Some people liken the hospital’s improvement process to steering an aircraft carrier. With an organization this big and complex, it takes time to change course, and it is easy to get impatient. It is natural for people to try and do everything at once, but in order to be successful, we have to focus on the most critical issues first. If we give each project equal priority and stretch our resources too thin, things get slowed down even more.

As you may know, one of the important findings of the Liberty Health Care report had to do with the size and function of the OSH Cabinet. Related to this was the observation that OSH has an excessive number of committees, some of which are duplicative and some of which may not be necessary.

As a hospital, we need to clarify roles and distribute the work evenly so we can focus on our priorities and make sure the work gets done in an efficient and timely manner. As the first steps toward this goal, we have made two new appointments and redesigned the cabinet.

First, I am pleased to announce the appointment of Lee Hullinger to the newly established position of deputy superintendent for operations. In this role, Lee will directly supervise the hospital’s operations commonly referred to as “Support Services” – Food and Nutritional Services, Housekeeping, Facilities, Warehouse and the Fiscal Office. It is important that all support services work in a coordinated fashion, not only with each other, but with clinical leaders, so that we can achieve the goals we seek. With Lee at the helm, I’m confident this will be the case.

This will also allow Deputy Superintendent Nena Strickland to focus on improvements within our clinical programs. As the head of clinical administration, Recovery Services and Forensic Psychiatric Services report to her. Nena’s knowledge and expertise will be a great benefit to these programs, and this change will help ensure they get the time and attention they deserve.

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After redefining the roles for the deputy superintendents, the next step is to redefine the role of the Superintendent’s Cabinet. Effective immediately, the cabinet will be comprised of only the following people: the superintendent, the two deputy superintendents, the clinical director, the human resources director, the chief nursing officer, the director of nursing, the chief of psychiatry, the chief of medicine, the director of strategic planning, and the president of the medical staff. Changing cabinet membership will help hospital leadership make decisions faster and focus on our priorities. It is likely that the cabinet membership will be revised again when the chief medical officer position is filled.

This new streamlined cabinet will be more of a steering committee, with the majority of improvement processes being delegated to subcommittees that will make regular reports to the cabinet on their progress, which leads us to the next step — streamlining the hospital’s committees. The “new” cabinet will work with our consultants from Kaufman Global to examine our existing committees and their functions. Through this process, we will clearly define each committee’s role and membership to avoid redundancies. I expect that the number of committees will be reduced as committees are condensed.

My second appointment is to a new position outside of cabinet. It is my pleasure to announce that Nikki Mobley has accepted the new position for OSH mall administrator. In this new position, Nikki will have overall responsibility for the five (soon to be six when we move into Trails) treatment malls; all mall managers and RN mall managers will report directly to her.

It is our goal to ensure that the six treatment malls operate in a standardized fashion, rather than as six independent units. We can better reach this goal by having one person concentrate on the program as a whole and guide the improvement process. Under Nikki’s leadership, mall programming will ensure the treatment provided is based on person-centered treatment plans, reflecting the patient’s expressed goals and treatment team recommendations. Mall programs will also include recreational/leisure activities seven days a week. Eventually, we expect to provide active treatment and leisure activities on both day and swing shifts.

All of these changes will help us establish clear objectives, so we can focus on our priorities and continue to move the hospital forward until we have achieved our goals — creating a safe, therapeutic environment where people living with mental illness can recover, heal and return to their lives in the community.

Sincerely,

Greg Roberts
Superintendent
Recent publication: Seclusion and restraint prevalence, comparing hearing and deaf or hard of hearing patients at OSH

By Callie H. Lambarth

Dr. Brian Hartman, a forensic psychologist at the Oregon State Hospital, and co-author Ann Blalock recently published an article entitled, “Comparison of Seclusion and Restraint Prevalence between Hearing Patients and Deaf or Hard of Hearing Patients in a State Hospital Setting” in the peer-reviewed journal *Issues in Mental Health Nursing*. This article is a result of the first project to be approved by the hospital’s Research Committee and Institutional Review Board and be accepted for publication.

