Senate Concurrent Resolution 112

of the 2018 Regular Legislative Session

Prepared by:

Pinecrest Workplace Violence

And

Employee Injury Task Force

Workgroup

February 2019

LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

During the 2018 regular session, the Louisiana Legislature Senate Concurrent Resolution 112 created the Pinecrest Workplace Violence and Employee Injury Task Force to study the reported problems relative to workplace violence and employee injuries at Pinecrest Supports and Services Center (Pinecrest) in Pineville Louisiana. Pinecrest is an Intermediate Care Facility for individuals with Intellectual and Developmental Disabilities operated by the Louisiana Department of Health (LDH). This report represents the findings of the Pinecrest Workplace Violence and Employee Injury Task Force. The workgroup was formed to consist of the following members; Chair of the Committee on Health and Welfare, or another member of the committee designated by the chair, the Chair of the Committee on Labor and Industrial Relations, or another member of the committee designated by the chair, the Secretary of the Department of Hospitals, or her designee, the Secretary of the Louisiana Workforce Commission, or his designee, the Attorney General, or his designee, and the executive director of the American Federation of State, County, and Municipal Employees Council 17 or his designee. The initial meeting was held on October 18, 2018 with a follow-up meeting held December 3, 2018. The workgroup reviewed detailed information and data regarding circumstances leading up to the temporary increase in employee injuries, causal/contributing factors to the temporary increase, actions taken by LDH to mitigate the issues, data pre- and post-interventions to analyze results, and evaluated whether or not other interventions were needed to assure safety for staff at Pinecrest.

Results of the study by the workgroup indicate clear, identifiable contributing factors such as closure of other facilities increasing demand for admissions of more challenging individuals with an inadequate regulatory and facility structure to support that level of need. The review indicated a plethora of actions and activities on the part of LDH staff to identify the issues and rectify the problems as quickly as possible. This included:

- onsite visits
- daily conference calls to review status on tasks
- creating better options to transfer individuals between LDH-operated facilities
- staff from other agencies to assist
- retraining of staff
- restructuring of the facility's programmatic structure
- implementation of Nonviolent Crisis Intervention Techniques to better deal with problem behaviors and violent situations
- increasing activities provided by the facility for the individuals
- increasing individual and group therapy options to better address underlying behavioral and mental health issues

Overall results indicate significant improvements in employee safety and an overall reduction of employee incidents at the Pinecrest facility. For example, it is now easier to transfer qualifying individuals who need transfer at a more appropriate setting, admissions who are screened more carefully to reduce the impact of admissions where individuals' needs are beyond the facility's programmatic capabilities.

As a result, employee injury rate is down, and lost work time due to injury is down at the facility. Staff satisfaction has improved as evidenced by Direct Care staff turnover rate is down 41 percent since January 2018 and overall facility vacancy rate is down. The programmatic structure and daily

activities have been enhanced to better meet the needs of the individuals supported resulting in less incidents. Staff are better trained and now have better understanding of how to deal with the increased level of behavioral and psychiatric challenges and better suited to deescalate challenging situations and reduce potential for incidents and injuries.

Section 1 – Findings

Causal Factors

- Originally, nine ICF/DD facilities were operated within OCDD. Currently OCDD only operates Pinecrest, which serves as the safety net facility for the State's Developmental Disabilities Service System.
- Privatization of Hammond facility resulted in subsequent closure of IDD Stabilization Unit.
- Privatization of Southeast Hospital resulted in the closure of Developmental Neuropsychology Program (DNP) unit.
- These closures and privatizations created a significant increase in need for admissions and placements at Pinecrest.
- Substantial staff layoffs occurred at Pinecrest during the previous administration.
- The previously required investigation process caused significant numbers of staff being unavailable to work which negatively affected Pinecrest's operation.
- There was a limited understanding among local law enforcement regarding the newer behaviorally/psychiatrically challenged population served by Pinecrest.
- The Developmental Disabilities Service System included no clear mechanism to discharge residents from Pinecrest whose needs were beyond the capabilities of the facility.
- By regulation, the facility cannot remove individuals' belongings without due process and an established mechanism to return the belongings.
- The antiquated CPSI system was not effective in dealing with the newer population.
- By regulation, the facility cannot use as needed (PRN) medications to suppress behavior.
- By regulation, the facility cannot use isolation and/or segregation techniques.
- The facility's programmatic structure was designed for a traditional Intellectual/Developmental Disability (IDD) population.

Actions Taken-Staff Training

- Updated Intensive Treatment Unit (ITU) procedures.
- Trained staff on ITU procedures.
- Trained staff on mechanical restraint protocols.
- Designed and implemented training on power struggles, which teaches staff to diffuse and deescalate situations and not argue with individuals.
- Trained staff on employee incident reporting system DA-2000.
- Trained staff on access to and requirements to seek medical attention when warranted.
- Implemented Crisis Prevention Institutes (CPI) nonviolent crisis intervention program.
- CPI certified five trainers initially for Pinecrest.
- Immediately began training staff in CPI based on priority and acuity of areas worked.

