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**CENTER FOR SUBSTANCE ABUSE  
TREATMENT TECHNICAL ASSISTANCE  
QUALITY ASSURANCE SURVEY:  
DEPARTMENT OF SUBSTANCE ABUSE,  
BENJAMIN RUSH**

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## **I GENERAL INTRODUCTION**

The mission of this quality assurance survey was to describe and assess the quality of care delivered to a needy target population of alcohol and drug users served by the Benjamin Rush facility. Recommendations regarding how to measure and improve substance abuse treatment outcome were also developed, based on the knowledge of the survey team members related to substance abuse treatment, as well as analyses based on data gathered during the survey. In accordance with this mission, the survey team used a variety of methods to gather this data, which are described below.

A questionnaire was developed to measure the perceptions of nursing and other clinical staff in the areas of patient care delivery, staff education and professional development, job satisfaction, administrative and ancillary support. The questionnaire was tested for readability and validity, and was modified accordingly, based on expert opinion. A Likert scale was utilized for the major body of the questionnaire, however, fixed-alternative questions were used as well as open ended questions in order to elicit specific types of information as necessary for data collection.

Nonstructured interviews were held with all available staff members to explain the mission of the surveyors and the methods to be utilized to obtain data. Upon completion of the interviews, questionnaires were distributed to all categories of personnel, including medical, nursing, clerical, social services and supervisory/administrative personnel (see Appendix C). To assure anonymity, the questionnaires were independently completed by personnel, placed in an unmarked sealed envelope and deposited in a collection box provided and placed in a convenient area for staff access. They were then collected by a member of the survey team for data tabulation and analysis.

Criteria for a comprehensive evaluation of the patient care record were determined and checklist forms were developed to facilitate data collection of pertinent facts from both the medical and the nursing documentation (see Appendices A and B). Standard operations procedures serving as norms for this survey were abstracted from current literature relating to quality assurance methodology.<sup>1, 2</sup>

A statistical analysis of the effects of demographic factors associated with the population served by Benjamin Rush was obtained from records over a 37 month period prior to the survey. This analysis looked at length of stay and re-admission rates on all admissions over that time frame.

A representative sample for review was then selected and separate but concurrent medical and nursing reviews of these patient care records were conducted utilizing the checklists developed to collect and document data for tabulation and analysis.

Standards of care applying to patients undergoing detoxification can be found in medical texts relevant to addiction medicine<sup>3</sup> as well as more specialized works relevant to alcohol abuse and dependence.<sup>4, 5</sup>

Following is a report on the findings of the survey as outlined above with recommendations for continuation of current services as provided and recommendations for change and/or improvement as determined by the surveyors based on the information garnered from the statistical analysis of the target population which includes demographics, patient care record reviews (both medical and nursing), and item analysis of questionnaires returned.

## **II DEMOGRAPHIC SURVEY OF THE POPULATION SERVED**

The first section of the survey is a statistical analysis of the effects of demographic factors associated with the population served by Benjamin Rush. Data for the analysis was from MIS. The data was in the form of an ASCII file incorporating the data fields

present in the State of RI - Executive Department - Office of Substance Abuse Contract Compliance Unit Admission/Transfer and Discharge Forms. The time frame for the analysis was from 12/11/90 to 1/10/94. Over this period, there were 7976 admissions and 58329 bed-days of utilization. Utilization of the Benjamin Rush inpatient units was 100% over this period of time.

The first analysis describes the characteristics of the population served by Benjamin Rush. Because of re-admissions, this first analysis is broken into two parts. The first part examines all admissions to Benjamin Rush, so that patients are counted more than once if they are re-admitted over the period of time of three years. In the second part, the same analysis is performed, but only the patients' first admission contributes to LOS, so that all patients are only counted for one admission. Results of the first analysis are outlined in Table 1. Results of the second analysis are outlined in Table 2. Further demographic data is outlined as part of the general analyses.

Alcohol is the primary drug associated almost 70% of the utilization of the facility, followed by opiates as primary drug of abuse.

The second analyses examine the effects of demographic and substance abuse variables on length of stay (LOS) and number of readmissions. The statistics compiled below are taken from the first patient admission over the period of time. Length of stay is compared between patient groups. This was accomplished using a parametric analysis-of-covariance (ANCOVA) with the initial model containing the following factors: Gender, Race, Primary drug of abuse (PD), Secondary drug of abuse (SD), Tertiary drug of abuse (TD). Age at admission was included as a covariate. Residual analysis revealed that the variance increased with increasing LOS, so that data was analyzed using a square root transform of LOS. This initial model revealed a significant effect of PD, SD, and TD on LOS (all with  $p < 0.0001$ ). There was no effect of Gender x Age ( $p < 0.3139$ ) and Race x Gender ( $p < 0.3137$ ). Type III sum of squares was used for deriving ANCOVA parameters. The model was simplified by removing the interaction effects which did not contribute to an explanation of the variance. The ANCOVA calculated parameters are shown in Table 2

Table 1 LOS DATA BASED ON ALL ADMISSION OVER THREE YEARS

Primary Substance Abuse Diagnosis

	N	Mean	SEM	Bed-Days	%
Alcohol	6488	6.24	0.12	40485.12	69.41
Heroin	1257	12.37	0.18	15549.09	26.66
Cocaine	84	8.76	0.69	735.84	1.26
Benzodiazepines	48	11.19	0.98	537.12	0.92
Other opiates and Synthetics	40	12.45	1.27	498	0.85
Other tranquilizers	20	12	1.65	240	0.41
None	25	7.5	1.03	187.5	0.32
Barbiturates	5	8.4	2.69	42	0.07
Marijuana/Hashish	2	12.5	4.5	25	0.04
Non-Prescription Methadone	2	8.5	.5	17	0.03
Inhalants	2	7	•	7	0.01
Other Sedatives or Hypnotics	1	3	•	3	0.01
Other	1	30	•	1	0.00171
Over-the-counter	1	7	•	1	0.00171
Total	7976			58328.67	100%

- cannot be calculated
- %refers to bed-days
- SEM = Standard Error of the Mean

Table 2 ANCOVA TABLE -- LENGTH OF STAY BY PATIENT DEMOGRAPHICS

Source	df	Sum of Squares	Mean Square	F-Value	P-Value
Gender	1	2.952	2.952	6.366	0.0117
Race	5	13.731	2.746	5.923	0.0001
PD	13	61.115	4.701	10.14	0.0001
SD	14	13.910	0.994	2.143	0.0078
TD	15	2024.215	134.948	2.466	0.0089
Age	1	9.018	9.018	19.451	0.0001
PD x SD	33	30.952	0.938	2.203	0.005
Residual	3530	1636	0.464		

Dependent: LOS(days)

There is a significant effect of Gender, Race, Primary Drug, Secondary Drug, and Tertiary Drug, as well as an interaction effect between primary and secondary drug, and age on length of stay.. These effects are explored further in the following section. Using the ANCOVA parameters, we perform the following contrasts to check for statistically significant differences in LOS data by demographic parameter. This is required because the model contains a covariate (age) which needs to be taken into account.

Table 3 MEANS TABLE FOR GENDER EFFECT ON LENGTH OF STAY

	Count	Mean (Days)	Std. Error
M	2863	6.771	0.09
F	749	7.816*	0.195

\*significantly different from male at  $P < 0.0001$ .  
 Result: Women have a longer length of stay than men.

We use a similar procedure to determine the effect of race on LOS, the results are tabulated in Table 4.

Table 4 MEANS TABLE FOR RACE EFFECT ON LENGTH OF STAY

	Count	Mean (Days)	Std. Error
American Indian	9	8.889	3.944
Asian or Pacific Islander	6	5.167	.792
African-American (Black)	492	7.811*	.233
Cape Verdean	34	8.941	1.414
Caucasian (White)	2797	6.814	0.09
Other	274	7.015	0.283

\*significantly different from Caucasian and Other  $P < 0.005$

We conclude that African-Americans have a longer length of stay as compared to

Caucasians, even when variables such as differences in age and primary and secondary drug use are factored in.

The effect of the primary drug of abuse on LOS is shown in Table 5. Alcohol use is associated with the lowest LOS, whereas heroin use is associated with an increased LOS. The total of 3636 patients represents the number of **new** patients admitted to the facility over the period of time from 12/11/90 to 1/10/94. Since the total number of admissions over the same time period (see Table 1) was 7976, the difference between these two figures represents the number of patients who represented readmissions to the facility over that time period, namely 4330 patients. The total number of admissions may vary throughout the analysis by  $\pm 0.05\%$ , depending on what particular factors are being studied. This is due to a small number of cases where individual data fields are missing, but the number is small and does not effect any of the statistical analyses or conclusions.

Table 5 LOS DATA BASED ON FIRST ADMISSION ONLY OVER THREE YEARS

	N	Mean	SEM	Bed-Days	%
Alcohol	2775	5.65*	.07	15678.75	61.377
Heroin	680	11.79	.23	8017.2	31.385
Cocaine	65	8.23**	.77	534.95	2.094
Other opiates and Synthetics	40	12.45	1.27	498	1.95
Benzodiazepines	26	12.46	1.38	323.96	1.268
Other tranquilizers	22	11.86	1.68	260.92	1.021
None	17	7.65	1.39	130.05	.509
Other	1	30	•	30	.117
Marijuana/Hashish	2	12.5	4.5	25	.098
Barbiturates	4	6	1.58	24	.094
Non-Prescription Methadone	1	9	•	9	.035
Over-the-counter	1	7	•	7	.027
Inhalants	1	3	•	3	.012
Other Sedatives or Hypnotics	1	3	•	3	.012
Total	3636			25544.83	

•cannot be calculated

%refers to bed-days

SEM = Standard Error of the Mean

\*significantly different from Heroin, Cocaine, Opiates and Other Synthetics at  $p < 0.01$  (Games-Howell)

\*\*significantly different from Heroin at  $p < 0.01$  (Games-Howell)

Of interest is the relatively high number of alcohol using patients who use cocaine as a secondary drug. Nevertheless, it appears that the primary drug of abuse has the most impact on LOS, while secondary drug use does not significantly effect LOS.