Although it is widely assumed that deaf and hard of hearing individuals experience higher rates of seclusion and restraint in state hospital settings, the authors set out to test this assumption. Dr. Hartman and Ms. Blalock hypothesized that deaf and hard of hearing patients would have higher rates of seclusion and restraint compared to hearing patients.

The authors reviewed charts for a sample of 22 deaf or hard of hearing patients and matched them to hearing patients on factors thought to be associated with behaviors that can result in seclusion and restraint. These factors included age at admission, gender, commitment type, Axis I and II discharge diagnoses and length of hospitalization in months. Charts were reviewed to identify restrictive events (seclusion and restraint) and calculate mean number of incidents per month, mean number of incidents per hospitalization episode and length in minutes of each restrictive event.

Deaf and hard of hearing patients showed significantly higher rates of seclusions and combined seclusions and restraints compared to hearing patients. Although not statistically significant, hearing patients experienced a higher mean length of both seclusion and restraint compared to deaf and hard of hearing patients.

Dr. Hartman and Ms. Blalock suggest that possible reasons for these differences are related to communication and the typical crisis cycle. For the vast majority of the restrictive events experienced by deaf and hard of hearing patients, an interpreter was not present at the time of the incident leading up to the seclusion or restraint. The authors hypothesize that this may have resulted in the deaf and hard of hearing patients being placed in seclusion and restraint sooner in the crisis cycle compared to their hearing peers as a result of limited communication between the patient and staff to de-escalate the precipitating incident. At the same time, the authors suggest that because deaf and hard of hearing patients were placed in seclusion and restraint earlier in the crisis cycle, their incidents escalated to a lesser degree than those of hearing patients. They were then able to calm themselves more quickly and therefore experienced a shorter restrictive event than their hearing counterparts.

Although the study is limited by a small sample size at a single institution, the authors describe several implications of their research. First, if direct, signed communication is not possible, the authors recommend that qualified interpreters be available at all times for deaf and hard of hearing patients. Second, interpreters should be certified, have experience with mental health interpreting, and be comfortable working with agitated individuals. Third, language strengths and limitations of patients should be known by psychiatric nurses. Fourth, psychiatric nurses

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What to expect when you’re expecting to use an Electronic Health Record

By Angel Bringelson, BHIP Business Analyst

Very soon you will be sitting in a computer lab, learning more than you ever wanted to know about the new charting software called Avatar. These classes are designed to be computer-based and hands-on software training, and will take place in small-group settings. The classes will be offered during all shifts in the six weeks before the “go live” date, and will be available in Salem and Portland. It is very important that you attend these classes because there will be very few make-up classes available, and we do not want you to be the only one on your unit who doesn’t know how to use the new system. Most Oregon State Hospital staff will have at least four days of training; however, some staff will undergo additional training.

As part of your training, you will also receive Avatar Training Guides. These guides are specific to each of the options or forms that you will use in Avatar. They have step-by-step instructions, so if you need assistance, you can turn to a certain page and find the help you need. An example of a training guide is here for you to see. Eventually, the Education and Development Department will maintain these documents and provide updates when needed.

As you begin using Avatar, you will notice a help menu in the upper right corner. A nice feature of this help function is that it allows users to search for a form or option they need. For example, if you put the word “group” in the search screen, you will get a link to the group note. Just click on that link, and voila – you are in the group note form and can enter information from the group you ran earlier that day.

In addition to the help menu, within many of the forms you will see light bulbs. Click on a light bulb and other helpful information appears on your screen. For example, in the RN Summary, there is a light bulb next to the “Communication Barriers” box. Click on the light bulb

(continued on page 6)
Last month, the Quality Improvement Department reported to you about the four-step, comprehensive auditing process that is taking place on all units this year. Taking a full-circle approach, we want to report preliminary findings for the first two units, 35B and 34C, which were “trailblazers” in the 100 percent chart audit. Major props and kudos to them for stepping up and being the first to undergo this intensive review. As the Recovery Times goes to press, both units are still in the process of follow-up meetings, Environment of Care audits and the creation of action plans to sustain improvements.