Actions Taken-Safety Initiatives

- Immediate environmental modifications in ITU (sinks, toilets, ceilings, tables, and chairs).
- Increased staffing in ITUs.
- Created a third ITU building to separate individuals.

- Designed a search protocol for individuals who had a history of contraband and weapons.
- Officers from Eastern Louisiana Mental Health System (ELMHS) deployed on site to assist.
- Increased number of Pinecrest Police Officers.
- Enhanced relationship with Pineville Police Department.
- Reestablished and filled Safety Officer Position lost in layoffs.
- Reinstituted the Safety Committee.
- Established an internal Work Safety Task Force.

Actions Taken-Facility Transfers

- Created a mechanism to transfer qualifying individuals to a more appropriate facility.
- Transferred five individuals to more appropriate facilities within LDH.
- Designed a formal protocol for transfer of qualifying individuals.
- Transferred subsequent individuals since implementation of this protocol.
- Revamped the screening process for admissions to the facility based on characteristics of individuals transferred.

Actions Taken-Programmatic Structure

- Revamped programmatic structure to meet distinct needs at the facility. Moved to a Program-based treatment structure.
- Crossroads – designed for residents with dual diagnosis, consisting of both intellectual disability and a significant mental health diagnosis.
- Bridges – designed for residents diagnosed with an Autism Spectrum Disorder with concurring behavioral challenges.
- Pace – designed for traditional intellectual disability geriatric population designed to meet both physical and mental needs related to aging.
- Compass – designed for high need medically fragile residents. These individuals have complex medical needs such as g-tubes, are non-ambulatory, require complex alternate positioning schedules to reduce risk for decubitus, and respiratory therapy.
- Gateway – transition program for individuals transitioning back into the community. These individuals are working on specific skills to help them live independently in the community
- Moved residents to distinct areas and designed Program-specific training, treatment, and therapy to meet their specific needs moving away from a one-size fits all traditional ICF/IID model.

Actions Taken-Programmatic Activities

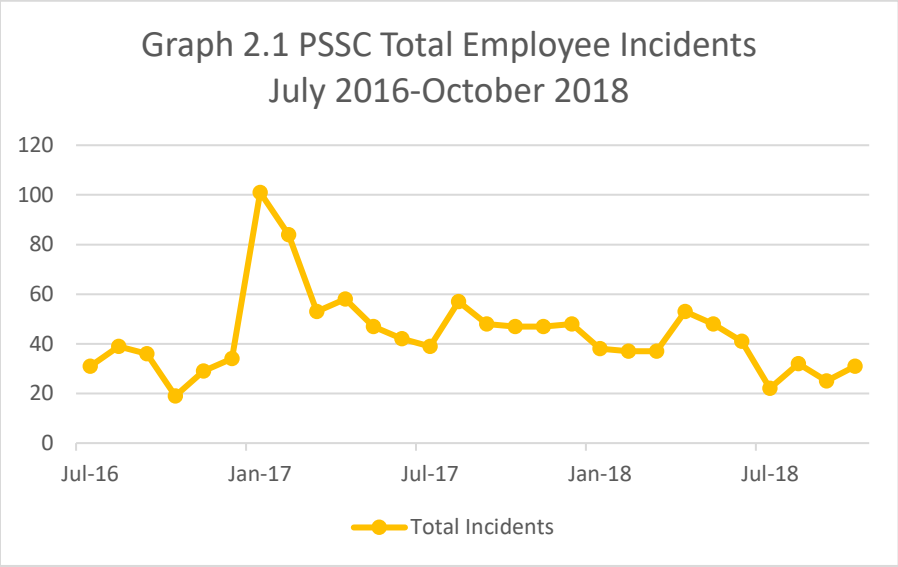
- Increased activities and events in the evenings.
- Designed and created the Loft area for individuals in Crossroads. This area has video games, pool table, air hockey, indoor basketball, a movie theater, and refreshments. Attendance is contingent on no admission to the Intensive Treatment Unit.
- Designed and created a Positive Behavior Support system including earning points for positive behavior and a points store with extensive inventory. Individuals earn points for appropriate behavior and can spend those points to buy various items in the point store.
- Created new job opportunities for individuals.
- Moved away from old subminimum wage system.
- Revamped work schedules to create additional treatment and therapy time for clinical staff.

