Medication Management improves safety, efficiency

By Andrea Rapoza, LPN on Mountain 1 in Junction City

I was apprehensive last May when I learned my job was about to undergo a significant change. The OSH-Junction City campus would no longer use paper medication administration records (MARs) and med carts. Instead, it would use electronic records and Omnicell, an automated medication dispensing cabinet.

Administrators told us the new system would result in faster medication distribution, fewer administration errors, and better documentation – but I had my doubts. Having always used paper records, the idea of the unknown was scary.

My morning routine was chaotic, but I knew what was involved. After morning report, I’d greet patients lined up at the window for their meds and tell them I’d need a minute. I’d also work with my fellow nurse on the time-consuming “narc count,” where we counted every narcotic we had.

Usually, clients would knock at the window, wondering what was taking so long. When I was finally ready for them, I’d pull meds night shift had put in individual drawers for each client. I checked them against a paper MAR with handwritten orders, and I’d initial for each med. Simple enough right? Except it wasn’t.

Once I opened the med room window, I ran around like a headless chicken for two hours – administering medications and

Andrea Rapoza, an LPN on Mountain 1, was nervous when Omnicell took up residence in her med room this fall. Now, she says the automated medication dispensing cabinet helps her provide better patient care.

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After years of work and preparation, Medication Management is coming to the Salem campus this spring. The system was successfully implemented in Junction City last fall, and Salem is in the process of making the change now.

Medication Management comprises two very important components of Avatar – pharmacy and medication administration. Medication Management is the term we use for all of the pharmacy and medication-related functions of the electronic health record, including:

- Pharmacy-entered medication orders
- Electronic medication administration records (eMAR)
- Bar code scanners, making it easier to document medication administration and ensure patient safety
- RxConnect – the Pharmacy system
- Omnicell automated dispensing cabinets (ADCs) – these will replace the old medication carts on each unit

From the beginning, people from throughout the hospital – who will actually use the system – have taken part in the development, planning, testing and training for Medication Management. Ultimately, the system will allow us to improve patient safety, streamline documentation, and reduce administration errors. It will also help us achieve the “five rights” of medication management: the right patients will get the right drug, in the right dose, by the right route, at the right time.

But don’t take my word for it. Talk to Andrea Rapoza, an LPN in Junction City. When she learned Medication Management was coming her way, she was nervous. She didn’t like the idea of a bulky machine invading her space in the med room, and she didn’t want to change a routine that had taken her months to perfect.

Three months later, Andrea is a fan. She no longer has to write orders, search through paper medication administration records for missing initials, or try to remember what “as-needed” meds patients received on a particular day. She’s able to provide better patient care, and patients are happy with the improved service.

I expect that the implementation of Medication Management will be just as smooth in Salem. Leadership will give staff the time and resources they need to learn the new system, and they are committed to impacting everyone’s current workflow as little as possible.

Trainings are now under way. If you have any questions, please contact Chief of Medicine, Dr. Brian Little at brian.little@state.or.us.
On an unrelated note, I also want to express my appreciation to everyone who helped out during our recent snow and ice storms. In Salem and Junction City, our people – nursing, transporters, housekeeping, Food Services, Facilities, and Warehouse staff – all did a masterful job coordinating various aspects of the Emergency Plan. Everyone gave above and beyond to keep each other, and our patients, safe. Thanks again for your outstanding work.

Sincerely,

Greg Roberts
Superintendent

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After putting her fingerprint on the Omnicell, LPN Andrea Rapoza can access the medications she needs in seconds.

treatments, taking blood sugars, and providing meal replacements. I was usually alone the whole time.

People often forgot to write names on the sheets, so I didn’t always know which medications went to which patients. Sometimes, I couldn’t read the handwriting, or people forgot to put their initials on the MAR. Other times, medications were missing, so I had to call the pharmacy to reorder what was needed.

Medication Management Heading to Salem

Now that the Junction City campus has successfully implemented Medication Management, it’s Salem’s turn.

