DIVISION OF MENTAL HEALTH AND HOSPITALS
ADMINISTRATIVE BULLETIN 9:02

DATE: April 6, 1983

SUBJECT: Sequence and Procedures for Program Reviews of State Psychiatric Hospitals and Facilities
Applicability: H, C, CO

I. Purpose

To standardize and clarify the procedures for program reviews in order to promote program accountability and remediation, to provide useful inspection reports on a timely basis and to provide recommendations to the New Jersey Department of Health for licensing where applicable.

II. Authority

State Psychiatric Hospitals: NJSA 30:1-15.1 and as designated by the Director, Division of Mental Health and Hospitals.

III. Implementation

A. Pre-Site Sequences and Procedures

1. Development of Priorities

a. Marlboro, Ancora, Greystone, Trenton, Forensic, Glen Gardner and Arthur Brisbane will be evaluated annually, and are referred to as State hospitals within this document.

b. At least 60 days prior to a proposed review, the Coordinator, Bureau of Standards & Inspections will arrange dates for the State hospital review in coordination with the Division Director and/or the Office of Institutional Services.

2. Scheduling (40 days)

At least 40 days prior to a review, the Coordinator, Bureau of Standards and Inspections, or a designee, will telephone the hospital Chief Executive Officer to inform him/her of the date of the review.

3. Confirmation of Scheduled Review (30+ days)

At least 30 days prior to the review, a standard letter will be sent to the hospital which will:

a. Describe the scope and purpose of the program review and survey procedures;

b. Describe procedures for reviewing client/patient records, observing programs, ward tours, conducting staff interviews; and

c. Describe the standard team composition.

The letter will also indicate that additional special projects may be conducted during the review (see Attachments A and E).

4. Consultants

All needed consultants, e.g., pharmacist, dietary, fire marshall and sanitarian will be called at this time to schedule services for the review.

5. Review Team Selection and Composition (30 days)

At least 30 days prior to the review, the review team will be selected as per Attachment A. The team leader and all team members will be notified of the review and the pre-site meeting. Team members will also be notified of their specific responsibilities (see format and responsibilities, attached). The referral agency questionnaires (Attachment B) will be mailed to the County Mental Health Administrator with the notification of the review. All team members must attend the scheduled pre-site meeting. There is generally no guest or observer status for any review.

6. Team Member Responsibilities

a. All team members must attend the pre-site meeting, be prepared to attend all scheduled days of the review (approximately 9am-4pm plus travel time), assume writing responsibility assigned by the team leader, and, during the review, prepare written drafts in accordance with writing assignments. Initial drafts will be edited by the Bureau of Standards and Inspections. There will be no review of the report by team members when the program review takes place only two months before a JCAH review. In such cases, the report must be mailed to the Bureau of Standards and Inspections within seven working days after the review.

Written findings for assigned sections must contain recommendations which are validated by documentation and/or specific observations.

b. The team leader shall review responses to intra-divisional requests for information about the subject hospital. S/he should also summarize and present recommendations from previous hospital site review reports. Special attention should be paid to complete resolution of previous division and JCAH identified deficiencies. Unresolved issues must be explained and documented at the review.

c. Office of Community Services regional staff shall interview all emergency/screening and identified liaison agencies, complete the attached referral agency questionnaire, and bring the results to the pre-site meeting (see Attachment B).

d. The Regional Coordinator shall provide the team leader with a list of any relevant systemic or other issues which should be addressed during the review (see Attachment C).

e. The County Mental Health Administrator should present findings based on other referral agencies' interviews. These must be completed prior to the pre-site meeting (see sections A 8). S/he should also review affiliation agreements and identify any systemic issues.

f. Office of Institutional Services staff shall review Office of Institutional Services work plans and special assignments to the State hospital, JCAH deficiencies, unified services problems and general compliance with Division goals and objectives. These should be critiqued and submitted to the team leader at least 30 days before the review (see Attachment D).

7. Pre-Site Data Collection (30 days)

a. Notification of the review and a request for information on issues to be addressed during the review will be sent to the following staff of the Division of Mental Health and Hospitals: Assistant Directors, Chief Executive Officers, Grants and/or Contracts Administrator(s), Bureau of Research and Evaluation, Bureau of Information Systems, Services for Children/Elderly, Office of Planning, Office of Policy, Technical Assistance Unit, Regional Coordinator and Program Analyst. This request will also be sent to the Department of Human Services Quality Assurance Unit and to the Department Ombuds Office.

b. These staff are responsible for notifying the Bureau of Standards and Inspections of any outstanding issues regarding the State hospital in the areas of interagency/systems development, fiscal or program operations problems or any pertinent incidents affecting client/patient care or rights.