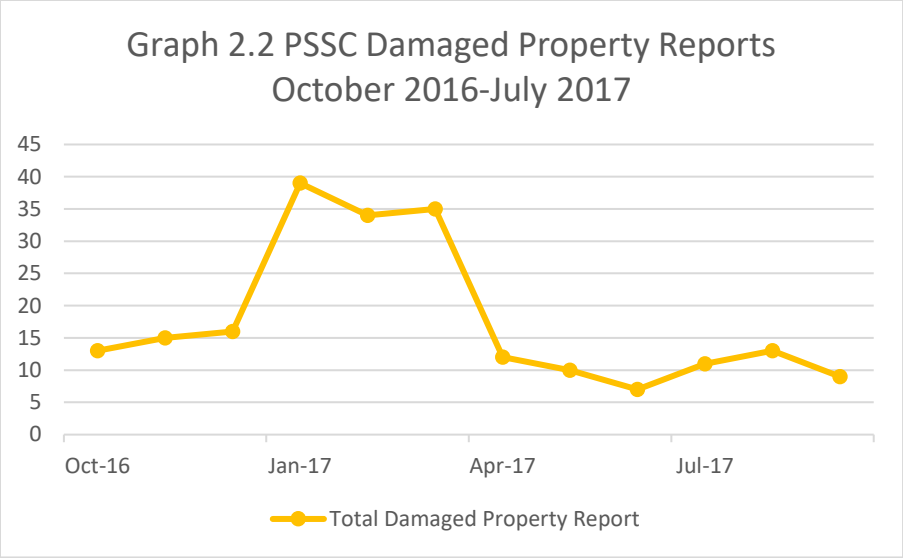
RESULTS

- Qualifying individuals needing transfer to a more appropriate placement are easily transferred now.
- Admissions are screened more carefully reducing the probability of inappropriate placement.
- Direct Care turnover rate down 41 percent since January 2018.
- Overall Vacancy rate is down.
- Employee injury rate is down.
- Lost work time due to injury is down.
- No mechanical restraint use at Pinecrest since February 19, 2018.

Section 2 – Graphs

The following graphs depict PSSC employee incident and damaged property report data prior to, during, and after the significant increase in incidents that led to the establishment of the taskforce. The work of which is reflected in this report.




Graph 2.2 PSSC Damaged Property Reports
October 2016-July 2017
45
40
35
30
25
20
15
10
5
0
Oct-16
Jan-17
Apr-17
Jul-17
Total Damaged Property Report

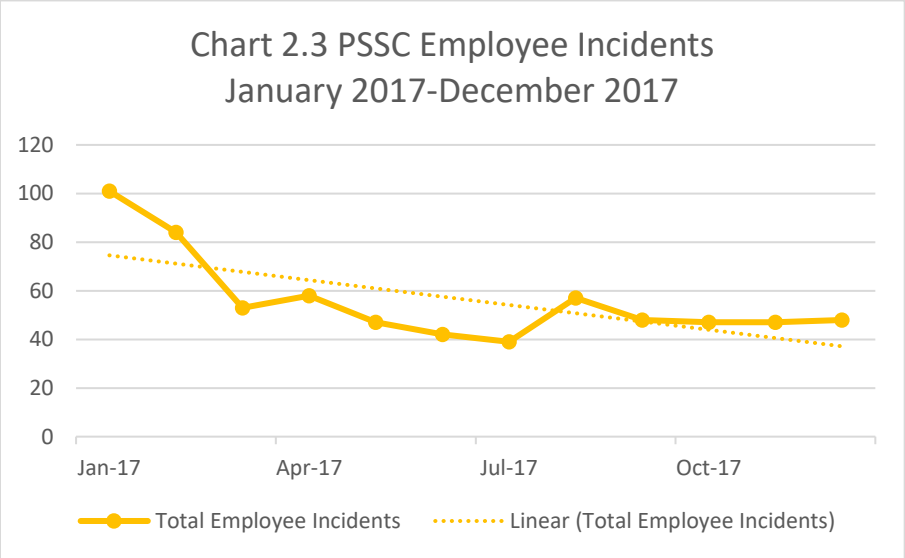


Chart 2.3 PSSC Employee Incidents
January 2017-December 2017
120
100
80
60
40
20
0
Jan-17
Apr-17
Jul-17
Oct-17
Total Employee Incidents
Linear (Total Employee Incidents)