There is a positive correlation between age and LOS, which is not unexpected, as older patients tend to have more comorbidities.

Analysis of re-admission rates was undertaken since it would provide another outcome measure based on a large sample size, where chronic users of the BR system would be identified by population group. Such information is important in determining if certain groups are prone to a higher relapse rate, and if differences in such rates are found, then a more rational allocation of resources based on such rates might be undertaken.

Table 6 MEANS TABLE FOR PRIMARY DRUG AND SECONDARY DRUG EFFECT ON LOS

	Count	Mean	Std. Error
None, None	16	6.938	1.266
None, Cocaine	1	19.000	0.000
Alcohol, None	1772	5.274*	.074
Alcohol, Cocaine	823	6.480**	.144
Alcohol, Marijuana/Hashish	67	5.104	.301
Alcohol, Heroin	66	5.970	.626
Alcohol, Other opiates/Synthetics	16	5.000	1.265
Alcohol, Group Other tranquilizers	1	6.000	0.000
Alcohol, Other sedatives	1	3.000	0.000
Alcohol, Benzodiazepines	19	5.842	.694
Alcohol, Other tranquilizers	5	8.800	3.072
Alcohol, Barbiturates	3	8.000	3.055
Alcohol, Inhalants	1	7.000	0.000
Alcohol, Over the counter	1	8.000	0.000
Cocaine, None	23	7.304	1.241
Cocaine, Alcohol	9	7.889	3.225
Cocaine, Marijuana/Hashish	7	6.571	.571
Cocaine, Heroin	16	9.250	1.109
Cocaine, Other opiates/Synthetics	5	14.600	3.906
Cocaine, Benzodiazepines	1	5.000	0.000
Cocaine, Other tranquilizers	4	6.000	1.472
Marijuana/Hashish, Cocaine	1	8.000	0.000
Marijuana/Hashish, Other opiates/Synthetics	1	23.000	0.000
Heroin, None	157	11.17	1.018
Heroin, Alcohol	55	12.291	.912
Heroin, Cocaine	352	12.034	.313
Heroin, Marijuana/Hashish	17	9.294	1.857
Heroin, Non-prescription Methadone	4	16.500	5.107
Heroin, Other opiates/Synthetics	45	11.933	1.048
Heroin, Benzodiazepines	31	11.903	0.904

\*significantly different from Alcohol/Cocaine, Heroin/None, Heroin/Cocaine, Heroin/Cocaine, Heroin/Alcohol at  $p < 0.0001$

\*\*significantly different Heroin/None, Heroin/Cocaine, Heroin/Cocaine, Heroin/Alcohol at  $p < 0.0001$

A parametric - ANCOVA procedure was used to determine the effects of Gender, Race, Primary drug of abuse, and Secondary drug of abuse on the number of admissions over a three year period. Initial analysis showed that race was not associated with number of admissions, so this factor was dropped from the final analysis. Since individuals were followed for a three year period, we needed to take this into account for the analysis, since the later an individual entered in the time period of study, the less chance of a re-admission for that individual. The two covariates are thus age at admission, and follow-up time, which appears as "Year Followed" on the ANCOVA table below. The zero time for this variable was set at 12/10/90 and was measured in Years. An inverse transformation of the independent variable was used to equalize the variance.

Table 7 ANCOVA TABLE ADMISSION NUMBER BY PATIENT DEMOGRAPHICS

Source	df	Sum of Squares	Mean Square	F-Value	P-Value
Gender	1	5.107	5.107	45.236	0.0001
Primary Drug	10	3.259	0.326	2.886	0.0013
Age	1	13.364	13.364	118.381	0.0001
Year Followed	36	13.051	0.375	3.322	0.0001
Residual	4267	481.713	0.113		

Dependent: Admission Number

We conclude that all the demographic variables retained in the model are important in explaining the variation in the number of admissions by group over the period of time of interest.

Table 8 EFFECT of GENDER on NUMBER OF ADMISSIONS

Variable	Mean Number of Admissions	SEM
Male	8.104*	0.204
Female	3.302	0.161

\*significantly different from Female at  $p < 0.0001$

This is a highly significant finding, since the readmission rate for women appears to be less than half that of men. The reasons for this discrepancy should be explored in further work.

Table 9 EFFECT of PRIMARY DRUG OF ABUSE ON NUMBER OF ADMISSIONS

Variable	Mean Number	SEM of Admissions
Primary Drug Use		
None	1.818	0.501
Alcohol	8.383*	0.210
Cocaine/Crack	1.852**	0.419
Heroin	2.656	0.153

\*significantly different from Cocaine/Crack and Heroin at  $p < 0.0001$

\*\*significantly different from Heroin at  $p < 0.01$

Only significant differences are reported in Table 9. The discrepancy between alcohol and heroin or cocaine is highly significant. This difference raises the issue of whether the needs of the alcohol using population are being met in this particular treatment environment.

Table 10 EFFECT of PRIMARY AND SECONDARY DRUG OF ABUSE ON NUMBER OF ADMISSIONS

Primary Drug and Secondary Drug

Variable	Mean number of Admissions	SEM
Alcohol, None	9.359*	0.276

Alcohol, Cocaine	4.609	0.200
Alcohol, Heroin	7.984	0.637
Heroin, None	2.168**	0.145
Heroin, Alcohol	5.207	0.888
Heroin, Cocaine	2.402	0.214

\*significantly different from all others at  $p < 0.001$

\*\* significantly different from Heroin,Alcohol at  $p < 0.04$ .

Again, only significant differences are shown in admission numbers for Table 10. Alcohol use is associated with an increased number of admissions over the time period in question. It also appears to be associated with an increase in the number of admissions when it is coabused with heroin. Note that these contrasts take into account age as well as other demographic differences, so that the effect seen with alcohol is stripped of the effects of confounders contributed by these other factors.

In summary, we can state with reasonable certainty that women tend to have a longer length of stay than men, yet the number of readmissions is much lower. African-Americans tend to have a longer length of stay than Caucasians. Alcohol use is associated with a short length of stay, but the number of readmissions is much higher than all other groups classified by primary drugs of abuse. Interestingly, the use of alcohol concomitantly with Heroin or Cocaine appears to be associated with an increase in the number of admissions over a period of time. As expected, age was correlated with both an increase in the length of stay, as well as the number of admissions over this period of time.

The data presented raises more questions than it answers. It is not within the mission of this survey to speculate as to why these differences in LOS or readmission rates might be occurring. Rather, we will use the results of these analyses to maximize the efficiency of operations, and so therefore we will not comment specifically on these findings except as they relate to operational procedures.

As measured by bed-days, the group using alcohol as primary drug, through an effect on readmission rate and not LOS, results in the largest number of bed-days and therefore facility utilization. Conversely, the group using heroin as primary drug, due to an increase LOS but a decreased re-admission rate, contributes to the second largest amount of facility use as measured by the number of bed-days.

The use of the BR facility for heroin/opiate detoxification may not be appropriate. Opiate withdrawal, except in the neonate or the pregnant woman, is rarely a medical emergency. Methadone, as used for opiate detoxification, is routinely begun in an out-patient setting, and does not require an inpatient hospitalization for stabilization. The utility of offering inpatient detoxification for opiates, unless it is for the express purpose of detoxifying an individual prior to admission to a drug-free therapeutic community, is not an appropriate use of resources. This is supported by DARP (Drug Abuse Reporting Program)<sup>6</sup> data, which clearly shows that drug free outpatient treatment does not result in a significant change in drug use or criminality as compared to drug-free therapeutic community or methadone maintenance. If only patients who were planning to self-admit to a drug-free therapeutic community were treated at BR, this would free up a significant number of beds. Patients requesting detoxification could be referred to community programs, or a specific out-patient transitional methadone program could be implemented to take care of the needs of this population. Elimination of inpatient heroin detoxification would clear approximately 12 beds per year, based on bed-utilization data.

Examination of all admissions over the three year period revealed the following sources of income, as shown in Table 11. Since discharges against medical advice

(AMA) provide an indication of treatment efficacy when patient dependent factors are taken into account, we examined the AMA rate over the period in question, broken down by primary drug of use. Table 12 shows the types of discharges over the time period of the study. The only death occurred in a patient with alcohol as primary drug of use. The AMA discharges represent 8.511% of all admission. Of interest is the types of primary drugs used by this particular group of patients. These results are shown in Table 13.

Table 11 SOURCE OF INCOME BY ADMISSION

SOURCE OF INCOME	Count	%Count	MLOS	Bed-Days*	%Bed
Wages/Salary	3547	44.449	6.989	24790.0	42.449
GPA	1195	14.975	7.644	9134.6	15.641
SSI	1182	14.812	7.447	8802.4	15.073
Other	679	8.509	8.165	5544.0	9.493
Disability (Public/Private)	413	5.175	6.923	2859.2	4.896
AFDC	340	4.261	8.003	2721.0	4.659
Unemployment Compensation	365	4.574	7.063	2578.0	4.414
Retirement/Pension	214	2.682	7.551	1615.9	2.767
TDI	45	.564	7.889	355.0	0.608
Total	7980	100.00%		54800	100%

MLOS = Mean length of stay in days

\*rounded to nearest tenth

%Bed = % Bed-Days

Table 12 REASON FOR DISCHARGE

	Count	%
Completed Treatment	5747	72.353
Discharge to another treatment facility	1421	17.89
Left voluntarily before completion (AMA)	676	8.511
Incarcerated	73	.919
Discharged for non-compliance	21	.264
Completed Treatment - some substance abuse	4	.05
Death	1	.013
Total	7943	100%

Table 13 AMA DISCHARGES BY PRIMARY DRUG OF USE

	Count	%
Heroin	438	64.793
Alcohol	193	28.55
Opiates and other synthetics	16	2.367
Benzodiazepines	11	1.627
Cocaine	9	1.331
Barbiturates	3	.444
None	3	.444
Other tranquilizers	2	.296
Non-prescription methadone	1	.148
Total	676	100%

The largest group of patients leaving AMA appears to be related to the group using heroin as primary drug. This might represent both a patient related factor, such as anti-social behaviors that are associated with this group of patients, as well as lack of appropriate therapy for opiate withdrawal.

