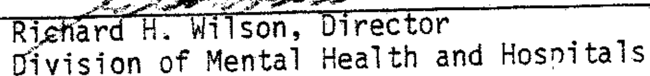
DIVISION OF MENTAL HEALTH AND HOSPITALS

Administrative Bulletin Transmittal Memorandum No. 41

April 18, 1983

SUBJECT: Administrative Bulletin 9:04
Sequence and Procedures for Program Reviews of Licensed Psychiatric Hospitals: County Psychiatric Hospitals, Private Psychiatric Hospitals and UMDNJ - CMHC (Piscataway)

This Administrative Bulletin standardizes and clarifies the procedures for program reviews of licensed county and private psychiatric hospitals and the University of Medicine and Dentistry - Community Mental Health Center at Piscataway.



Richard H. Wilson, Director
Division of Mental Health and Hospitals

RW:PK:er

DIVISION OF MENTAL HEALTH AND HOSPITALS

ADMINISTRATIVE BULLETIN 9:04

DATE: April 18, 1983

SUBJECT: Sequence and Procedures for Program Reviews of Licensed Psychiatric Hospitals: County Psychiatric Hospitals, Private Psychiatric Hospitals and UMDNJ - CMHC (Piscataway)
Applicability: C, CO

I. Purpose

To clarify and standardize the procedures for program reviews in order to provide useful reports on a timely basis for program accountability and to provide an inspection report with recommendations to the New Jersey Department of Health for licensing.

II. Authority

N.J.S.A. 30:1-15, et seq.

III. Implementation

A. Pre-Site Sequences and Procedures

1. Development of Priorities

All licensed psychiatric hospitals shall be reviewed between three and six months prior to the expiration of their licenses.

2. Preparation for Scheduling (60+ days)

a. At least 60 days prior to any proposed reviews, the Coordinator, Bureau of Standards & Inspections, will prepare a schedule of site reviews for the subsequent quarter based on:

(1) Hospital license expiration dates; and

(2) Scheduling constraints.

b. The Coordinator will notify the Office of Community Services and the County Mental Health Administrators, who will have seven calendar days in which to respond to the proposed schedule.

3. Scheduling (60 days)

   At least 60 days prior to a scheduled review, the Coordinator, Bureau of Standards and Inspections, or a designee, will telephone the hospital director to provide him/her with the date(s) of the review.

4. Confirmation of Scheduled Review (60+ days)

   a. At least 60 days prior to the review, a mailing will be sent to the hospital which will:

      (1) Describe the scope and purpose of the program review and survey procedures;

      (2) Describe procedures for reviewing client/patient records, observing programs, conducting staff interviews; and

      (3) Describe the standard team composition (see Attachment A).

   (b) The Pre-site Questionnaire will be enclosed, with instructions that it is to be completed and returned to the Bureau of Standards and Inspections on a specified date (four weeks prior to the review).

5. All needed consultants will be contacted by the Coordinator, Bureau of Standards and Inspections, or designee, to schedule services for the review.

6. Review Team Selection and Composition (40 days)

   At least 40 days prior to the review, the review team will be selected as per Attachment A. The team leader and all team members will be notified of the review and the pre-site meeting. Team members will also be advised regarding their specific responsibilities. The referral agency questionnaires (see Attachment B) will be mailed to the County Mental Health Administrator with the notification of the review. <u>All team members must attend the scheduled pre-site meeting</u>. There is generally no guest or observer status for any review.

7. Pre-Site Data Collection (30 days)

   a. Notification of the review and a request for information on issues will be sent to the following staff of the Division of Mental Health and Hospitals: Assistant Directors, Grants and/or Contract Administrator(s), Bureau of Research and Evaluation, Bureau of Information Systems, Services to Children/Elderly, Technical Assistance Unit, Office of Planning, Administrator, Office of Community Services, Regional Coordinator and Program Analyst.

b. These staff will be responsible for notifying the Bureau of Standards and Inspections of any outstanding issues regarding the hospital in the areas of inter-agency systems development, fiscal or program operations or any pertinent incidents affecting client/patient care or rights.

c. The Bureau of Information Systems is responsible for reviewing the hospital's compliance with Unified Services Transaction Form (USTF) requirements, Level of Functioning (LOF) documentation and the Admission/Discharge notification system. In addition, the Bureau will provide statistical information regarding target groups, length of stay and other regional, demographic and service information.