Successes

- The RNs and mental health therapists on 35B and 34C deserve recognition for excellence in progress note documentation. Times were consistently present on progress notes. (Entering times on all notes is an area in which other disciplines could still develop strengths.) Of course, the progress notes were also dated and signed.

- Group notes have continued to be refined with more and more group notes documenting treatment services.

- To their credit, the Rehabilitation Services Department staff have added a stamp that clearly identifies their notes specifically and certainly makes auditing and documenting their excellent work much easier.

- Treatment plans continue to evolve and have greater detail, so congratulations to the treatment care plan specialists. Specific, responsible staff members are regularly identified for interventions.

Areas to continue to develop

- New patients (first 60 days) require weekly progress notes from all disciplines.

- Each treatment plan intervention needs frequency and duration identified.

- Assessment information, such as dietary considerations, and treatment mall services need to be increasingly integrated into treatment plans.

Next up on the review process are the cottages and then all five of the new units in Harbors. Again, as a reminder, the audits and tools used in these reviews are consistent with the Joint Commission tools that will be used when they come and survey the Oregon State Hospital. As of August, the Joint Commission can come and visit OSH at any time.
should advocate for consultation with experts in deafness to distinguish between behaviors or issues of patients that are attributed to deafness compared to a psychiatric condition. Finally, psychiatric advance directives, developed in collaboration with the individual and their primary mental health provider, could serve as a tool to prepare for emergency situations when direct communication is not possible.

Citation for the referenced article is: Hartman, B. & Blalock, A. (2011). Comparison of seclusion and restraint prevalence between hearing patients and deaf or hard of hearing patients in a state hospital setting. *Issues in Mental Health Nursing, 32*, 42-45.

Recent publication: Seclusion and restraint prevalence, comparing hearing and deaf or hard of hearing patients at OSH

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and it reads “i.e. English as a second language, hearing loss, speech, aphasia, inability to read/write, etc.” So, when you are in the dark, remember the light bulb.

We will not leave you alone following training. We are training approximately 150 OSH staff to be what we call “BHIP super users.” Super users were chosen from every discipline, every department, every unit and every shift. These individuals will receive a little extra training and assist us as we train the rest of the staff. Then these super users will be there for you to ensure you have the support you need when we “go live.”

Members of the OHA Service Desk also have been trained and will continue to receive training to support OSH at “go live.” While we want you to use local resources such as the training guides and the super users, you also will have someone you can call for help.

One of the service desk members, Dan Thao, has been with our project for the past year. He is learning all he can about Avatar so that when you call, he and others on his team can help you. We are working with the Service Desk to ensure 24/7 coverage is available. So, late at night, when you are having difficulties with the software, help is only a phone call away.

And if that isn’t enough, remember that the BHIP team is not going anywhere yet. We, along with members of the Technology and Services Management Unit and other OSH administrative staff, will be available during “go live” to help you.

As you can see, the BHIP Project Team and others are doing all we can to ensure a successful “go live” with the Avatar Electronic Health Record (EHR) this spring. If you have questions or concerns, we want to hear from you and welcome your feedback. You can e-mail us at bhip.project@state.or.us.
Nutrition news you can use

Vegetables and fruits: Your personal health insurance

Remember the “eat your vegetables” routine at the dinner table? Well, guess what — this childhood advice is supported by scientific research.

Health experts now recommend we eat at least five servings of vegetables and three servings of fruit every day. Here’s why: Vegetables and fruits are low in fat, cholesterol-free, low in calories, loaded with vitamins and minerals, and great sources of fiber.

Scientists believe following this advice alone would go a long way toward improving health in America. Vegetables also contain phytochemicals and antioxidant vitamins. For example, a tomato contains approximately 10,000 phytochemicals, while just one bite of broccoli or Brussels sprouts serves up thousands of phytochemicals.

What are phytochemicals and antioxidant vitamins?

The term phytochemicals refers to chemicals found in plants. You won’t need to shop for them because they occur naturally in vegetables, fruits, grains, nuts and seeds. Scientists believe these plant chemicals may protect our cells from the damaging effects of toxic substances that can result in cancer and heart disease and speed up the aging process.