Trainings are underway. Springs will “go live” in mid-April, and the rest of the campus will follow suit in early May. Talk to your supervisor to learn more about the Medication Management training schedules.

If you have any questions about Medication Management, please contact Chief of Medicine, Dr. Brian Little at brian.little@state.or.us.
If I needed to clarify an order, I’d close the window, tell everyone to wait, and go into the chart room to find the written order. Clients were not happy with this, understandably. Sometimes, I even have to rewrite orders during the med pass! With all that being said, I had my system down, and I feel like I was pretty good at it.

Then, on Nov. 1, this big, imposing machine showed up in the med room. I didn’t like it. It was bulky, and it cramped my style. I didn’t know how it would affect my job, or if it would make my life easier or more difficult. Luckily, I gained the answers I needed through an influx of training and support in the weeks ahead.

After using the new system for more than two months, I can enthusiastically state that the new way is much, much better! Now, I only have to do the narc count on meds accessed during the previous shift, meaning I usually have to count only a couple of meds with the machine. You walk up, put your fingerprint on the Omnicell, and you are ready to go. I also have another LPN, Lindie Nelson, with me during the entire med pass. We both have windows open, and clients appear more calm and relaxed with very little wait involved. The Omnicell has everything available, from long-acting injections to skin treatments. If someone needs Tylenol, we pull it out in seconds. If there is a new order, Pharmacy processes it, and we quickly pull it out of the Omnicell. Lindie and I help each other all day long, and the stress of having to “do it all” has been cut in half.

If I forget something, she remembers. If she needs something when giving meds, I get it for her. No closing the window. No repeating the phrase, “hold on a minute, and I’ll get that.” No writing orders, period. Now, I don’t have to constantly search through the paper MAR to find missing initials or try to remember what as-needed meds were given out to patients that day. There’s a report for that. In fact, there is a report you can print for just about anything.

Within three days of using the new system, I had established a good, solid routine. I still can’t believe I get paid to put my fingerprint on a machine and have medications pop out of it. It’s ridiculously easy. Now, I’m far less stressed and I’m able to provide better patient care. More importantly, patients get the correct drug, in the right dose at the right time, and they’re happier – and safer – for it.

As hard as change can be, I am so thankful leadership saw that this change was needed. They gently led us to this much-needed transition, and they supported me the entire time. I thought I’d have to figure this out by myself, and I couldn’t be more wrong. We’re all in this together.
CPS now offers practice labs to all hospital staff

Last fall, Collaborative Problem Solving (CPS) coaches began offering practice labs on CPS principles for the first time.

These monthly, two-hour trainings are designed to give all OSH employees an opportunity to learn more about why Oregon State Hospital (OSH) uses CPS and what tactics staff can employ to help patients with behavioral challenges.

“You aren’t sitting in a classroom listening to a speaker the whole time,” said CPS Coach Jeremy Fleener, who led the first training. “This is interactive. You play games, you discuss problems. You learn.”

Launched at the hospital more than two years ago, CPS is an evidence-based approach used to enhance patients’ decision-making abilities and forge cooperative relationships with staff. The foundation of CPS is that people do well if they can, and patients are more likely to succeed in the community if they possess skills to manage their behaviors.

During the first practice lab, Fleener emphasized that CPS is about creating an empathetic, therapeutic environment where staff seek to understand patients’ concerns.

“This is about having a different frame of mind,” he said. “You need empathy, lots of it, to charter the demands in life. When you have triggers, lagging skills and trauma, challenging behaviors result.”

Together, the class’ 15 participants identified several troubling behaviors they routinely see in patients — from yelling and punching walls to kicking and inflicting self-harm. The class then played the “lagging skills game” to help explain why patients may act out the way they do.

For example, if they bang on a wall, it may be because they don’t know how to tell someone what’s bothering them, or they might be seeking attention in an inappropriate way.

“People struggle with these issues. Sometimes we forget that,” Fleener said. “You see a grown person in front of you, and you don’t understand why they can’t control their behavior.”