The data in Table 10 suggests that some individuals with third party coverage, such as SSI or AFDC are referred to BR, however, no monies are collected by the state

on their behalf. It is unclear why these individuals are not being treated in community facilities which are capable of billing SSI or AFDC. This might be due to lack of expertise in substance abuse treatment, a prior history of problems with the individual which precludes admission to a particular facility, or an over-utilization of community facility resources.

Another large group receives GPA. Services provided to individuals carrying GPA are not reimbursable to community agencies under current state law. However, if substance abuse treatment services were reimbursable for this group, this would allow a significant percentage of these individuals to receive treatment at community facilities which might be closer to home or work. If patients belonging to these three groups: GPA, SSI, and AFDC could be treated in a community facility, this alone would result in a decrease of 35% in bed utilization rates for BR.

### **III REVIEW OF NURSING AND MEDICAL PROCEDURES**

#### **1.00.00 NURSING PROCEDURE**

##### **GENERAL DESCRIPTION**

A review of Nursing Practices and Standards utilized in the area of Substance Abuse during the performance of routine patient care at Benjamin Rush was conducted. Survey methods included employee interviews and questionnaires as well as a review of patient care records, personnel records and documentation of existing standards (nursing policies and procedures). This survey identified the following problems:

#### **1.01.00 PROBLEM IDENTIFICATION**

##### **1.01.XX Admission Documentation**

- 1.01.01 A copy of the patient's Bill of Rights is not present in the patient care record.
- 1.01.02 There is no copy of the patient rules and regulations present in the patient care record.
- 1.01.03 Patient Identification: No wrist bands or other system of patient identification in use, addressographed or hand written. No Addressograph system for identifying patient care records.
- 1.01.04 Allergies are noted on 66% of patient care records, but type of reaction to allergen is not documented.
- 1.01.05 Vital Signs A complete set of admission Vital Signs including temperature, heart rate, respiratory rate and blood pressure were noted on 2% of patient care record reviews
- 1.01.06 Blood Alcohol Level is not routinely obtained on all patients during the admission process. Documentation of Blood Alcohol Levels obtained at referring agency is not corroborated or verified upon reception of patient during transfer or admission.

1.01.07 Urine toxicology screen is not routinely obtained on every patient upon admission or transfer into facility. When urine toxicologies are obtained, they are virtually useless as indicators of care required due to lengthy turnaround time in obtaining reports from outside agency contracted to perform said tests.

1.01.08 Urine for chorionic gonadotropin is not routinely documented on all female patients of child bearing age. When a UCG is obtained, due to time lapse between obtaining specimen and laboratory results being reported to nursing unit (24 hours), appropriate care is not always provided as patients receive medications with potentially teratogenic effects prior to test results being obtained by care givers.

#### 1.02.00 Risk Factors

1.02.01 Tuberculin testing is not documented consistently in patient care record. If results are positive, there is no documentation of referral or follow up in patient care record. There are no documented standards for patient care /Infection Control on patient care units as staff resources for proper handling of positive Tuberculosis cases during hospitalization.

1.02.02 Human Immunodeficiency Virus population is not routinely identified by documentation in the patient care record. Infection control resources are not available for staff on patient care units.

1.02.03 Sexually transmitted diseases are not routinely documented in nursing record. Identification of problem and follow up care is not documented.

#### 1.03.00 Biopsychosocial factors

1.03.01 Prior withdrawal histories are not documented, although history of substance use/ abuse is documented in 91.6% of patient care record reviews.

1.03.02 Communication barriers including language, speech disorders or impairments are not documented.

1.03.03 Spiritual/ emotional factors are not addressed.

1.03.04 Chaplaincy availability/ support is not documented.

1.03.05 Biophysical factors identified in the nursing admission note are not followed up by successive caregivers, i.e., a witnessed Grand Mal seizure documented by the admitting nurse, was not addressed following patient admission to the in-patient unit.

1.03.06 Psychosocial factors are identified and documented in 27.7% of the patient care records.

1.03.07 Evidence of environmental factors are documented in 5% of the patient care

records.

1.03.08 Evidence of patient education factors was documented in 5% of the records reviewed.

1.03.09 Documentation of treatment plans was found in 25% of patient care records reviewed.

#### 1.04.00 Physical Assessment

1.04.01 Assessment of the signs and symptoms of withdrawal documented in 36% of patient care record reviews.

1.04.02 When symptomatology of withdrawal is identified, there is no documentation of appropriate interventions.

1.04.03 Documentation of outcomes, including signs and symptoms of toxicity as well as those of withdrawal are noted in 2% of records reviewed.

1.04.04 Nutrition is addressed, during admission inspection only, in 36% of patient care record reviews.

1.04.05 Elimination is not documented as an indicator of care.

1.04.06 Mobility exceptions are addressed in 8% of the patient care record reviews. There is no documentation of interventions.

1.04.07 Cognitive/behavioral/neurological impairments are noted in 47% of patient record reviews. No documented evidence of interventions noted.

1.04.08 Assessments do not include neurological signs or levels of consciousness. No prior histories of head trauma or other neurological events are noted.

1.04.09 Suicidal ideation with appropriate interventions such as contracting for safety, restraints, and 1:1 nursing observations are not documented. One record indicated every 15 minute checks for close observation.

#### 2.00.00 Nursing Plan of Care

##### 2.01.00 Pharmacological interventions

2.01.01 Physician's orders for medication administration are not always legible.

2.01.02 Patient medication administration records (MAR) are illegible. Legends are xeroxed with staff signatures and corroborating initials.

2.01.03 Standardization of medication administration times and dosages does not allow for individualization of pharmacological plans of care.

2.01.04 Patient responses and effectiveness of medications administered are not documented.

- 2.01.05 The determining factors for obtaining a physician's order for deviance from standardized medication orders was not documented in the nursing record.
- 2.01.06 Criteria for implementation for protocols or "Build-ups" is not documented.
- 2.01.07 Effectiveness of pharmacologic interventions relationship to manifested signs and symptoms of withdrawal are not documented.
- 2.02.00 Supportive/ Non-pharmacological interventions
  - 2.02.01 The environment is not conducive to support a therapeutic milieu or learning atmosphere for patients.
  - 2.02.02 The effectiveness of 12 step programs within the facility cannot be determined due to the voluntary (non-mandatory) attendance by patients.
  - 2.02.03 There is no available documentation to support patient attendance at the 12 step meetings offered.
  - 2.02.04 Attendance and effectiveness of facility based support/ educational offerings for patients is not documented.
  - 2.02.05 There is no documentation to support the use of non-pharmacological interventions such as the use of relaxation techniques, the use of hot showers/baths to alleviate physical discomfort during withdrawal.
  - 2.02.06 There is no documentation of therapeutic communication or patient responses.
- 2.03.00 Patient Education/ Discharge Planning
  - 2.03.01 Evidence of Discharge planning/screening was noted in 52.7% of patient care record reviews.
  - 2.03.02 Evidence of patient/significant other involved in aftercare planning was noted in 16.6% of the patient care record reviews.
  - 2.03.03 Documentation of Patient education was evident in 2% of the patient care record reviews.
  - 2.03.04 No formal documentation of patient education related to addiction relapse prevention establishment of support systems to prevent relapse was noted.
  - 2.03.05 Discharge orders were written by physicians 7 days prior to actual patient discharge date.
  - 2.03.06 No documented evidence of patient education regarding medications, side effects and potential complications was noted.
- 3.00.00 Staffing Issues

- 3.01.01 There was no formal personal identification of staff noted (identification badges or name tags), nor was there evidence of a clear delineation of staff by categories (licensed personnel vs. non-licensed personnel)
- 3.01.02 Completed job descriptions were available, however, there were no formal evaluation of staff competencies outlined.
- 3.01.03 Staffing patterns do not allow for close patient observation. e.g. One licensed nurse and 2 to 3 treatment aides for 24 patients on each in-patient unit.
- 3.01.04 Staffing patterns/ role responsibilities as outlined do not facilitate patient/employee safety.
- 3.01.05 Written documentation of patient care/ patient care issues (nursing progress notes) are routinely documented by non-licensed staff.

3.02.00 Staff Education

- 3.02.01 Although a formal orientation program has been developed and implemented, there is insufficient documentation to support the educational needs/ professional development of nursing staff.
- 3.02.02 Staff education needs are not identified.
- 3.02.03 Basic Cardiopulmonary Resuscitation (CPR) certification is not documented for licensed or non-licensed personnel. It is not a requirement at this facility.
- 3.02.04 Standard resources/ written references were not available for staff utilization on patient care units.
- 3.02.05 Quality Assurance documentation consists of an annual report (1993) without indicators of care, evidence of continuous monitoring, or statistical data available for review.
- 3.02.06 Monthly minutes of staff meetings available for review were dated between 12/93 and 2/94 only.
- 3.02.07 Attendance of licensed personnel was documented but not verified by those listed in attendance.
- 3.02.08 There was no evidence of attendance by non-licensed personnel.

4.00.00 MEDICAL PROCEDURES

The initial medical evaluation which a patient receives depends on what time of the day the patient is brought to the admitting area. If the patient is seen between 09:00 and 16:00 hours, the patient is first seen by one of the two staff physicians. If this occurs, the patient receives a history and physical examination. If the patient arrives between 16:00 and 09:00 the

next day, the patient will first be seen by the consultant physicians, with a full medical and psychosocial evaluation accomplished the next day. In this case, the intake amounts to a cursory history and very brief physical examination, which may not include vital signs, as noted in the chart reviews. This initial contact is the only contact the patient will have with a physician until the next morning. In many cases, this initial contact provides the information used for determining which detoxification protocol the patient will be assigned.