8. Team Member Responsibilities

a. All team members should prepare a list of issues and mail it to the team leader one month prior to the review. They must also review the Pre-site Questionnaire, attend the pre-site meeting, prepare to attend all scheduled days of the review (approximately 9am-4pm plus travel time), assume writing responsibility assigned by the team leader, and, during the review, prepare written drafts in accordance with writing assignments. Initial drafts will be edited by the Bureau of Standards and Inspections with reviews by team members. Written findings for assigned sections must contain recommendations validated by documentation and/or specific observations.

b. The team leader shall summarize and present previous hospital site review reports. Special attention should be paid to complete resolution of previous division and JCAH identified deficiencies. Unresolved issues must be explained and documented at the review. The team leader shall also review responses to intra-divisional requests for information about the subject hospital, and determine surveyor access to confidential clinical records.

c. The County Mental Health Administrator should present findings of the referral agency interviews which must be completed prior to the pre-site meeting (see Section A9). (Not required for private psychiatric hospitals.)

d. Program Analyst(s) shall review affiliation agreements and Office of Community Services correspondence files as necessary. (Not required for private psychiatric hospitals.)

e. The Regional Coordinator and Program Analyst shall submit a list of problem issues to the team leader. This should include, but not be limited to, compliance with the Rules and Regulations and previous JCAH and DMH&H recommendations. This must be submitted at least one month prior to the review.

9. Referral Agency Interviews

a. Interviews with referral agencies are the responsibility of the County Mental Health Administrator. They shall be scheduled at least 30 days prior to the review and should be completed before the pre-site meeting (see Attachment B).

b. In preparation for the review, the County Mental Health Administrator should interview at least six referral agencies including emergency/screening providers, designated liaison agencies, ambulance/rescue squads and police. The completed forms, including the agency name, name of person interviewed, and date of the interview, should be brought to the pre-site meeting along with a summary of the findings which identifies any difficulties with, or recommendations for, the hospital to be reviewed. (Not required for private psychiatric hospitals.)

10. Preparation for the Pre-Site Team Conference

At least three weeks prior to the review, the team leader shall:

a. Distribute the completed pre-site document to all team members who will review the document prior to the pre-site meeting.

b. Mail a tentative survey agenda to the hospital. The survey team participants and their positions or affiliations should be clearly indicated.

11. Pre-Site Team Conference (7 days)

The pre-site team conference will be conducted by the team leader. All team members must attend. The pre-site questionnaire, the identified issues and any outstanding recommendations from the last review will be carefully reviewed. The team leader will review the list of relevant issues. Additionally, individual team members will present general areas of concern regarding the subject hospital, including measures of the hospital's performance and problems indicated in the pre-site material, as per item A9. The team leader will review the tentative agenda and assign to the members their survey and writing responsibilities.

12. Additional Instructions to Surveyors

    a. As a condition of participation in a survey conducted by the Bureau of Standards and Inspections, all members of the review team are subject to the direction of the team leader regardless of formal employment relationships.

    b. All team members are required to accept survey and report assignments. Such assignments will be determined and assigned in advance of the survey according to individual expertise and the needs of the site review process. Assignments are generally identified at the pre-site meeting but may be amended during the survey by the team leader with the agreement of the team member.

    c. As a precondition to participating in a review conducted by the Bureau of Standards and Inspections, all team members must be present for the entire review period with the exception of special consultants chosen to review specific programs, e.g., pharmacist, sanitarian and dietician. Reviews are scheduled sufficiently in advance to permit individuals to identify potential scheduling conflicts to the team leader at least 30 days before the survey.

    d. Team members should familiarize themselves with standardized questionnaires and checklists for interviews, ward tours, etc. This will assure the smooth, efficient conduct of the survey process. The team leader is available for arranging or conducting in-service training for individuals unfamiliar with the procedures for onsite inspections, data collection and program evaluation.