Behaviors are “fruits of the tree, because they’re in plain sight,” Fleener said. What’s more difficult is identifying the triggers that cause problems.

Triggers could be a troubling phone call from home, a loud noise, or even the smell of a familiar perfume. Only by paying close attention to patterns and talking to patients can one hope to learn what caused the behaviors, Fleener said.

Register Now

CPS practice labs will take place on both the Salem and Junction City campuses. In Salem, a lab is offered on Thursday, Feb. 16, from 7 to 9 a.m. and on Monday, March 20, from 3 to 5 p.m. In Junction City, a lab will take place on Monday, April 3, from 10 a.m. to noon.

To register, go to ilearn.oregon.gov. Enter “CPS Practice Lab” in the search box, scroll down, and register for the “OHA-OSH Collaborative Problem Solving Practice Lab.” There are no prerequisites for this workshop, but your manager’s approval is needed. Space is limited.

For more information, contact CPS Coach Jeremy Fleener at 503-358-2537 or jeremy.fleener@state.or.us.

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CPS now offers practice labs to all hospital staff

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Before CPS was implemented at the hospital, he said staff were taught to control outbursts. If someone yelled, you’d make them go to their room. As a result, patients didn’t learn how to avoid making an outburst in the first place – a skill they need to handle themselves in the community.

“Our job is to ask why,” Fleener said. “You can’t change a behavior without getting to the root of the problem.”

Jerry Weller, an MHT2 on the Crossroads Treatment Mall, and Erik Kjall, a master-level institution teacher, both took part in the first CPS practice lab. Wanting to refresh their skills and learn something new, they said the course gave them a firm foundation in CPS principles.

“I love the idea that clients’ goals are the center point of treatment we provide,” Weller said. “I believe that people do well if they can, and if they aren’t doing well, we need to help them identify skills they can improve.”

Kjall agrees, adding that CPS can be used with co-workers, family and friends. What he enjoyed most was learning how triggers, lagging skills and challenging behaviors are connected.

“The training exceeded my expectations,” he said. “Jeremy was a great teacher, and the lessons were practical. If you don’t want the full training but want to stay in touch with CPS, I recommend registering for this course.”

Going forward, Fleener said he hopes people who take the class gain an improved knowledge of CPS and a desire to learn more.

“I want them to be curious about CPS and come back to more practice labs,” he said. “The labs are not just for a select group of people. They benefit everyone.”

Overcoming the ‘traumaverse’

By Timothy A. Connor, clinical psychologist

In 1999, I began working in a North Portland community mental health center. My clients were poor and on Medicaid. All of them had extensive histories of trauma – including physical, sexual and emotional abuse, loss, racism, sexism and periods of hunger and homelessness. What’s more, they routinely faced new traumas, from neighborhood violence to serious health problems.

I was trained to help people change the way they viewed their lives. My training assumed if they had a more positive attitude and belief in themselves, they would stop feeling depressed or anxious and act to solve their problems. But in the face of their overwhelming burdens, it seemed patronizing, even insulting, to assume my clients’ suffering would be resolved through optimism, positive self-talk and self-confidence.

They had adapted to life in the “traumaverse,” where dreadful events were routine and beyond their control. That’s when I began to study everything I could about trauma – what it is, how it affects us, and how we overcome it. Two things I learned: the defining feature of trauma is helplessness, making every experience of being dominated and disempowered a retraumatization; and people can’t recover from trauma while trauma is still happening.

When I came to OSH, I learned virtually all our patients are likely to have suffered significant trauma in
their lives. And while the hospital is designed to heal, the environment here can be nearly as traumatizing as the environment in which they were raised.

Only by adopting a trauma-informed approach to serving our patients can we build a system in which trauma survivors can rediscover their capacity to create their own future.

To do this, we must first understand that our patients still live in a “traumaverse” and feel helpless. Here, they learn to accept, without question, the judgment of others about their experience and needs; to comply with rules and routines that often have more to do with the smooth running of the institution than with their condition; and to surrender their privacy. They learn to act deferential to not seem entitled or aggressive, and they limit their emotional expression to avoid being seen as symptomatic.