In all cases, once the patient is evaluated by the staff physician, it is unlikely that the patient will again be seen by a staff or consultant physician, unless serious problems develop during the course of the stay. Progress notes in the medical chart are written mainly by attendants, nurses and social workers. Discharge plans are developed by the social workers in conjunction with nursing and attendant input, as reflected by conversations with staff and by notes in the medical record. The physicians appear to have little input into the discharge planning procedure. In many cases, discharge orders were written by the physician up to 10 days ahead of the planned date of discharge.

#### 4.00.XX Medical Evaluation, Problems identified

4.00.01 If the patient is seen after 16:00 hours, the initial assessment is much too limited to substantiate any medication orders for detoxification. Monitoring the response of the patient as drug levels decrease over a period of time is critical in gauging the expected severity of withdrawal, while at the same time matching drug therapy and intensity to withdrawal symptoms.

4.00.02 Based on initial assessment, supportive care and pharmacological agents attenuating alcohol and other drug withdrawal are not individualized for a particular patient's needs. In one instance on chart review, methadone was given to a patient for treatment of perceived opiate withdrawal symptoms even after the patient had been witnessed to have a grand mal seizure in the admitting area. Alcohol withdrawal was perceived to be a secondary problem, so that over a 24 hour period, the patient received methadone doses for increased heart rate and blood pressure, most likely reflecting alcohol withdrawal symptoms. In another case, where the patient was examined by the physician member of the survey team, the patient had not developed any withdrawal symptoms from alcohol for 24 hours after admission, as the patient had been drinking heavily for less than four days. Yet the patient had been offered and refused Librium, and was kept at least 48 hours longer than necessary before discharge back to home.

4.00.03 Initial assessment does not include relevant laboratory data in developing a patient care plan. Relevant laboratory data would include a blood alcohol level, which can be measured by breathalyzer, as well as urine toxicology data. In one case, a patient was given a benzodiazepine (Librium) 4 hours after an emergency room had documented a blood alcohol level of >350mg%. In an unmonitored setting, this has the potential of causing severe respiratory depression or possibly death as a result of a benzodiazepine-alcohol interaction.

- 4.00.04 Abnormal laboratory results are, in a majority of cases, not adequately followed up. In one case, highly elevated liver function tests in an intravenous drug user, (IVDU), suggestive of active viral hepatitis received no mention in the progress notes, in spite of the hazards presented to this patient, other patients and staff if this case involved active hepatitis B.
- 4.00.05 Tuberculosis testing results, while in most cases performed when indicated, are not logged in the patient chart, but are logged in a Rolodex file which is separate from the medical record. Since there is no mention of the Rolodex file in the medical record, it would be impossible to ascertain from the record itself what the results of the test were, and if adequate follow-up was planned.
- 4.00.06 Since there are no medically related discharge planning notes, it is impossible to tell whether medical problems which are identified are referred to community-based health providers.
- 4.00.07 Discharge orders are written days ahead of the time of discharge. This is a dangerous practice as the patients condition can change in the interim, and such a change could affect the discharge planning.
- 4.00.08 There are no available psychiatric support services. All staff expressed dissatisfaction with the level of psychiatric support for acutely suicidal or psychotic patients.

#### 5.00.00 DIAGNOSTIC, DETOXIFICATION AND TREATMENT PROCEDURES

- 5.01.00 Heroin and other opiates -- There is current protocol available for detoxification of the opiate dependent patient. There are no specific symptoms of opiate withdrawal written into the protocol, therefore doses of methadone are dispensed to patients on the basis of subjective criteria evaluated by nursing staff. During this "build-up" period, patients may receive up to 50 mg of methadone over a 9 - 12 hour period without physician contact. Subsequently, orders are written to decrease methadone 5 mg/day and the patient is considered detoxified on the day they do not receive methadone. Time for detoxification will vary based on the initial dose. On occasion, charts may document in the progress notes the presence of dilated pupils or blood pressure and heart rate before the time of administration. The average length of stay (LOS) for heroin addicted patients (n=830) is 15.4 days  $\pm$  0.5 ( $\pm$ SEM). The average LOS for other street opiate addicted individuals (n=35) is 21.0 days  $\pm$  3.7. In the past month prior to this survey, group therapy was begun by social work to provide a supportive environment for patients to work on recovery issues.

#### 5.01.XX Detoxification Protocols, Heroin and other opiates, Problems identified

- 5.01.01 Since few objective data regarding opiate withdrawal appears in the progress notes or the initial history and physical examination, it is unclear what withdrawal symptoms are being treated with methadone, and whether such withdrawal symptoms are due to opiates. For example, recent cocaine

use can mimic opiate withdrawal symptoms, and alcohol withdrawal symptoms can be mistaken for opiate withdrawal.

- 5.01.02 There appears to be no attempt to match pharmacological treatment of opiate addicted patients to discharge planning. This planning includes tracking patients into one of three treatment modalities: Methadone maintenance (MM), drug-free therapeutic community (DFTC), or drug-free outpatient (DFOP). Patients opting for DFTC or DFOP would still experience withdrawal symptoms if a slow tapering schedule was followed as indicated in the protocol. Patients opting for MM would not need to be tapered, since stabilization could be accomplished as an outpatient, and thus would not need continued inpatient care.
- 5.01.03 The LOS for this group of patients is much longer than that which is required for detoxification. Part of the problem is the use of methadone for detoxification. The drug has a long duration of action, thereby resulting in an increase in the time taken for the drug to wash out after stabilization phase.
- 5.01.04 Urine toxicology screens are not routinely obtained on these patients, either on admission nor during the inpatient stay. The possibility of continued illicit drug use by a sub-class of these patients on the wards is thereby not addressed.
- 5.01.05 Discharge planning based on the psycho-social history does not appear to be individualized. Patients who have repeatedly failed DFOP programs are not directed to DFTC and MM programs on discharge.
- 5.01.06 HIV testing is not offered to subjects with self-reports or clinical evidence of IVDU.
- 5.01.07 There is no documentation of group therapy attendance by the patients, nor of the subject matter which is addressed by the group leader.
- 5.01.08 Movement of patients to a conference room to attend self-help group sessions is hampered by perceived lack of staff to accomplish patient movements. There is no documentation of when self-help groups are made available to patients.
- 5.02.00 Detoxification Protocols: Alcohol -- An alcohol history is usually obtained from self-report, with corroboration from outside hospital staff or emergency medical personnel. A hand-held breathalyzer is available to the intake staff for estimation of blood alcohol level, but staff indicated that it was not in good working order. In most cases, the BAC, when it is documented in the chart, is taken from the inter-agency transfer form if the patient is brought to BR from an outside hospital emergency room. There is a current protocol available for detoxification of the alcohol dependent patient (Appendix B). This protocol is based on the administration of a benzodiazepine (Librium) for treatment of alcohol withdrawal symptoms. Patients are given a series of doses of the drug based on subjective and occasionally objective symptoms of alcohol withdrawal as determined by nursing staff. The average LOS for this group of patients (n=2775) is 5.66 days  $\pm$  0.7 days. From the chart

reviews, there appeared to be a great variability in Librium doses given to patients, with reasons for these discrepancies not documented in the progress notes. The staff has a great deal of experience in the treatment of alcohol withdrawal, and it is possible that these discrepancies represent individualization of care which is not documented in the chart.

#### 5.02.XX Detoxification Protocols: Alcohol, Problems identified

- 5.02.01 Patients are not observed closely when such observation would be necessary based on initial assessment. This would be the case for those patients with high blood alcohol levels who exhibit behavioral and physiological tolerance to the effects of the drug and who might be expected to develop more severe withdrawal symptoms as the alcohol levels decrease.
- 5.02.02 Librium, although effective in treating most patients exhibiting alcohol withdrawal symptoms, is not a proper drug for certain sub-classes of patients with the following associated conditions: advanced age, severe liver impairment, severe respiratory disease, frontal lobe dysfunction secondary to alcohol dependence or head injuries, delirium or confusional state, pregnancy. Treatment of patients with this agent in the presence of these conditions can result in adverse effects.
- 5.02.03 Patients who exhibited hypertension or increased heart rates in the setting of alcohol withdrawal did not receive serial evaluation of blood pressure and heart rate response to medication. In a few instances, nursing staff noted a high blood pressure or high heart rate in the progress notes. No evidence that a physician was notified or that follow-up of this data was present in the notes.
- 5.02..04 Laboratory evaluation did not include a urine toxicology screen. This is important to ascertain the presence of other sedative hypnotic drugs such as benzodiazepine, which would effect treatment.
- 5.02..05 Laboratory evaluation did not include a potassium level or a magnesium level, and blood glucoses were made available up to 2 days after the patient was admitted. Deficits in potassium and/or magnesium in this setting can result in heart rhythm disturbances and/or seizures. Deficits in blood glucose can result in misinterpretation of the signs of alcohol withdrawal, and in the malnourished alcoholic can result in seizures or heart rhythm disturbances, as well as alterations in the level of consciousness.
- 5.02.06 Librium is ordered IM when IM absorption is known to be erratic.
- 5.02.07 Follow-up blood electrolytes are not obtained. This is especially important as re-feeding and/or an increase in blood adrenalin can severely depress serum potassium, which can result in disturbances of heart rhythm.
- 5.02.08 Compazine is ordered for nausea or vomiting on a prn basis. This is a dangerous practice since the patient must first be medically evaluated before prescribing anti-emetics to rule out other causes of emesis such as

gastric outlet obstruction due to an active ulcer, or pancreatitis.

5.02.09 The doses of Librium in the protocol may not be adequate for some individuals who exhibit severe tolerance.

5.02.10 A breathalyzer should be checked prior to the institution of Librium therapy, since administration of Librium in the presence of a high alcohol level may result in respiratory depression.

5.02.11 Most problems resulting from alcohol withdrawal are evident within the first 48 hours of admission. There is no indication the alcohol dependent patients receive any further medical contact other than the contact received admission procedures.