B. <u>Onsite Protocol, Guidelines and Content</u>

1. Ward Tours

Ward tours will be conducted (see Attachment F). During these tours, surveyors will minimally address standards for patient safety, patient care, patient rights, appropriateness of service provided, the therapeutic environment, quality of staff-patient interaction and administrative internal controls for quality assurance and resource utilization. Staff and patients may be interviewed. The completed ward tour checklists will be copied and given to the Chief Executive Officer before the end of the review.

2. Review of Clinical Records

Surveyors will be assigned to review clinical records for compliance with standards for assessment, treatment planning, progress notes, discharge planning and justification of services provided. This review will begin with a check of the content and quality of the record using a check list provided by the Bureau of Standards and Inspections. It may extend to interviews and investigation of discharge planning and linkage with community agencies. The completed check list will be copied and given to the Chief Executive Officer before the end of the review. The original of all the check lists and a summary of the findings must be provided to the team leader before reconciliation.

3. Reporting of Deficiencies

In the event that a surveyor observes a deficiency or specific instance which may represent a potential danger to patients, it must be brought to the attention of the Chief Executive Officer immediately and to the Assistant Division Director for Program Evaluation within 24 hours. Written explanations must follow within five days and be copied to the Division Director.

4. Quality Assurance/Utilization Review

Surveyors will address the quality assurance/utilization review of the hospital through a review of the policies, procedures and committee minutes.

5. Reconciliation Meeting

This is a team meeting in which each surveyor's observations, data and resulting recommendations are discussed. Input by all team members will be obtained, and agreement reached, on final recommendations for summation.

6. Summation Conference

The scheduled Summation Conference should be attended by all team members, except consultants. At this conference, feedback will be provided to the hospital on major findings and recommendations by the review team. Specific emphasis will be given to special assessment and the status of compliance with each major requirement of JCAH, the Division of Mental Health & Hospitals and life safety codes.

C. Post Site-Review Report Preparation

1. Submission of reports by team members (0-2 days)

Within two working days of review completion, team members must submit written reports to the team leader. Complete and neatly handwritten reports are acceptable, while outlines or notes are unacceptable. Time will usually be set aside during the survey for report preparation. The report should be written in accordance with the standardized format for the assigned section as provided by the Bureau of Standards and Inspections.

2. Completion and Review of Draft Report

a. The first draft of the report shall be completed by the team leader within five working days of review completion.

b. The steps in report processing will be as follows:

(1) Editing by Bureau supervisors.

(2) Circulation of first draft for comments to all team members.

(3) Review of comments and development of second draft by team leader.

(4) Editing by Bureau supervisors.

(5) Circulation of second (final) draft for review by team members for errors in fact and/or interpretation. All comments shall be written in a memorandum under separate cover. This draft may be shared in confidence with Divisional Staff for verification of factual information.

(6) Preparation of final draft for submission to Word Processing within 50 days of review completion.

(7) Mailing of the complete report within 60 days of the last day of the review.

3. Completion & Signature Requirements of Final Report

County and private hospital survey reports will be signed by the Director, Division of Mental Health and Hospitals.

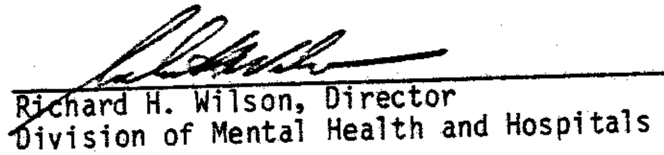
4. Dissemination of Report

Copies of the survey report will be sent to the Commissioner of Human Services, Commissioner of Health, Health Licensing, Hospital Director, County Mental Health Administrator and Regional Coordinator.