Note that these conditions are not so different from being in an abusive relationship: abusers restrict their victims’ contacts with the outside world, deny them the reality of their experience, monitor the victims’ activities, insist on deference and submission, and don’t tolerate emotional expressions outside an “acceptable” range.

This must change. By practicing a trauma-informed approach, we can shift our cultural attitudes at every level of an organization. We need to learn about trauma – how common it is, how it affects behavior, and how people can recover. We should avoid potentially retraumatizing actions, such as loud noises or standing too close to people. We must also ask, “What happened to you?” instead of “What’s wrong with you?”

Patients’ needs must be taken seriously. We should respect and support their choices whenever we safely can, even if they are not the choices we would make. After all, it’s their lives. We must also be transparent about what we’re doing and why, never make promises we aren’t prepared to keep, and avoid unnecessary displays of power – like keeping your keys on your belt rather than tucked away in your pocket.

By taking these steps, and by showing respect and common courtesy to the people we serve, patients can start to believe in their own power to change. Together, we can help them find the internal resources and external support to take back the lives they lost, or build the lives they never had a chance to make.

Six Guiding Principles of a Trauma-Informed Approach:

1) **Safety** – You can’t resolve trauma until the trauma stops and you are in a place of physical and emotional safety.

2) **Trustworthiness** – It isn’t the patient’s job to trust us; it’s our job to prove ourselves worthy of trust.

3) **Choice, Voice and Empowerment** – If helplessness makes trauma, healing happens when you author your own life story.

4) **Collaboration and Mutuality** – Healing can’t be done to someone; healing happens when a person makes use of helpers who have offered their support.

5) **Peer Support** – The most powerful force for recovery is the support of others who share your lived experience.

6) **Identity** – The sense of self can be the first casualty of trauma. To take your life back, know and accept who you are as a person and community member. Trauma is not just an individual experience, nor is recovery.
FES helps determine capacity to stand trial and criminal responsibility

Before criminal defendants may be prosecuted, the Constitution requires that they must understand the nature of the charges filed against them. They must be able to assist and cooperate with counsel, and they must be able to make decisions regarding their legal defense.

Forensic Evaluation Service (FES) helps determine whether a patient is well enough to work with their attorney and understand their charges.

FES also conducts criminal responsibility evaluations to help courts determine if defendants should be found not guilty, responsible for their alleged criminal acts and sentenced, or if they should be found Guilty Except for Insanity (GEI) and placed under the jurisdiction of the Psychiatric Security Review Board or the State Hospital Review Panel.

Made up of about 25 staff members, FES performs more than 1,000 evaluations of criminal defendants every year. FES works neither for the defense nor the prosecution. Instead, it responds directly to court orders and evaluates defendants at the hospital, in prisons, and in care facilities throughout the state.

FES evaluators are either psychologists or psychiatrists, and they are all certified forensic evaluators in Oregon. Many have completed both specialized, often highly competitive, pre- and post-doctoral training in forensic assessment.
What FES Staff Have To Say…

“I am always impressed with my colleagues. Everyone works hard, cares about producing high-quality work, and withstands the pressures of our position. Since starting at FES, I have been consistently impressed with how welcoming and supportive our work environment is. It is easy to become overwhelmed, and I am grateful to have the support and friendship of my colleagues.”

Dr. Kaley Raskin, clinical psychologist II

“What fuels me to come to work each day is knowing my job is important. If I don’t receive records or contact an attorney in time, or if I don’t arrange transport correctly, it can affect the evaluation. It could postpone it, delay it, or make it to where the evaluator doesn’t have adequate information going into the interview. There are a lot of factors that go into making an evaluation happen. I’d like to think that as support staff, we are responsible for quite a bit of it.”

Kelly Kahn-Bass, executive support specialist

“I enjoy working with a team of colleagues who are intelligent, ethical and very collegial. They are always willing to consult on difficult cases. The work itself is engaging and challenging. It drives me to do my best.”