5.02.12 Patients do not receive education regarding recovery issues during their stay.

5.02.13 Discharge planning fails to address the patient's psychological and cognitive function, social supports, and motivation for recovery. Patients are not tracked to drug-free outpatient counseling and/or self-help groups, long-term residential treatment, or long term care based on these parameters.

5.03.00 Detoxification Protocols: Cocaine -- Since urine toxicology results are not available, this remains a diagnosis based on self-report. Currently, based on chart reviews, it appears that psychomotor agitation perceived to be due to cocaine withdrawal is treated using the Alcohol detoxification protocol.

#### 5.03.XX Detoxification Protocols: Cocaine, Problems Identified

5.03.01 Treatment of cocaine withdrawal with Librium is not an accepted medical detoxification procedure.

5.03.02 Electrocardiograms are not obtained on this group of patients, who may have ongoing heart muscle damage or may have had damage in the past.

5.03.03 This group of patients does best in a structured residential program, especially after attempts at outpatient detoxification have failed. This issue was not addressed in discharge planning.

5.03.04 The possibility of severe depression and/or suicidal ideation was not addressed in the history and physical examination.

5.04.00 Detoxification Protocols: Benzodiazepines -- Both the protocols for alprazolam and diazepam withdrawal are based on re-intoxication with the particular benzodiazepine. In the case of Valium, there is no provision for a taper. In the case of Xanax, the taper is quite slow (0.5 mg every other day or every third day).

#### 5.04.XX Detoxification Protocols: Benzodiazepines, Problems identified

5.04.01 Both protocols are designed for outpatient use. Therefore, a prolonged period of time is required for detoxification. With closer patient monitoring, much faster detoxification procedures are available, based on use of carbamazepine and/or valproic acid.

5.05.00 Detoxification Protocols: Barbiturate -- This protocol uses phenobarbital re-intoxication followed by a slow taper. The phenobarbital is given every one hour.

5.05.XX Detoxification Protocols: Barbiturates, Problems identified

5.05.01 Since peak concentrations of phenobarbital occur several hours after an oral dose, dosing of the drug every hour is dangerous and may result in severe over-sedation.

#### **IV REVIEW OF OPERATIONS AND NON-CLINICAL PROCEDURES**

6.00.00 Operations:

6.01.00 Licensing, Credentialing, and Performance Evaluations

6.01.01 All licenses for Registered nurses and Licensed Practical Nurses were noted to be documented and current.

6.01.02 SATA's were not certified as nursing assistants.

6.01.03 Documentation of physician licensure gave evidence that 75% of staff physician's did not hold valid state licenses (in one instance, the license had expired).

6.01.04 Licensure for controlled substances was not evidenced in 75% of the staff physicians' personnel files.

6.01.05 In 37.5% of personnel files, physicians did not have documented DEA licensure.

6.01.06 There is no procedure for yearly evaluation of staff performance.

6.02.00 Scheduling and Related Procedures

6.02.01 There was no documented evidence of a staffing and scheduling policy for nursing personnel.

6.02.02 During review of productive vs. non-productive time, it was noted that time clocks were not in use at this facility.

6.02.03 Hand written time sheets were maintained by Nursing Service on a daily basis.

6.02.04 Time sheets reviewed did not substantiate noted discrepancies in personnel files (long term absences were not annotated).

- 6.02.05 Daily time sheets allowed for increased margin for error due to "red-lining" (a method used to note tardiness and its severity).
- 6.02.06 Use of overtime impacts cost and may jeopardize both staff and patient safety.
- 6.02.07 Information relating to number and length of extended leaves was reviewed. 1 of 3 LPN's on WC (maternity leave) 4 of 10 RN's on WC. 5 of 25 SATA on WC.
- 6.02.08 During interviews, staff did not perceive the negative impact of non-productive time on current job responsibilities.
  
- 7.00.00 Non-clinical Procedures
- 7.01.01 Fire and Safety plan is not in evidence in the patient care areas.
- 7.01.02 Scheduled fire drills were not documented, therefore, not monitored for effectiveness in Quality Assurance format.
- 7.02.01 Infection control policies and procedures were not in evidence on the patient care units.
- 7.05.01 Patients were admitted into nurses' station to receive medications, as observed by the surveyors.
  
- 7.06.00 Pharmacy Procedures
- 7.06.01 Unit based medication systems did not allow for safe storage of controlled substances on each in-patient care unit.
- 7.06.02 Controlled substances were not signed for as administered.
- 7.06.03 Pharmacy services were lacking in dispensation of medications, including controlled substance.
- 7.06.04 Nursing supervisors were performing pharmacy responsibilities including the dispensation of and accounting for controlled substances, in bulk.
- 7.06.05 Accurate account of controlled substances was not available during this survey. (There was an overage of 298 Xanax 1 mg. tablets, and a 100 tablet shortage of Methadone 10 mg. tablets).
- 7.06.06 There was a period of time that no documentation of one controlled substance was available during this survey.
- 7.07.07 Pharmacy personnel stated computer error resulting in loss of records to substantiate bulk number of controlled substances released to this facility.

#### 7.08.00 Medical Record Related Procedures

- 7.08.01 Clerical services (unit secretaries/ ward clerks) were not available for transcription and/or other clerical duties in the patient areas, therefore, these duties were relegated to nursing.
- 7.08.02 Medical record clerks were knowledgeable about components of the medical record.
- 7.08.03 Discharge summaries were not completed by physicians.
- 7.08.04 Signatures on Psycho/social histories by one social worker, were noted to be xeroxed.

#### 7.10.00 Support Services

- 7.10.01 During interviews, patient and staff complained about the quality and quantity of food available for patient consumption.
- 7.10.02 On interview staff and patients complained about the quantity of available linen for patient care use, especially the paucity of blankets during the winter months.
- 7.10.03 Laboratory turnover time, > 48 hours, is not adequate for acutely ill patients.

#### 8.00.00 Physical Plant

- 8.01.01 Precludes close observation of patients in acute withdrawal.
- 8.01.02 Bare light bulbs and exposed electrical wires are hazardous to both patients and staff.
- 8.01.03 No physical separation between male and female patient quarters exist.
- 8.01.04 General state of disrepair exists (no doorknobs even in staff areas, one door noted to be off hinges in female patient's bathroom, plumbing leaks also noted, wall and ceiling paint noted to be chipped and peeling).
- 8.01.05 Hazardous chemicals consisting of toilet bowl cleaner containing 10% hydrochloric acid, and bleach containing sodium hypochlorite noted to be stored in patient bathrooms.
- 8.01.05 Electrical wiring is exposed in a patient bathroom on second floor, constituting an electrical hazard.

### **V RECOMMENDATIONS**

Providing state-of-the-art substance abuse services to a needy population, if accomplished in an efficient and effective manner, may decrease costs in the long term, both in human suffering as well as the economic costs to society. It is with this philosophy in mind that the following recommendations are made.

The following recommendations are based on staff interviews, record reviews and direct observation by the survey team.

#### 9.00.00 Patient Care

- 9.01.01 All patients must be identified upon admission and said identification must be evident throughout the patient's length of stay within the facility.
- 9.01.02 Admission documentation should be streamlined to include the use of an addressograph system to properly identify patient care records while freeing licensed nursing staff from performing additional clerical duties.
- 9.01.03 A nursing assessment including a complete set of vital signs (temperature, heart rate, respiratory rate and blood pressure), allergies and a past medical history with documentation of prior history of withdrawal symptomatology when appropriate.
- 9.01.04 A complete physical and psychological assessment with education and environmental factors could be accomplished by use of a checklist or flow sheet in addition to a direct patient care interview.
- 9.01.05 A baseline Blood Alcohol Level (BAL) must be obtained on admission and documented in each patient care record.
- 9.01.06 Any patient with an elevated BAL on admission must be closely monitored due to compromised condition.
- 9.01.07 Urine toxicologies should be obtained routinely on all patients upon admission.
- 9.01.08 Turnaround time must be shortened to provide a basis for developing an accurate data base upon which to establish an individualized plan of patient care.
- 9.01.09 Determination of potential pregnancy should be confirmed by laboratory results on all female patients of child bearing age prior to administering pharmacological therapy. If positive, patient counseling related to options available must be provided.
- 9.01.10 Risk factors related to lifestyles, i.e., Tuberculosis testing, Human immunosuppressive virus, and sexually transmitted diseases need to be identified in this high risk population and patient education and counseling provided and documented.
- 9.01.11 Initial contact with the physician should result in a complete history and physical examination, which includes the following: Chief Complaint, History of Present Illness, Allergies, Medications (including over the counter), Past Medical History including past psychiatric history, Family History, Social History including occupation history, Vital signs, complete physical examination including a mini-mental status examination. It is imperative that this occur as soon as the patient is admitted. It constitutes malpractice

to initiate drug therapy for a presumed withdrawal syndrome before such a complete assessment is accomplished.

- 9.01.12 Patients who have a blood alcohol level estimated by breathalyzer need to have repeated estimations of blood alcohol every one to two hours to ascertain that the alcohol level is falling.
- 9.01.13 Standardized protocols for detoxification need to include specific parameters which result in drug administration. For example: "symptoms of withdrawal" does not constitute a specific parameter. A specific parameter might include blood pressure, heart rate, tremulousness, or pupillary dilation.
- 9.01.14 The phenobarbital protocol is dangerous and should be abandoned.
- 9.01.15 Librium should not be administered IM.
- 9.01.16 Patients older than 65, or those with clinical or laboratory evidence of severe liver dysfunction should not receive long acting benzodiazepines such as Librium or Valium.
- 9.01.17 Librium should not be given to patients with positive blood alcohol levels unless the patient is closely monitored for oversedation, and the doses of Librium are decreased accordingly.
- 9.01.18 Any patient who is receiving any medication to treat withdrawal signs and symptoms should be evaluated by a physician and the results of the evaluation documented in the chart every 24 hours.
- 9.01.19 Discharge summaries must be completed by the physicians, not the medical records clerks.
- 9.01.20 Physicians need to note abnormal lab results in the progress notes.
- 9.01.21 Any patient who is discharged and who needs medical follow-up needs to have evidence that an appointment was made for the patient and the patient is aware of the appointment.
- 9.01.23 Patient discharge instructions sheets need to be developed and signed off by nursing staff, physician and patients on discharge outlining any follow-up appointments and any medications that the patient needs to continue.
- 9.01.24 Witnessed toxicology screens should be obtained twice per week in a random fashion on all patients in the facility. Positive urine toxicology screens that do not correlate with medical treatment should be documented in the chart and appropriate action taken.
- 9.01.25 Agitated patients need to be chemically, as well as physically restrained. A procedure for rapid neuroleptization utilizing intramuscular haloperidol needs to be instituted.