5. Response to Final Report

   a. Within 40 days after receipt of the survey report, the hospital must respond to the survey recommendations. The response must include current and future compliance plans. The hospital must furnish copies of this response to the original report recipients.

   b. 30 days after the report is received by the hospital, it will become a public document with the hospital's response attached. If no response is received, the report will become a public document without a response.



Richard H. Wilson, Director
Division of Mental Health and Hospitals

Attachment A
A.B. 9:04

Review Team Composition

Source of Surveyors	Hospitals	
	County	Private
Standards and Inspections	X	X
Office of Community Services Program Analyst	X	0
Community Mental Health Administrator	X	0

X = Required
0 = Optional

Attachment B
A.B. 9:04

INTERVIEW QUESTIONS FOR MENTAL HEALTH AGENCIES WHICH REFER TO STATE AND/OR COUNTY HOSPITALS

INSTRUCTIONS:

This questionnaire is to be completed prior to the pre-site meeting for State and county hospital reviews. The results of the interview should be reported at least verbally at that meeting and a written report provided by the conclusion of the site review.

It is strongly recommended that there be face-to-face interviews. Telephone contact will be accepted if face-to-face is not possible. The agencies who should be contacted for this information are:

1. The designated transitional provider in each service area.
2. The Emergency Service/Screening provider in each service area.
3. Some of the community inpatient facilities.
4. Selected municipal or other courts.*
5. Selected police departments.*

*If detainers and/or court referrals are a problem.

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1. a. Do you refer clients to this hospital? ____________

   b. How many clients were referred from your service area to this hospital during the last Month _____ Quarter _____ or Year _____?

   c. How many were referred directly by your agency? (without being seen by an emergency or screening agency in the community)?

   Month ________ Quarter __________ Year __________

2. a. Is this hospital receptive to your referrals? ____________

   b. What proportion of admissions, if any, have been rejected as inappropriate? ________

   c. Please explain reasons and actions taken by the hospital or bases for differences in recommendations about the necessity for hospitalization: ______________________________

   ____

11. a. Are you aware of any follow-up/linkage services for discharged clients provided by the hospital to your agency? ____________

Comment on the nature, extent and adequacy: ____________

____

b. Do they arrange appointments at your agency prior to discharge? ____________

12. a. Does your agency have primary responsibility for the liaison activities for this service area? ________ If not, who does?

____________ What is your relationship to

that agency? ____________

____

b. Do representatives of your agency provide regular liaison services to this hospital? ________

c. Explain how the liaison participates in discharge planning:

____

____

d. Are any other staff from your agency involved in discharged planning? ____________

e. Are there transportation problems? ____________ Explain: ____

____

f. Do the liaisons face barriers dealing with hospitalized clients? ______ Explain: ____________

____

g. Is the majority of liaison time spent in direct face-to-face contact with clients? ______ If not, where is it spent?

ISDP development ______ Team meeting__________ Records review________ Post discharge________ Activities__________

h. Comments on liaison responsibility:____________

____

Attachment C
A.B. 9:04

TO: Distribution List

FROM: ____________________, Coordinator
Bureau of Standards and Inspections

SUBJECT: Information for Site Review

A site review for ________________________________ is scheduled for ____________________.

Please forward information or identify significant issues or problems that should be considered in reviewing this hospital. This must be provided by ____________________ which is at least 30 days from this notification and one week prior to the pre-site meeting.

Thank you for your attention to this important procedure.

Distribution

Attachment D
A.B. 9:04

Scope and Purpose of the Review of Private Psychiatric Hospitals

These facilities are surveyed by the Division of Mental Health and Hospitals, Bureau of Standards and Inspections, in compliance with NJSA 30:1-5 et seq. The Division provides recommendations to the New Jersey State Department of Health for licensure.