Vitamin C, vitamin E and beta carotene are examples of phytochemicals better known as antioxidant nutrients. Research suggests that people are at less risk of developing cancer when their diets contain antioxidant-rich foods. Other studies suggest the antioxidant vitamins in vegetables and other plant foods may help reduce heart disease risk.

The best single piece of advice to manage your personal health is to eat a wide variety of plant foods, including vegetables and fruits. Antioxidant vitamins will be just one of the many benefits you will receive by improving your diet.

For a delicious array of foods rich in cell-protecting antioxidants, check out the list below. Think of it as personal health insurance that’s easy to swallow.

Antioxidant-rich foods

**Beta carotene**

Choose yellow-orange and dark green, leafy vegetables and fruits:

- Carrots, sweet potatoes, winter squash, spinach, broccoli, romaine lettuce
- Apricots, cantaloupe, papayas, peaches

**Vitamin C**

- Brussels sprouts, broccoli, cabbage, cauliflower, tomatoes, green peppers, potatoes
- Citrus fruits (such as oranges and grapefruits), strawberries, cantaloupe

**Vitamin E**

- Dark green, leafy vegetables such as broccoli, spinach, romaine lettuce
- Whole grain breads and cereals
- Nuts and seeds such as almonds, hazelnuts, sunflower seeds

Your best bet

Remember, the best way to get phytochemicals and antioxidant vitamins, as well as other nutrients, is to eat a wide variety of foods. This includes multiple servings of vegetables, fruits and whole grains every day. One serving equals approximately half a cup of cooked or raw vegetables, one cup of leafy vegetables, a medium piece of fruit, half a cup of canned fruit, a slice of whole grain bread, or half a cup of cooked brown rice or whole grain pasta.

*National Center for Nutrition and Dietetics: Nutrition Fact Sheet*
March 2011 EDD events
Following is a list of classes being offered at the OSH Education and Development Department (EDD) during March. Classes are located at EDD unless otherwise noted. For more information about these classes, call 503-945-2875.

Pro-ACT refresher:
Held in 40C, conference room 3
Mar. 1 (8 a.m. to 5 p.m.) Day 1
Mar. 2 (8 a.m. to 12 p.m.) Day 2
Mar. 3 (8 a.m. to 5 p.m.) Day 1
Mar. 4 (8 a.m. to 12 p.m.) Day 2
Mar. 15 (8 a.m. to 5 p.m.) Day 1
Mar. 16 (8 a.m. to 12 p.m.) Day 2
Mar. 29 (8 a.m. to 5 p.m.) Day 1
Mar. 30 (8 a.m. to 12 p.m.) Day 2
Mar. 31 (8 a.m. to 5 p.m.) Day 1

General orientation:
Held in 40C, conference room 1
Mar. 7-11 (8 a.m. to 5 p.m.)
Mar. 14 (8 a.m. to 5 p.m.)
Mar. 21-25 (8 a.m. to 5 p.m.)
Mar. 28 (8 a.m. to 5 p.m.)

ED day/CPR:
Held in 40C, conference room 2
Mar. 8 (8 a.m. to 5 p.m.)
Mar. 22 (8 a.m. to 5 p.m.)

Nursing orientation:
Held in 40C, conference room 1
Mar. 15 (8 a.m. to 5 p.m.)
Mar. 29 (8 a.m. to 5 p.m.)
Mar. 30 (8 a.m. to 5 p.m.)

START training:
Held in 40C, conference room 1
Mar. 16 (9 a.m. to 11 a.m.)

Motivational interviewing: the basics:
Held in 40C, conference room 3
Mar. 23 (8:30 a.m. to 3:30 p.m.)

Generations:
Held in 40C conference room 1
Mar. 10 (1 p.m. to 5 p.m.)

Assertive boundary communication:
Held in 40C, conference room 2
Mar. 23 (8 a.m. to 1 p.m.)

Nurse mentor training:
Held in 40C conference Room 3
Mar. 9 (8:30 a.m. to 4:30 p.m.)