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

8. Referral Agency Interviews

a. Interviews with referral agencies shall be scheduled at least 30 days prior to the review and completed before the pre-site meeting (see Attachment B).

b. In preparation for the review, all emergency/screening and designated liaison agencies in the region should be interviewed and the referral form completed by Office of Community Services Program Analysts. Select police and ambulance units should also be interviewed by the County Mental Health Administrator.

c. The completed forms, including agency name, name of person interviewed and date of the interview should be brought to the pre-site meeting along with a summary of the findings which identifies any difficulties with, or recommendations for, the State hospital.

9. Preparation for the Pre-Site Team Conference (21 days)

Three weeks prior to the review, the team shall:

a. Review the information/lists of issues submitted by the Regional Coordinator and the Office of Institutional Services to assess the issues relevant to the review. Progress in compliance with the recommendations of the last site review, with Division Rules and Regulations and with survey recommendations from the recent JCAH survey must be specifically addressed.

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

10. Pre-site Team Conference (approximately 7 days)

The pre-site team conference will be conducted by the team leader. All team members must attend. The team leader will present identified issues and any outstanding recommendations from the last review will be carefully reviewed. Additionally, individual team members will present general areas of concern regarding the subject

hospital including measures of the hospital's performance and problems identified by referral agencies. The team leader will review the tentative agenda and assign to the members their survey and writing responsibilities.

11. Additional Instructions to Surveyors

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

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

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

d. Team members should familiarize themselves with the Bureau's standardized questionnaires and checklists for assigned interviews, record reviews, ward tours, etc. This will assure the smooth, efficient conduct of the survey process. Prior to the review, the team leader is available for arranging or conducting in-service training for individuals unfamiliar with the procedures for on-site inspections, data collection, and program evaluation.

B. Onsite Protocol, Guidelines and Control

1. Ward Tours

Ward tours will be conducted. During these tours (see Attachment F), surveyors will address standards for patient safety, patient care, patient rights, appropriateness of service provided, the therapeutic environment, quality of staff/patient interaction and administrative controls for quality assurance and resource utilization. Staff and patients may be interviewed. The completed ward tour check lists will be given to the Chief Executive Officer before the end of the review. An aggregation of the ward tour findings will be included in the final report.

2. Review of Clinical Records

Surveyors will be assigned to review clinical records for compliance with standards for assessment, treatment planning, progress notes, discharge planning and justification of service provided. The review will begin with a check of the content and quality of the record using a check list provided by the Bureau of Standards and Inspections (see Attachment G). It may extend to interviews and investigation of discharge planning with community agencies and liaison services. The completed check lists will be copied and given to the Chief Executive Officer before the end of the review. An aggregation of the findings will be included in the final report.

3. Program Deficiencies

In the event that a surveyor observes a program deficiency or specific item/action which may represent a potential danger to patients, it must be brought to the attention of the Chief Executive Officer immediately and to the Assistant Division Director, or his/her designee, within 24 hours. Written explanations must follow within five days and be copied to the Division Director.

4. Hospital Policies and Procedures

a. The policies and procedures of the hospital will be reviewed for compliance with all JCAH standards.

b. A hospital staff person, assigned to each specific manual, will identify for surveyors the policies for each specific JCAH standard.

5. Reconciliation Meeting

This is a team meeting during which each surveyor's observations, data, and resulting recommendations are presented to the entire group for validation and discussion. Input by all team members is obtained and consensus is reached on final recommendations for summation. Minority reports/opinions will not be issued.

6. Summation Conference

The scheduled Summation Conference should be attended by all team members, except consultants, at which time feedback will be provided to the hospital on all major findings and recommendations of the review team. Specific analysis will be given to the findings of the special assessments and the state of compliance with each major requirement of JCAH. Identification of progress in Annual Workplan Objectives may also be underscored. Only feedback, discussed and agreed upon during the reconciliation meeting, may be presented at the summation.

7. A written summary of the major findings and recommendations will be provided to the Division Director, and his/her designee(s), for program remediation within seven work days of completion of the review.

C. Post-Site Review Report Preparation Sequence and Procedures

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

Within two working days of review completion, the team members must submit written reports to the team leader. Complete and neatly handwritten reports are acceptable, while outlines or unorganized notes are unacceptable. Time is set aside during the survey for report preparation whenever possible. The report will identify JCAH and divisional performance standards with a finding of "Compliance", "Partial Compliance" or "Non-compliance" clearly marked, and corroborating data provided for the "Partial" and "Non-compliance" ratings.

2. Within four working days of review completion, the first draft shall be completed by the team leader. The complete report shall be forwarded to the Division Director and Assistant Director, Office of Institutional Services, within seven working days after the review.