The reviewers for private psychiatric hospitals will include representatives of the following sections of the Division of Mental Health and Hospitals:

Bureau of Standards and Inspections and
Office of Community Services
County Mental Health Board Administrator

The onsite process will include review of the physical facility, patient care, treatment planning, discharge planning, follow-up medical records, participation and integration in a system of unified mental health services, a review of policies, procedures, and client records. Interviews will be conducted with the administration, department/service heads and other staff. Program content will be reviewed and programs will be observed.

Attachment E
A.B. 9:04

Scope and Purpose of Review of County Psychiatric Hospitals

These facilities are reviewed annually by the Division of Mental Health and Hospitals, Bureau of Standards and Inspections. The survey is intended to be both evaluative and developmental. Recommendations are provided to the Commissioner of the Department of Health.

The onsite review of county psychiatric facilities may include representatives of the following:

Bureau of Standards and Inspections
Office of Community Services
County Mental Health Administrator

The onsite process will include review of the physical facility, patient care, treatment planning, discharge planning, follow-up, medical records, participation and integration in a system of unified mental health services plus a review of policies, procedures and client records. Interviews will be conducted with the administration, department/service heads and other staff. Program content will be reviewed and programs will be observed.

SP#200-278/324

Attachment F
A.B. 9:04

d:______ Surveyor:______ Date:______ Hospital:______

Standard	Rating	Standard	Rating	Standard	Rating	Standard	Rating	Standard	Rating

BATHROOMS

- Hot water temperature controls must be inaccessible to patients (35.50.1) ______
- In bathing areas non-ambulatory patients must have access to grab-bars, etc. (35.48) ______
- 1 toilet per 8 patients (HEW 7.2) ______
- 1 tub/shower per 12 patients (HEW 7.2) ______
- Toilets must have seats (36.15) ______
- Bathrooms and toilets must have privacy partitions (36.15) ______
- Ventilation must remove undesirable odors (36.7.2) ______
- Toiletries (soap/towels/toilet paper/toothpast) must be provided (36.15) ______
- Bathrooms must be clean/sanitary (inc. no mold or mildew) (36.1) ______

BEDROOMS/DORMITORIES

- In room housing 4 or more patients, furniture placement or partitions should provide privacty (36.14.1) ______
- No more than 8 patients can sleep in each room unless clinically justified in writing (36.14.3) ______
- Ample closet/drawer/lockable storage space must be provided (36.18.1) ______
- Patients must be allowed to personalize and decorate rooms (36.19) ______
- Patients encouraged to maintain their ...

OVERALL ENVIRONMENT

- The environment must be normalized and enhance the positive self image of patients (36.1) ______
- The unit must be accessible to the handicapped (36.3) ______
- A telephone must be available for private conversations (36.4) ______
- Mirrors that mini-distort must be provided (36.6.5) ______
- Clocks and calendars should be available (36.6.6) ______
- Ventilation must contribute to the habitability of the unit (36.7) ______
- Smoking rules must be enforced (35.63) ______
- Unit must be clean well maintained and free of vermin (36.1) ______
- Staff/patient interaction must be encouraged (36.10) ______
- The Bill of Rights must be posted. (14.5.1) ______

LIFE SAFETY

- Fire extinguishers must be inspected monthly. This must be documented (NCF 4.3.1) ______
- All exits must be clearly illuminated (life safety code 5-10.1.1) ______
- Fire drills must be at least held quarterly for each shift in each building (35.68) ______
- Stairways/egress must not be cluttered or obstructed (35.77)

MEDICATION ROOM

- Distrubution and administration of controlled drugs must be properly documented (29.3.1.4) ______
- An emergency kit must be available; contents must be listed and it must be inspected montly or after each use (29.3.1.6) ______
- All drugs must be kept in locked storage. Controlled drugs must be under double lock (29.30.1) ______
- Outdated drugs can not be stocked (29.3.11.3) ______
- Antidote charts and the regional phone poison control number must be posted (29.31.1 & 2) ______
- Metric weight and measure conversion charts must be posted (29.31.1) ______
- The policy and procedure manual must be available (4.1.5) ______
- Drugs requiring special conditions to assure stability must be stored accordingly (29.3.1.2) ______
- Self medication programs should be initiated when appropriate (29.9)

PATIENTS' APPEARANCE

- Clothing must be normalized (36.21.4) ______
- Good standards of personal hygiene and grooming (hair, teeth, nails) must be maintained (36.16) ______
- Clothing provided by the program must not be dehumanizing (36.21) ______
- Training and help in the selection and proper care of clothing must ...