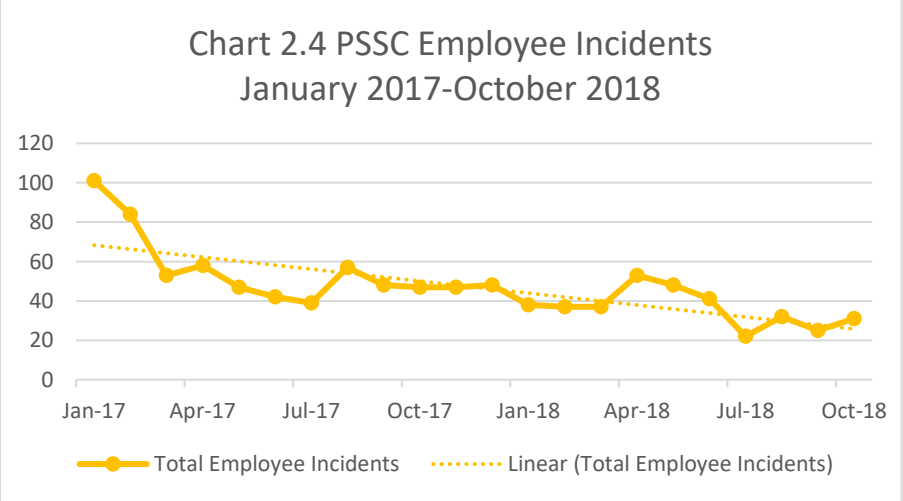


Chart 2.4 PSSC Employee Incidents
January 2017-October 2018
120
100
80
60
40
20
0
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Total Employee Incidents
Linear (Total Employee Incidents)

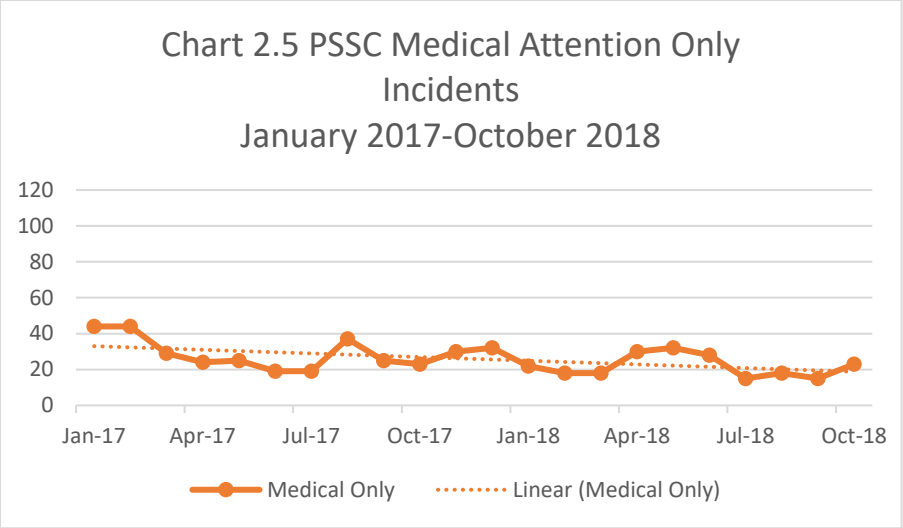


Chart 2.5 PSSC Medical Attention Only Incidents
January 2017-October 2018
120
100
80
60
40
20
0
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Medical Only
Linear (Medical Only)

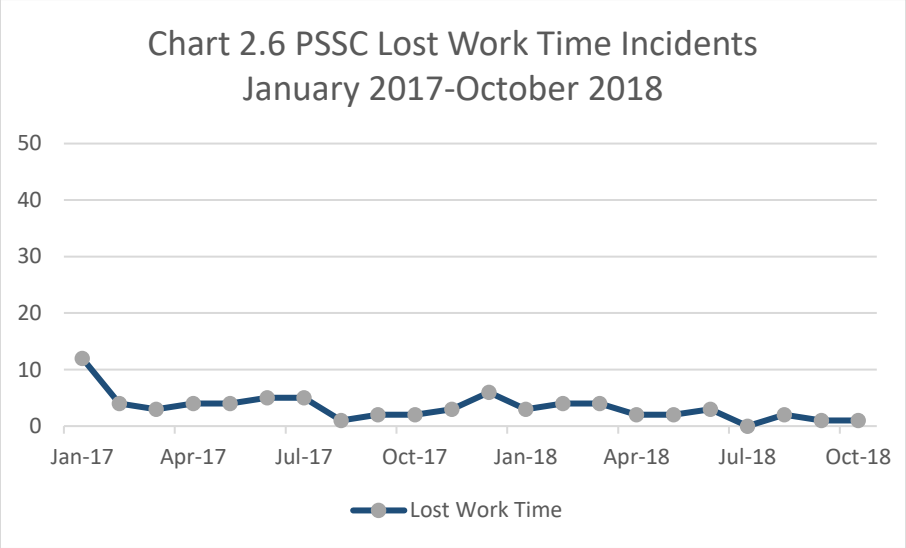


Chart 2.6 PSSC Lost Work Time Incidents
January 2017-October 2018
50
40
30
20
10
0
Jan-17
Apr-17
Jul-17
Oct-17
Jan-18
Apr-18
Jul-18
Oct-18
Lost Work Time

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov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