3. Dissemination of Report

Copies of the completed hospital review will be sent to the Commissioner, Department of Human Services; Director, Division of Mental Health and Hospitals; Assistant Director, Office of Institutional Services; Chief Executive Officer; County Mental Health Administrator; and team members.

4. Response to Final Report

Within 30 days from receipt of the program review report, the hospital shall provide a response to the survey recommendations, to the Division Director. The response must include current and future plans for compliance with recommendations. The report will become a public document 30 days after the report is received by the hospital. The report, with response, will be forwarded to the County Mental Health Administrator who was not able to participate in the review.

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

Review Team Composition

Standards and Inspections	R
OCS Regional Coordinator	R
OCS Program Analyst	R
OIS Staff	R
County Mental Health Administrator	R

O = Optional
R = Required

ATTACHMENT B
A.B. 9:02

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

INSTRUCTIONS:

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

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

1. The designated transitional provider in each service area.

2. The Emergency Service/Screening provider in each service area.

3. Some of the community inpatient facilities.

4. Selected municipal or other courts.*

5. Selected police departments.*

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

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

   b. How many clients were referred from your service area to this hospital during the last: Month_____Quarter_____or Year_____?

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

      Month_____ Quarter_____ Year_____

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

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

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

      _____

3. What is the general disposition of people deemed "inappropriate for admission" by the hospital? _____

_____

4. What is the role of your agency in this case (e.g., link clients to community services)?_____

_____

5. Do you know the specific admission criteria of this hospital?_____

6. Do you regularly call the hospital to:

   a. Notify them that a client is coming? _____

   b. Provide the information you gathered? _____

   c. Comment _____

   _____

7. a. What percentage of all admissions from your service area to the hospital were screened by a community agency prior to application for admission? _____

   b. What does screening consist of? _____

   c. Please explain _____

   _____

8. What screening/emergency services are regularly provided prior to referral of a client to a hospital? _____

_____

9. Are you/your clients satisfied with the clinical services provided to clients you refer? _____ If not, why not? _____

_____

Discharge Planning:

10. Do you receive notice of admission/discharge for all your service area clients from this hospital? _____

    Admission #_____%_____ (estimated)

    Discharge #_____%_____ (estimated)

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

Comment on the nature, extent and adequacy _____

_____

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

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

_____. What is your relationship to

that agency? _____

_____

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

c. Explain how the liaison participates in discharge planning.

_____

_____

d. Are any other staff from your agency involved in discharge planning? _____

e. Are there transportation problems? _____ Explain _____

_____

f. Do the liaisons face barriers dealing with hospitalized clients? _____ Explain _____

_____

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

ISDP development_____ Team meeting_____ Records

review_____ Post discharge_____ Activities_____.

h. Comments on liaison responsibility: _____

_____

ATTACHMENT C
A.B. 9:02

TO: Regional Coordinator

FROM: _____, Coordinator
Bureau of Standards and Inspections

A program review of _____ is scheduled for _____. _____ is the team leader.

Please provide to the team leader by _____ a list of relevant systemic or other issues which you feel should be addressed during this review.

ATTACHMENT D
A.B. 9:02

TO: Office of Institutional Services

FROM: _____, Coordinator
Bureau of Standards and Inspections

A review of _____ is scheduled for _____.

Please critique the workplans, special assignments, JCAH deficiencies and general compliance with the Division's goals and objectives.

Please provide this information to _____, team leader, by _____ (one month prior to the scheduled review).

SCOPE AND PURPOSE OF REVIEW OF STATE PSYCHIATRIC FACILITIES

The Division of Mental Health and Hospitals, Bureau of Standards and Inspections will provide a JCAH-type evaluation annually. Recommendations are provided to the Director of the Division of Mental Health and Hospitals and to the hospital.

The onsite review of the State psychiatric facilities will include representatives of the following:

Bureau of Standards and Inspections
Office of Community Services
Office of Intitutional Services
County Mental Health Administrators

The onsite process will include ward tours (format attached), records review (format attached) and evaluation of policies and procedures. The completed ward tour and record formats will be provided to the administration during the review, and quality assurance, as well as program observation. There may be special reviews of some projects during the overall review.

All emergency/screening and designated liaison agencies will be interviewed, using the attached format, during the pre-site process. The results of these interviews will be used to identify hospital and systemic strengths and procedures in preparation for the review.

Please assign a person to each manual. It will be that person's responsibility to identify for the surveyor the item/policy that meets each of the JCAH standards.

Programs are observed based on a schedule provided by the facilities. This schedule should include on and off ward activities/meetings/treatment team meetings. This activity schedule should be provided to the team ahead of time to minimize disruption to clients and staff. Programs/activities/meetings will probably be observed during the third and fourth days of the review. Please have a complete schedule available.