CMA pharmacology:
Held in 40C, conference Room 3
Mar. 16 (1 p.m. to 4:30 p.m.)

Learning styles: co-worker dynamics:
Held in 40C, conference room 3
Mar. 25 (1 p.m. to 4:30 p.m.)

Wellness: mind/body connection:
Held in 40C conference Room 3
Mar. 8 (1 p.m. to 5 p.m.)

Forensic nursing orientation:
Held in 40C, conference room 1
Mar. 31 (8 a.m. to 5 p.m.)

Trauma informed care:
Held in 40C, conference room 3
Mar. 16

Wellness: mind/body connection:
Held in 40C conference Room 3
Mar. 8 (1 p.m. to 5 p.m.)

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Forensic nursing orientation:
Held in 40C, conference room 1
Mar. 31 (8 a.m. to 5 p.m.)

OSH new hires and retirees for February

Welcome to OSH

Higa, Justin
Clinical Psychologist 1
Sharpe, Linda L
Mental Health Registered Nurse

Boyd, Montana L
Custodian
Walker, Christine E
Mental Health Registered Nurse

Byrd, Lewis M
Custodian
Anglin, Richey
Mental Health Therapy Tech

Stanley, Glenn A
Custodian
Nicholas, David M
Mental Health Therapy Tech

Bibens, Catherine S
Food Service Worker 2
Overbay, Robin A
Mental Health Therapy Tech

Douglas, Lorie A
Food Service Worker 2
Kohut, Dorothy
Occupational Therapist

Vallejo, Sandra
Food Service Worker 2
Bogdan, Kathleen R
Office Specialist 2

Balladolidsondon, Lupe
Licensed Practical Nurse
Muzzy, Brett V
Procurement and Contract Assistant

Ellis, Rebecca J
Licensed Practical Nurse
Oldham, Marc
Program Analyst 2

Geephart, Tiffany L
Licensed Practical Nurse
Birlew, Amber R
Psychiatric Social Worker

Holcomb, Angela R
Licensed Practical Nurse
Bell, Bruce
Recreational Specialist

Kaufman, Antoinee D
Licensed Practical Nurse
Boggs, Loretta K
Recreational Specialist

McCammon, Lou A
Licensed Practical Nurse
Davidson, Shelley
Recreational Specialist

Multine, Kelsey
Licensed Practical Nurse
Farrell, Cullen
Recreational Specialist

Prather, Priscilla D
Licensed Practical Nurse
Hageman, Justin
Recreational Specialist

Medley, Stephen
Maintenance and Operations Supv
Loftin, Dorothy
Recreational Specialist

Berggren, Zoey
Mental Health Registered Nurse
O Meara, Robert
Recreational Specialist

Castillo, Juan Luis
Mental Health Registered Nurse
Smith, Jessica
Recreational Specialist

Hardwick, Jennifer L
Mental Health Registered Nurse
McCord, Scott D
Rehabilitation Industries Rep

Kirkpatrick, Amber
Mental Health Registered Nurse

Moreno, Sheila R
Mental Health Registered Nurse

Nelson, Rebecca L
Mental Health Registered Nurse

Raikes, Christopher G
Mental Health Registered Nurse

Promotions and reassigments

Jordan, Holly A
Administrative Specialist 1
Obrien, Matthew N
Program Analyst 2

Aguirre, Miguel L
Mental Health Security Tech
Dague, Michelle
Psychiatric Social Worker

Callaway, Anthony D
Mental Health Therapist 2
Johnson, Cynthia
Psychiatric Social Worker

Roy, Kathryn M
Nurse Manager
Applebaum, Jonathan K
Supply Specialist 1

Gonzales, Marlenah
Pharmacy Manager 1

Retirees

Collver, Sharon J
Chaplain
Rye, Gifford J
Mental Health Therapy Coordinator

Leonard, John E
Mental Health Therapist 2

Promotions and reassigments

Jordan, Holly A
Administrative Specialist 1
Obrien, Matthew N
Program Analyst 2

Aguirre, Miguel L
Mental Health Security Tech
Dague, Michelle
Psychiatric Social Worker

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