ACTIVITIES

- Games, reading matter, arts and crafts materials must be available 36.25 ______
- An activities room, visiting area, quiet sitting area must be provided (36.11) ______
- Appropriate activities must be scheduled and posted days/evenings/weekends (36.11) ______
- Accurate/complete list of patients to attend (36.5.3) ______
- Patients must be encouraged to use leisure time appropriately (33.7) ______
- Patients should have access to the outdoors unless clinically contraindicated (36.28) ______
- Corridors can not be used as day rooms (36.11) ______

COMMENTS:

STORAGE AREAS

- Storage area, stairwells must be clean and uncluttered (35.77) ______
- The lowest shelves must be sealed to the floor or leave space underneath to facilitate cleaning (35.79) ______
- Sotred items must not obstruct fire detecting or extinguishing systems (36 inches) (35.80) ______
- Clean and dirty linen must be stored separately with minimum cross traffic (HEW 7.22) ______

Attachment G

Ward A.B. 9:04

Hospital Record Review

BS&I Rev. 8-8[illegible]

KEY: Y = Yes, N = No, P = Partial

	Pt. #	Pt. #
1. Identifying Data 15.1.6		
2. Referral Source 16.6		
3. Assessments 17.1		
a. Physical (24 hrs.) 17.2.1		
b. Medical History 17.2.1.2		
c. Medication History 17.2.1.2		
d. Substance Abuse 17.2.1.2		
4. Psychiatric/Psychological Eval 17.4		
a. History 17.4a		
b. Previous Treatment 17.4a		
5. Functional Assessment 17.4f		
a. Initial		
b. Revised Periodically		
6. Social Assessment 17.5		
a. Environmental		
b. Developmental		
c. Financial		
d. Social		
7. Vocational Status 17.8		
a. Vocational History 17.8a		
b. Educational History 17.8b		
8. Activities Assessment 17.6		
9. Initial Treatment Plan (72 hrs) 18.1.3		
10. Master Treatment Plan 18.1.3.2 (address fundamental needs)		
a. Multidisciplinary 18.1.3.2		
b. Services related to LOF 18.1.3.2		

	Pt. #	Pt. #
c. Services justified by goals 18.1.9.1		
d. Patient input 18.1.14		
e. Family involvement 18.1.15		
f. Long/short term goals 18.1.10		
g. Time framed goals 18.1.10		
h. Measurable Goals 18.1.10		
i. Specific Interventions		
j. Designated Staff Responsible		
k. Discharge Orientation		
11. Case Conferences 18.3		
a. Multidisciplinary 18.3		
b. Occurs regularly (3 mos.) 18.3.3		
c. Validated 18.3.1		
d. Justification for LOS every 6mo		
12. Restrictive Measures 19.1		
a. Justification sec./restraint 19.1		
b. MD sign. every 24 hrs. 19.2.5.1		
13. Progress Notes 18.2		
a. Describe clinical course 18.2		
b. Describe response to treatment 18.2e		
c. Address treatment goals 18.2a		
d. Non-subjective 18.2.2		
e. Multidisciplinary 18.2.6		
f. Reflect Advocacy Efforts		
14. Individual Discharge Plan 15.1.13		
a. Pt./Family Input 18.4.4		
b. Liaison Input		
c. Identify Aftercare Provider		
15. Consents		
a. For treatment 16.8a		
b. Release of information 15.2.8.2		
c. Signed Med. Fact Sheet 19.7c		

Put any comments on back of form