Line staff are chosen for interviews either at random or by job function (if there are specific areas for surveyors to address). This balances the review in that not all findings are based on either surveyor observation or administrative feedback.

200-278/419

ard: [redacted] Surveyor: [redacted] Date: Hospital: [redacted]

Standard	Rating
BATHROOMS	
Hot water temperature controls must be inaccessible to patients (35.50.1)	
In bathing areas non-ambulatory patients must have access to grab-bars, etc. (35.48)	
1 toilet per 8 patients (HEW 7.2)	
1 tub/shower per 12 patients (HEW 7.2)	
Toilets must have seats (36.15)	
Bathrooms and toilets must have privacy partitions (36.15)	
Ventilation must remove undesirable odors (36.7.2)	
Toiletries (soap/towels/toilet paper/toothpast) must be provided (36.15)	
Bathrooms must be clean/sanitary (inc. no mold or mildew) (36.1)	
BEDROOMS/DORMITORIES	
In room housing 4 or more patients, furniture placement or partitions should provide privacty (36.14.1)	
No more than 8 patients can sleep in each room unless clinically justified in writing (36.14.3)	
Ample closet/drawer/lockable storage space must be provided (36.15.1)	
Patients must be allowed to personalize and decorate rooms (36.19)	
Patients encouraged to maintain their own living quarters	

Standard	Rating
OVERALL ENVIRONMENT	
The environment must be normalized and enhance the positive self image of patients (36.1)	
The unit must be accessible to the handicapped (36.3)	
A telephone must be available for private conversations (36.4)	
Mirrors that mini-distort must be provided (36.6.5)	
Clocks and calendars should be available (36.6.6)	
Ventilation must contribute to the habitability of the unit (36.7)	
Smoking rules must be enforced (35.63)	
Unit must be clean well maintained and free of vermin (36.1)	
Staff/patient interaction must be encouraged (36.10)	
The Bill of Rights must be posted. (14.5.1)	
LIFE SAFETY	
Fire extinguishers must be inspected monthly. This must be documented (NCF 4.3.1)	
All exits must be clearly illuminated (life safety code 5-10.1.1)	
Fire drills must be at least held quarterly for each shift in each building (35.68)	
Stairways/egress must not be cluttered or obstructed (35.77)	

Standard	Rating
MEDICATION ROOM	
Distrubution and administration of controlled drugs must be properly documented (29.3.1.4)	
An emergency kit must be available; contents must be listed and it must be inspected montly or after each use (29.3.1.6)	
All drugs must be kept in locked storage. Controlled drugs must be under double lock (29.30.1)	
Outdated drugs can not be stocked (29.3.11.3)	
Antidote charts and the regional phone poison control number must be posted (29.31.1 & 2)	
Metric weight and measure conversion charts must be posted (29.31.1)	
The policy and procedure manual must be available (4.1.5)	
Drugs requiring special conditions to assure stability must be stored accordingly (29.3.1.2)	
Self medication programs should be initiated when appropriate (29.9)	
PATIENTS' APPEARANCE	
Clothing must be normalized (36.21.4)	
Good standards of personal hygiene and grooming (hair, teeth, nails) must be maintained (36.16)	
Clothing provided by the program must not be dehumanizing (36.21)	
Training and help in the selection and proper care of clothing must	

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

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

Attachment G
Ward A.B. 9-82

Hospital Record Review

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

BS&I Rev. 8-82

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

Put any comments on back of form

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

Subject: A.B. 9:03
Date: Mon, 21 May 2001 12:45:05 -0400
From: Alan Kaufman <akaufman@dhs.state.nj.us> Internal
Organization: New Jersey Department of Human Services
To: Pete Revesz <prevesz@dhs.state.nj.us>
CC: Bob Immordino <bimmordin@dhs.state.nj.us>, Lyn Gates <lgates@dhs.state.nj.us>, Mike Sclafani <msclafan@dhs.state.nj.us>, Paula Turek <pturek@dhs.state.nj.us>, Michael Greenstein <mgreenste@dhs.state.nj.us>

Pete,

It appears to me that when we revised the certification procedures (and soon the licensing procedures) we -- in practice -- revised A.B. 9:03. In doing so, it looks like we neglected to rescind this A.B. and should have done so.

In this regard, I've recently asked Michael Greenstein to review all of our Administrative Bulletins with an eye for identifying those which require revision, repeal, etc. I suspect we may have others that have become out of date.....

I recognize that this issue raises the question of what reviews are conducted for programs funded by DMHS for which we do not have program standards and/or regulations. For some, program reporting and regional reviews may be sufficient; but for others we may need to look at what procedures, if any, should be utilized. In this regard, and by copy of this note, I'd ask that Mike Sclafani take the lead in looking at this issue, conferring with OFMO and other Central Office units, and making recommendations.

Thanks!

Alan