- 9.01.26 Use of quiet rooms rather than chemical or physical restraints is dangerous to staff and patients. Staff need to be instructed in use of physical restraints, as well as the care of the patient who is physically restrained.
- 9.01.27 EKG's should routinely be obtained as part of the admission procedure for any patient over 55 years of age.
- 9.01.28 Patients who exhibit elevated blood pressure or heart rate in the setting of alcohol withdrawal need to be closely monitored.
- 9.01.29 Elevated blood pressure not responding to a benzodiazepine in the setting of alcohol withdrawal has to be treated with an alternate agent.
- 9.01.30 Discharge orders cannot be written more than 24 hours in advance of the patient's discharge.
- 9.01.31 All alcohol using patients need at least a blood potassium and magnesium level. Low serum potassium and/or magnesium needs to be treated to avoid cardiac compromise.
- 9.01.32 Before patients are given sedative-hypnotics for treatment of alcohol withdrawal, a blood glucose needs to be obtained.
- 9.01.33 Use of Dilantin for prevention of alcohol related seizures is not effective. In place of Dilantin, such patients might benefit from earlier and more aggressive treatment with benzodiazepines.
- 9.01.34 Patients who have seizures in the setting of alcohol withdrawal should have at least a neurological examination post seizure, as well as laboratory work including a serum glucose, potassium, magnesium, and calcium.
- 9.01.35 In the opinion of the survey team, Benjamin Rush should seek accreditation through the Joint Commission on Accreditation of Health Organizations (JCAHO).
- 9.01.36 A contractual agreement with an individual or individuals board certified by the American Board of Psychiatry and Neurology needs to be made to provide 24-hour emergency psychiatric support services. These services would be used to evaluate suicidal or psychotic patients.
- 9.02.00 NURSING PLAN OF CARE: Recommendations are based on nursing responsibilities related to assessment, planning, implementation, evaluation and reassessment of the disease process. Knowledge of pharmacologic actions and interactions is necessary in order to provide appropriate therapeutic pharmacological interventions.
- 9.02.XX Pharmacological Interventions:
- 9.02.01 Criteria for initiation of physicians orders need to be established.

- 9.02.02 In collaboration with the physician the drug of choice for detoxification should be based on patient history of present use, past withdrawal history, medical condition and presenting symptomatology.
- 9.02.03 In the case of patients presenting for Alcohol withdrawal, it must be ascertained that the blood alcohol levels are such that administration of medication will not physiologically compromise the patient.
- 9.02.04 In opiate and other drug dependent patients a witnessed urine toxicology should be obtained to determine the appropriate treatment to be utilized.
- 9.02.05 It is the opinion of the surveyors that due to the frequency of cross addiction and the low cost of urine toxicology screens, a witnessed urine should be obtained on each patient admitted to the substance abuse unit.
- 9.02.06 Careful documentation of patient responses and effectiveness of therapy is needed to validate that appropriate therapy is being utilized.
- 9.02.07 In order to ensure safe medication administration, medication administration records (MAR) need to be more legible and each nurse must validate their own signature.
- 9.02.08 Standardized medication administration times are sometimes appropriate, but more often, an individualized schedule provides more optimal therapy.
- 9.03.00 Supportive/ Non-pharmacological Interventions:
- 9.03.01 To provide safe and effective nursing care, an environment conducive to supportive therapy needs to be established.
- 9.03.02 The patient must feel safe in order to benefit from the care being provided.
- 9.03.03 Non-pharmacological interventions such as relaxation techniques, therapeutic communication and patient education regarding the disease process is essential.
- 9.03.04 Group and individual counseling can facilitate this important aspect of care. Attendance at all offerings, including 12 step meetings, should be required unless specifically contraindicated by the patient's physical, cognitive or behavioral status. This should be determined by the multidisciplinary staff which consists of the physician, the nurse, and the social worker.
- 9.04.00 Patient Education/Discharge Planning:
- 9.04.01 As part of the nursing process, the patient population must be provided with the opportunity for learning about their disease and the available resources to facilitate individualized choices for recovery.

- 9.04.02 Discharge planning must take place with all patients as the primary goal is for all patients to return to the community, whether it be a therapeutic community, outpatient focus or selected choice by the individual.
- 9.05.00 STAFFING ISSUES: During interviews, the staff verbalized awareness of the hazards posed by the present staffing patterns. They also expressed feelings of hopelessness about being able to effect change citing past administrative responses to their needs as the rationale for this manner of thinking.
- 9.05.01 In reviewing the patient/staff ratio it is determined that there are insufficient numbers of licensed personnel to provide safe patient care. Given the potential acuity of the addicted patient during the initial detoxification period, it was noted that there are occasions when only one licensed staff member is on duty during an eight hour tour of duty. With a census of 48 patients situated on three separate levels in the facility, this is perceived as a threat to both patient and staff safety. Only licensed personnel are educated in emergency measures that are required at the bedside in a critical situation, and at the same time, these same personnel have the only access to the emergency equipment and medications that are required in such a situation. This makes adequate/ safe patient care difficult if not impossible.
- 9.06.00 Staff Education:
- 9.06.01 Nursing care will be improved by addressing the needs for staff education related to the disease of addiction and signs and symptoms of withdrawal among specific patient populations. All nursing staff should be provided with ongoing education in the care of the Substance Abuse Patient with a focus on basic issues as they relate to current trends in therapy. The staff needs to acquire the knowledge and skills necessary to determine the appropriate treatment for the minimization of withdrawal signs and symptoms through appropriate nursing interventions and to prevent the complications inherent during the detoxification process.
- 9.06.02 Effectiveness of interventions and change in patient condition must be documented by licensed personnel in the patient care record. Increased documentation by licensed nursing personnel in the patient care record will provide accurate and comprehensive information on which to base a plan of care for individual patients and to monitor measurable patient outcomes. Emphasis should be placed on the importance of cross addictions related to symptomatology, i.e., pupillary dilatation, in opiate withdrawal and /or recent cocaine abuse.
- 9.06.03 Resource manuals including standards for patient care and safety must be made available to all nursing staff on the patient care units. Classes and/or staff meeting will have to be held in order to present information related to changes in, and implementation of patient care standards to all staff members. Documentation of attendance will have to be kept in order to maintain attitudes of accountability and responsibility for the appropriate

delivery of care. Verification of minutes by absent staff members must also be documented.

9.06.04 Classes in Cardio-pulmonary resuscitation to maintain basic life support systems until Rescue team arrives and, in non-violent crisis intervention to minimize/prevent patient and employee related injuries should be considered as requirements with the need for annual recertification.

9.06.05 Quality Assurance indicators for patient care must be established and outcomes must be monitored and documented with an ongoing schedule for reassessment and recommendations for implementations of improvements. Suggested indicators would be: 1) Number of unplanned transfers to another facility; 2) number of seizures; 3) number of discharges against medical advice; 4) number of deaths. Any such occurrence should be reported to a manager and the chart reviewed to assess what, if any, problems occurred in the delivery of care to the patient.

#### 10.00.00 Operations

10.01.01 Licensing and Credentialing: All professional nursing personnel are currently licensed, but the SATA are not licensed as certified Nursing Assistants. This should be reviewed as they provide direct patient care and indeed are responsible for the bulk of personal care administered to the patient as well as for the bulk of nursing documentation in the patient care record, at the time of this survey.

10.01.02 Medical licensure must be ascertained on hire and a system for maintaining evidence of current certifications must be instituted.

10.01.03 Although not included in the mission of this survey, a more detailed inspection of the utilization of productive and non-productive time with potential effects on positive patient outcomes, patient and staff safety as well as financial considerations should be addressed as a separate issue.

10.01.04 A yearly evaluation of staff performance based on fulfillment of criteria as outlined in the job description for the particular staff member should be instituted as soon as possible.

10.01.05 Full-time and consultant physicians should review and sign a privilege statement which clearly states what medical procedures can be performed at the facility by the staff member, and what scheduled medications can be prescribed, based on documentation from the appropriate regulatory agency, such as DEA and the State Department of Health (Controlled Substances Registration).

#### 10.02.00 Non-clinical Procedures

10.02.01 Fire/safety: Fire drills must be routinely scheduled and carried out on all three shifts. Documentation of such events must be maintained and

monitored as critical indicators of Quality Assurance.

10.02.02 A documented plan must be readily available to all staff members in patient care areas. Common practice of taping a cigarette lighter to the corridor wall by the elevator for community use should be considered as unsafe and eliminated.

10.02.03 Blood and body fluid precautions should be uniformly understood and practiced by all staff members. A written plan should be available for ready reference in all patient care areas. During review of personnel files, a human bite suffered by a staff member was treated by the inappropriate application of bleach solution to the employee's skin without further follow up documented.

10.02.04 A formal chain of command needs to be established for reporting, documenting and implementing corrective actions in the case of patient incidents, and/or untoward events.

#### 10.03.00 Medication System

10.03.01 The medication system must be evaluated and a more efficient, safe system must be put in place. Patients must not be allowed to enter the nurses station to receive medications.

10.03.02 Each patient care unit should have a locked medication cart with controlled substances under double lock and key.