Dr. Terri Fernandez-Tyson, clinical psychologist II

Every full-time FES evaluator conducts two or three evaluations each week – depending on the type of evaluation being performed. Some interviews last a minute, while others extend to nine or more hours. Some involve thousands of pages of records, and others only a hundred. The writing time, as well, can extend anywhere from five to 50 hours per evaluation.

While FES communicates with treatment teams and has access to their notes, FES does not provide treatment. This allows FES to be more objective in its evaluations. This is also one of the reasons why many attorneys and judges throughout the state trust FES evaluators to not have a bias toward or against defendants.

Each year, as the number of forensic patients has increased at the hospital, so has the number of FES reports. In 2006, FES completed 582 evaluation reports. In 2016, that number grew to more than 1,300. The increased workload is directly linked with the rise in Aid & Assist (“.370”) patients both inside and outside of Oregon State Hospital.

For most “.370” patients, the law requires FES perform its first evaluation within 90 days of admission. The process is repeated 180 days after admission, and then again every 180 days after that. However, treatment teams may request an evaluation as soon as they believe a patient is ready.

FES reports help the court determine when, or if, patients are able to stand trial. If they are able, they typically return to their county jails. But on some occasions, charges are dropped while the patient is still at OSH, or patients return to being on their own recognizance.

If there is no substantial likelihood that within the foreseeable future the patient could gain or regain the capacity to stand trial, the court may issue a discharge order or initiate civil commitment proceedings. FES may also recommend that patients are not yet able to stand trial, but may become able to participate in the foreseeable future. With that finding, patients typically remain at OSH for further treatment.

For more information about Forensic Evaluation Service, contact osh.fesdirector@state.or.us, mandy.g.davies@state.or.us, or call 503-947-1063 or 503-945-9958.
Winter happenings at OSH

While snow and ice prevented staff from driving to work several times this winter, the disruptions didn’t quell people’s spirits. Through music, food and games, patients and staff put their stamp on the holidays and rang in the New Year in style.

For the 30th year, Volunteer Services collected, wrapped and delivered a present for every patient as part of its Caring Tree Project. More than 600 gift tags were available on the trees, located in the main lobbies on both the Junction City and Salem campuses.

The Junction City campus was encased in ice after one of several recent snow storms. Photo credit, Mary Stone, operations and policy analyst.

Snow blanketed the Salem campus after a winter storm.
Transport staff James Horsley, Ken Niffen, Paul Dimeglio and Nicholl Helms were all smiles during the staff holiday party in Salem.

Roger Sullivan of Mountain 2 made fast friends with Ginger, a service dog that visited the patient holiday party in Junction City in December.

Diane Zeman of Mountain 2 made snowflakes out of coffee filters during the patient holiday party on the Junction City campus.

Using gumdrops, frosting and sprinkles, patients in Junction City showcased their creativity as part of the gingerbread house contest this year.
The Employee Recognition Committee would like to congratulate the latest recipients of the Team Recognition Award:

Innovating

Recipient: Springs Food & Nutrition Services
Nominating Managers: Nurse Supervisor Patty Ott and other Butterfly 1 unit staff
Team Members: Gary Woelfle, Jennie Cribbs, Ken Ballew-Renfro, Lou Anne Unruh, Michael Miller, Theresa Leopold, Karen Eichinger, Jaina Jesse and Grace Cajuelan.

(The following is an edited excerpt from the nomination entry)

This team consistently goes above and beyond to provide wonderful meals and services to our patients, families and staff. This summer, they provided two meals to our patients outside, which was quite a feat as many of our patients have limited mobility and are easily confused and distracted. We could not ask for better people to take care of the nutritional needs of our patients.

For innovation, they found special dessert products that our less dexterous patients can manage independently. They found ways to make pureed food look like regular textures for our special events, and they were willing to serve the food to our patients in the yard instead of the kitchen. They made this a very special event that families of our patients also enjoyed. They are always willing to work with our patients, meet their individual needs, and provide wonderful customer service.