful for the honesty, transparency, and cooperation of API and DHSS staff involved in this investigation. The Ombudsman and her staff had the opportunity to speak at length

[56] Critical Incident Stress Management is an evidence-based model of debriefing and supporting individuals after a traumatic event. It is a short-term, time-limited intervention delivered soon after a traumatic event (suicide, workplace shooting, natural disaster, etc.) to assist people in understanding their emotions and reactions to the event and connecting them to additional supports and services if needed.
[57] DHSS Response at 8.
[58] *Id.*
[59] *See id.*

with API administrators, managers, doctors, psychologists, social workers nurses, psychiatric nursing assistants, advocates, and patients. Every member of staff interviewed spoke not just about the problems and deficits at API, but also about assets present at API. Each person interviewed identified a colleague they felt like provided good care to patients or strong support for staff. In their own ways, each expressed hope for the hospital's future. Not all staff have the same vision for the hospital, nor do they share the same perspectives on patient care, but staff do share common goals and values that could help API implement the recommendations made to overcome the systemic issues identified by this investigation.