10.03.03 Controlled substances must be signed out as administered to the patient from the cart on the patient's assigned unit. Only licensed personnel should have access to the medication cart and keys. There should only be one set of keys on each unit.

#### 10.04.00 Building Design:

10.04.01 The physical plant itself was not found to be conducive to safe patient care as previously mentioned.

10.04.02 Emphasis must also be placed on the separation of male and female patients in this setting as both genders are at risk for compromise due to the nature of the disease and also the disinhibition accompanying pharmacological therapy during the withdrawal phase of treatment.

10.04.03 The facility itself had electrical wires and bare bulbs exposed during the survey. Chemical detergents and disinfectants were found to pose a hazardous threat to patient safety due to their presence in the patient washroom areas.

#### 10.05.00 Pharmacy Services:

- 10.05.01 Pharmacy services should be updated and improved in relation to dispensation, delivery and record keeping of all medications, but especially of controlled substances.
  - 10.05.02 A formalized system to insure precise documentation of drug inventory must be established and standardized.
  - 10.05.03 Nursing supervisors must not be placed in a position of dispensing medications, especially controlled substances.
  - 10.05.04 We suggest a formal Drug Enforcement Agency Audit (DEA) to review the records of the Central Pharmacy as well as the Benjamin Rush Pharmacy given the lack of documentation found on initial inspection at the BR facility, as well as the non-co-operation of Central Pharmacy in providing controlled substance records, specifically relating to Xanax 1mg tablets.
- 10.06.00 Other Support Services:
- 10.06.01 Equipment needed to provide adequate patient care was not found to be in working order, for example the Breathalyzers.

## **VI RECOMMENDATIONS FOR REORGANIZATION**

Given the present staffing patterns, it is unreasonable to expect that patients receive individualized treatment in the current setting. This is related to staff training as well as staff availability. There are a number of problems which may obstruct implementation of recommendations which relate to the ability to hire trained staff within the current budget:

- 1) New staff cannot be hired within the current budget;
- 2) Extended leaves and overtime use represents more than 25% of the budget allocated to staff salaries. (See budget spreadsheet Appendix D) Classified regular time for FY93 = \$1,555,298, Classified overtime = \$409,299 which represents 20.84% of the FY93 expenditures for staff time. Since this is at least 1.5 times the cost of the regular hourly rate, this represents a considerable drain on the budget for a correspondingly small marginal increase in staff availability.

To preserve the capability of this facility to serve the sickest and neediest population, the number of beds in the BR facility must be scaled down. However, it does not follow that the number of patients served by the facility must also decrease. A smaller facility would allow better patient assessment and triage, and may reduce LOS and readmission rates in the future.

As this scaling down process is implemented, reducing pressure on the facility can be accomplished by the following measures, which are supported by the appropriate LOS data.

Heroin and opiate withdrawal are not life-threatening conditions. For reasons outlined above, use of an inpatient facility designed to treat alcohol withdrawal, which is a life-threatening condition, does not efficiently allocate detoxification resources to the sickest segment of the drug using population, namely, those with alcohol dependence or alcohol abuse.

Table 14 shows how facility utilization is impacted by the number of bed-days for the time period of the study allocated for heroin and opiate detoxification.

Table 14 BED UTILIZATION FOR HEROIN AND OPIATE DETOXIFICATION

Number of Patients	Bed-days
7981	58402
minus heroin related utilization	
6724	42852
minus opiate and synthetics related utilization	
6684	42354

If we examine bed utilization by patients who have third party coverage, either SSI or AFDC, the following utilization table is obtained, Table 15.

Table 15 BED UTILIZATION FOR AFDC AND SSI AND OPIATE DETOXIFICATION

Number of patients	Bed-days
7981	58402
minus AFDC related utilization	
7641	55681
minus SSI related utilization	
6459	46879
minus heroin and opiate related utilization	
5162	37075

The number of bed-days available for the BR facility for this period was  $((365*3)+30)*48 = 54000$ . This number is smaller than the measured utilization of 58402 bed-days since in the case where a patient is discharged and another patient is admitted the same day, this procedure adds an extra patient-day to LOS not measured by bed-days. We will utilize the figure of 58402 bed-days in future calculations, since this represents the real utilization level of the facility.

Since 48 beds are available, the proportion of beds remaining when beds used for heroin and opiate detoxification are removed is  $(42354/58402)*48 = 35$  beds (rounded off to nearest whole bed).

In similar fashion, if there was a way to triage patients with third party coverage (either SSI or AFDC), to a community facility, then the following savings would be realized using the same calculations:  $(46879/58402)*48 = 39$  (rounded off to nearest whole bed).

The combined savings on bed utilization would be as follows:  $(37075/58402)*48 = 31$  beds, assuming that patients with SSI or AFDC coverage would be treated in community facilities, and patients with heroin or other opiate addiction would be treated as outpatients.

Given that SSI and AFDC reimburse 72% of charges at some community hospitals, and given that these charges are approximately \$600.00/day, it is not unreasonable to assume that such patients could be triaged to community facilities that are appropriate for detoxification and assessment, removing the obstruction to treatment resulting from lack of financial resources. If a patient's coverage under SSI or AFDC was checked at the BR facility during the admission procedure, triage to a community facility would be enhanced.

Patients with a primary diagnosis of heroin or other opiate addiction should be triaged to an outpatient program, rather than admitted for detoxification.

In either or combined cases, it should be possible to decrease the number of beds of the facility to 36, while continuing to provide services to the patients whose primary drug of abuse is alcohol, and who represent the greatest medical risk during detoxification. The savings generated by decreasing overtime utilization could be used to add additional staff specifically trained in the delivery of substance abuse treatment services.

## **VII OPERATIONAL RECOMENDATIONS**

- 11.00.01 The facility should be scaled down to 36 inpatient beds.
- 11.00.02 12 beds should be allocated for close observation and evaluation of new admissions.
- 11.00.03 24 beds should be allocated as a rehabilitation unit.
- 11.00.04 Remodeling of the facility to take into account operational requirements of a close observation unit and a rehabilitation unit.
- 11.00.05 Cease offering inpatient detoxification for patients whose primary drugs of use are heroin or other opiates. Patients admitted between 16:00 and 08:00 whose primary drugs of use are heroin or other opiates can be stabilized on methadone and discharged to an outpatient detoxification or methadone maintenance program.
- 11.00.06 Both full-time physicians should be Board-certified or Board-eligible in The American Board of Internal Medicine or The American Board of Family Practice. They should also have documented training in substance abuse medicine.
- 11.00.07 Minimal Staffing for a 12 bed medical detoxification and observation unit should consist of 2 RN's, 1 LPN, 1 SATA. This staffing pattern should be maintained for all three shifts. All staff should have documented substance abuse treatment or counseling experience, with preference given to staff with certification in same. 2 Social Work positions with week-end coverage, with SW personnel having substance abuse counseling experience are also required.
- 11.00.08 Minimal staffing for a 24 bed rehabilitation unit should consist of 2 SATA's with substance abuse counseling certification, 1 RN qualified as described above, all per shift. In addition, 4 Clinical Social Work positions with week-end coverage having experience in group process, group psychotherapy, and substance abuse counseling skills would be required.
- 11.00.09 The economic effects of implementing these recommendations needs to be studied to ascertain the financial feasibility of re-organization.
- 11.00.10 A feasibility study examining the costs and benefits of the utilization of

existing community substance abuse treatment resources to provide services to this population not currently offered by the Benjamin Rush facility such as outpatient drug detoxification, drug-free outpatient day treatment, weekly or biweekly individual counseling, weekly or biweekly group therapy and educational groups, and long-term drug-free residential treatment should be performed.

The 12 bed unit (Medical Detoxification and Observation Unit) MDOU is seen as a high acuity unit where staff:patient ratio is high, allowing close monitoring of patients during early withdrawal, where most problems would be expected to develop. The function of the medical detoxification unit would be to provide individualized care, where the acuity of the patients requires frequent monitoring of withdrawal symptoms, vital signs, and psychologic functioning. This would be important in completing the medical assessment, as well as to determine the need for pharmacologic management of withdrawal.

Patients admitted to the unit should receive a full history and physical examination at the time of admission, as well as complete nursing and psychosocial assessment. Staff physicians would be required to examine each patient daily to individualize diagnosis and treatment procedures. Discharge plans to the community or rehabilitation unit (RU) should be developed using a multidisciplinary team approach, where each team consisting of a physician, nurse, attendant, and social worker would develop a treatment plan.

The (RU) is a step-down unit for patients who are admitted, observed for 24 hours, and are not felt not to require a medically supervised detoxification, or patients who have completed detoxification in the MDOU and are awaiting disposition. The function of the RU would be to provide both group as well as individual therapy to patients recovering from alcohol and other drug use, while awaiting disposition to home or a community facility. The unit milieu would be geared to the early recovery process, and would include group therapy twice per day, education groups once or twice per day, individual counseling daily, as well as availability of ongoing self-help group therapy such as AA, NA, and CA in the evenings. In both units, a multidisciplinary team approach regarding the development of treatment plans would be instituted where each social worker and counselor would review treatment plans of assigned patients, and develop plans matching patient's needs with community resources.

In the opinion of the survey team, these are the minimal changes that are necessary to allow implementation of the survey team's recommendations. Since the survey team is not qualified to analyze the financial aspects of the operation, we cannot comment on the financial feasibility of this proposed reorganization.

## **VIII ACKNOWLEDGEMENTS**

We gratefully acknowledge the cooperation of all of the staff of the Benjamin Rush facility for sharing their time and thoughts with us during the audit process. All staff displayed the highest professional courtesy to the survey team during the audit process. We owe special thanks to Rear-Admiral Paul J. Mulloy, for the opportunity to perform this survey, to Ms. Sheila Hildebrandt, who helped coordinate the review process, to Ms. Gail Hebert, who was always on hand to answer technical questions and provided invaluable assistance during the course of the survey, to Mr. David Como of the MIS department, without whose help the population survey data would not have been available, to Mr. Eric Babilewicz, computer consultant for MIS, who managed to retrieve all needed data in a compatible format in record time, to Ms. Gail Lamphere, who helped coordinate all staff interviews and helped maintain a cooperative and friendly atmosphere during the survey process.

# APPENDIX A MEDICAL RECORD REVIEW RESULTS

## MEDICAL RECORD REVIEW RESULTS

PERCENTAGE PRESENT OUT OF 36 CHARTS

CHIEF COMPLAINT-----	97.2
HISTORY OF PRESENT ILLNESS	
Narrative of alcohol/drug use (for each drug abused)-----	72.2
Previous detox-----	77.0
Quantity consumed-----	77.0
Last use-----	77.0
Frequency of use-----	77.0
Licit/illicit use obtainment-----	25.0
OTC use-----	8.0
Significant Medical problems relating to use-----	8.0
Allergies (including type of reaction)-----	44.0
Medications (prescribed, OTC, illicit)-----	19.4
Habits (caffeine, nicotine)-----	5.0
PAST MEDICAL HISTORY	
ER visits-----	27.0
Hospitalizations (medical/surgical)-----	25.0
Trauma-----	11.0
MVA-----	8.0
PSYCHIATRIC HISTORY (OTHER THAN SA)	
Major/Minor disorder-----	36.0
FAMILY HISTORY	
Substance abuse-----	30.5
Psychiatric-----	25.0
Physical/ sexual abuse-----	11.0
Medical risk factors-----	11.0

SOCIAL HISTORY

Sexual orientation-----	0.0
Sexual history/ multiple partners-----	0.0
Safe sex practices-----	0.0
Marital status-----	41.6
Religious orientation-----	0.0
Support systems/significant others-----	36.0
Legal involvements (include DWI)-----	39.0
Education-----	41.6
Language barrier-----	0.0
Financial problems-----	0.0

OCCUPATIONAL HISTORY

Current work history-----	47.0
Past employment record-----	33.3
Job performance relating to substance abuse-----	0.0
Review of systems (pertinent to drug of choice)-----	0.0

PHYSICAL EXAM

Vital signs-----	11.0
Neuro exam-----	72.0
Mental status check-----	13.8
Orientation-----	2.0

LAB DATA

BAC-----	25.0
tox screen-----	8.0
Glucose-----	50.0
B-HCG-----	50.0
SGOT, SGPT, GGT-----	47.0
PT, PTT-----	0.0
CBC-----	55.0
Lytes, BUN, Cr, Mg, PO4-----	0.0
RPR-----	55.0
HIV (if hx warrants) include pre and post test counseling---	0.0
PPD (if hx warrants) indigents, HIV+-----	8.0
U/A with micro-----	13.8
EKG>= 55 years of age, cardiac history, cocaine abuse-----	0.0

DOCUMENTATION OF INTERVENTIONS FOR PROBLEMS IDENTIFIED 25.0

## APPENDIX B NURSING RECORD REVIEW RESULTS

NURSING RECORD REVIEW RESULTS	PERCENTAGE OUT OF 36 CHARTS
<b>ADMISSION ASSESSMENT</b>	
Problem identification-----	94.0
Vital Signs-----	2.0
Allergies-----	66.0
BAC-----	25.0
Lab Work-----	39.0
UCG-----	50.0
History of Use-----	91.6
Risk Factors-----	16.6
Biophysical factors-----	19.4
Psychosocial factors-----	27.7
Environmental factors-----	5.0
Educational factors-----	5.0
Discharge Planning-----	27.7
Past Medical History-----	47.0
<b>ASSESSMENT</b>	
Safety-----	2.0
Nutrition-----	36.0
Mobility-----	80.0
Elimination-----	0.0
Cognitive/Neurological function-----	47.0
<b>PLAN OF CARE</b>	
Assessment of current signs and symptoms----	36.0
Effectiveness of management of withdrawal---	22.0
Medications-----	63.8
Nonpharmacological interventions-----	0.0
Complications of withdrawal-----	2.0
Implementation of standards-----	0.0
Appropriate interventions-----	8.0
<b>EVALUATION</b>	
Patient responses-----	16.6
Response to treatment-----	27.7
Response to education-----	0.0
<b>REASSESSMENT</b>	
of identified problems)-----	11.0
<b>DISCHARGE PLANNING</b>	
Early intervention/Counseling (within 24 hours)	52.7
Aftercare planning-----	41.6
Involvement of patient/significant other-----	16.6
<b>EDUCATION</b>	
Disease of Addiction-----	2.0

Relapse Prevention-----	2.0
Alterations in Lifestyle-----	0.0
Establishment of Support Systems-----	0.0
DOCUMENTATION OF TREATMENT PLAN-----	25.0

## APPENDIX C STAFF QUESTIONNAIRE RESULTS

The following questionnaire was developed for gathering data for informational and statistical purposes only. Do not sign or include your name. Individual answers will be kept confidential. Please answer all questions to the best of your ability and place completed questionnaire in envelope provided. Thank you.

QUESTIONNAIRE:

PLEASE CIRCLE THE ITEM THAT BEST DESCRIBES YOUR POSITION:

ATTENDANT NA CASE WORKER LPN RN SOCIAL WORKER OTHER

SHIFT MOST OFTEN WORKED: DAYS EVENINGS NIGHTS

HIGHEST LEVEL OF EDUCATION COMPLETED:

GED VOCATIONAL SCHOOL HIGH SCHOOL CERTIFICATION COLLEGE

ADVANCED DEGREE

PLEASE FILL IN THE NUMBER OF YEARS EMPLOYED AT THIS FACILITY \_\_\_\_\_ years.

DEFINITIONS:

\*\*"Safe" is defined as : being harm free to patients and staff alike.

\*\*"Available" is defined as: being on the patient care unit daily.

\*\*"Emergency" is defined as: any situation requiring immediate intervention to prevent harm to patients and staff.

\*\*"Emergency equipment" is defined as: airways, resuscitative masks, suction, oxygen, crash cart, and emergency medications.

\*\*"Policies and procedures" are defined as: the written standards which are established by which administrative and clinical patient care issues as well as staff related issues are governed.

Likert Scale response: 0 = Never, 1 = Not Usually, 2 = Some of the Time,  
3 = Usually, 4 = Most of the time, 5 = Always.

PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE MOST APPROPRIATE ANSWER:

MEAN LIKERT RESPONSE

1. Formal orientations are provided for new employees.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.2
2. Orientations to unit policies and procedures are provided to new employees.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.0
3. There are specific educational requirements for my job.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.18
4. Administrative policies are available for staff use.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.85
5. Staff know where the administrative policies are kept.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.9
6. Patient care policies are available for staff use.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.7
7. There are guidelines to follow in a patient related emergency.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.0
8. There are guidelines to follow in a psychiatric emergency.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.9
9. Emergency equipment is available on the unit.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.9
10. There is a physician available to the unit staff.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.72
11. There is a psychiatrist available in a psychiatric emergency.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 1.36
12. Patient education is provided.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.09
13. The patient Bill of Rights is posted on the unit.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.54
14. Patients are made aware of the patient Bill of Rights on admission.  
ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.0

15. The building that I work in is safe.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.09
16. My work area is safe.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.45
17. Staffing schedules are made out fairly.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.64
18. There is enough nursing staff to care for patients.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.0
19. The patients are cared for adequately.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.6
20. There is time made available for staff education.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 1.6
21. I am happy in my work.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.27
22. I provide safe patient care.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.55
23. I am aware of staffing and scheduling policies for my unit.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.55
24. I am satisfied with the staffing on my unit.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.5
25. I am satisfied with my own schedule.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 4.09
26. I am aware of opportunities for staff education.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 2.36
27. When time is made available, I do attend staff education programs.  
 ALWAYS MOST OF THE TIME USUALLY SOME OF THE TIME NOT USUALLY NEVER 3.27
28. I receive support from administration.

	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	
29. I am supported by my supervisors.							2.73
	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	3.54
30. I know where the patient care policies are kept.							
	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	3.09
31. I know where the administrative policies are kept.							
	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	2.73
32. In a patient related emergency, a physician does come to the unit.							
	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	4.8
33. In a psychiatric emergency, the psychiatrist comes to the unit.							
	ALWAYS	MOST OF THE TIME	USUALLY	SOME OF THE TIME	NOT USUALLY	NEVER	3.18

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE RESPONSE, YES or NO. IF YOU ARE UNSURE OF THE RESPONSE, THEN DO NOT ANSWER THE QUESTION.

The following patient care equipment is available on the unit:	PERCENTAGE POSITIVE RESPONSES
Vital signs (thermometers, BP cuffs, stethoscopes)-----	100
Breathalyzer-----	60.0
Personal hygiene items (soap, shampoo, etc.)-----	100
Seizure pads-----	25
Oral airways-----	87.5
Oxygen-----	77.8
Suction equipment-----	28.5
Bedpans/ urinals-----	0.0
Slippers-----	100

The following support services are available to the unit:

Pharmacy-----	100
Central Supply-----	100
Housekeeping-----	100
Laboratory-----	100
Phlebotomists-----	100
Dietary-----	100
Kitchen-----	80
Radiology-----	90
Secretary (clerical)-----	80

Did you receive a formal orientation When you started working here?-----	72
Were you oriented to the unit policies and procedures?-----	72
Have you ever been physically harmed by a patient?-----	20
Has a patient ever physically harmed themselves?-----	90.1
Has one patient ever physically harmed another patient?-----	90.1
Has a patient ever physically harmed another staff member?--	90
Is training in non violent crises intervention available to you?-	25
Have you been trained in non violent crisis intervention?-----	36.4
Is there an employee assistance program available to staff?-----	100

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YOUR OWN WORDS:

What do you like **best** about your work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you like **least** about your work? \_\_\_\_\_

---

---

---

What would you **change** about your work? \_\_\_\_\_

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Thank you for your time and consideration.

**APPENDIX D BUDGET FY93**

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