Government of the District of Columbia
Department of Mental Health (DMH)

Saint Elizabeths Hospital Compliance Report 9

April 14, 2012

Table of Contents

Janet Maher
Chief Compliance Officer

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	The Compliance Officer shall serve as the liaison between Saint Elizabeth's Hospital, the District of Columbia, the Department of Mental Health, and the United States Department of Justice regarding compliance with this Settlement Agreement. The Compliance Officer's exclusive duties are to oversee and promote implementation of the provisions of the Agreement.	
	Specifically, the Compliance Officer's duties shall include, but not be limited to:	
1	Monitoring and facilitating the District's compliance with each of the provisions in this Agreement;	
2	Preparing semi-annual reports for the parties regarding compliance with each of the provisions of the Agreement;	
3	Facilitating the organizing of and conducting formal meetings between the parties on a regular and periodic basis, at least quarterly, to update the parties regarding compliance with the Agreement, including areas of improvement and areas of concern; and	
4	Providing to the parties any relevant information known, or available to the Compliance Officer, under any provision of the Agreement upon reasonable request.	
	The Compliance Officer shall not be prohibited from conducting ex parte communications with the Department of Justice, Civil Rights Division, regarding any matter related to this Agreement.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.	**INTEGRATED TREATMENT PLANNING**	
	By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in. a single, integrated plan.	
V.A	**Interdisciplinary Teams**	
	By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	
V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	
V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Recommendation:** Maintain current level of practice. SEH Response: Psychiatrists/treatment team leader psychologists continue to lead teams and clinical administrators continue to facilitate IRP meetings.
V.A.2.a	assume primary responsibility for the individual's treatment;	
V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;	**Recommendation:** Continue with identified corrective action plan, but quickly trouble-shoot obstacles if there continues to be lower than 90% compliance for family invitations. SEH Response: Data shows substantial improvement in the Hospital's efforts to invite family members and community case workers to the IRP conferences. IRP observation results show the invitation of family members to the IRP

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
conference improved from 84% during last review period to 88 % during this review period, with most months at 100%. A similar improvement is noted in the invitation of community case workers, with the mean improving from 87% in the prior review period to 94% during this review period. Social workers continue to be reminded about their responsibility, with the individual in care's consent, to invite family and community workers and data concerning this is routinely shared with social workers during regular staff meetings. In addition, social work supervisors conducting monthly social work audits are also checking to ensure the record reflects social workers are inviting family to IRP meetings.

Facility's Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C[1]</td></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>11</td><td>8</td><td>10</td><td>11</td><td>11</td><td>11</td><td>16</td><td>10</td></tr>
<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C Data fields: Family Member invited?</td><td>100</td><td>67</td><td>100</td><td>100</td><td>100</td><td>78</td><td>84</td><td>88</td></tr>
<tr><td>%C Data fields: Community support worker invited</td><td>88</td><td>100</td><td>100</td><td>90</td><td>90</td><td>100</td><td>87</td><td>94</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 1 audit per unit per month)
Targeted Sample size is 11, one per unit
See Tab # 7 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data shows significant improvement in performance related to the inviting of family members and community case workers to IRP meetings during this review period with means at 88% and 94% respectively. Audits will continue and social work supervisors are continuing to work with specific staff, but, given the current level of performance, no additional actions are needed.
</td></tr>
<tr><td>V.A.2.c</td><td>require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;</td><td>
Recommendations:

Continue to analyze social worker attendance rate monthly and develop additional corrective action plans as necessary if data does not show improvement as a result of staffing enhancements.

SEH Response: Staffing shortages in the social work department during the late spring and early summer 2011 had an adverse impact on the attendance of social workers at the IRP conferences, but this has been resolved with recent hiring; the Social Work Department appointed a deputy to the Supervisory Social Worker and filled all three of its social worker vacancies effective August 15, 2011. (In February 2012 two positions became vacant; one was filled in March 2012 and recruitment to fill the second vacancy continues.) Attendance of social workers improved significantly beginning in September 2011 and was maintained throughout the review period. The mean for attendance by social workers at IRP conferences improved from 83 % during the prior review period to 97% during this review period. Attendance continues
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[1] The Hospital is using a weighted mean in calculating all means set forth in this report.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>to be monitored through the IRP audits.

Facility's Findings:

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<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C Data fields: Social work Attendance</td><td>82</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>83</td><td>97</td></tr>
</table>

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<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C. #2. Each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatment.</td><td>91</td><td>88</td><td>90</td><td>100</td><td>100</td><td>100</td><td>96</td><td>95</td></tr>
</table>
N = All IRPs scheduled in the review month
n = number audited per audit sample plan
Targeted Sample size is 11, one per unit
See Tab # 7 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data shows high level of compliance with this requirement. IRP observers continue to find that the treatment teams are functioning well, with each member participating in assessing the individual on an on-going basis and in developing, monitoring and revising treatment. The mean for social worker attendance improved to above 90% and remained above 90% for each core team member's participation in the IRP conference. See Tab # 7 IRP Observation Audit Results. IRP conference observations and discipline audits will continue. No further steps are needed at this time.</td></tr>
<tr><td>V.A.2.d</td><td>require that the treatment team functions in an interdisciplinary fashion;</td><td></td></tr>
<tr><td>V.A.2.e</td><td>verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and</td><td>Recommendations:

1. Ensure that the psychiatric update addresses the individual's response to behavioral treatment.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Ongoing. The Psychiatric Update form was modified effective in April 2011. The Avatar Psychiatric Update form includes a specific tab to address non-pharmacological interventions that are being used with an individual in care. Pre-identified choices include "PBS", "TLC", "behavioral guidelines", "individual therapy", and "other". The form *requires* the psychiatrist to describe the interventions (mandatory field) and also prompts the psychiatrist by asking, "Are there any specific behavioral and/or psychodynamic issues that are affecting the patient's lack of progress?" and, if answered yes, the description is a mandatory field. ***See Tab # 15, Psychiatric Update Avatar Form.*** The Hospital is monitoring compliance with this requirement through the psychiatric update audits (indicator # 7). ***See Tab # 16 Psychiatric Update Audit Tool*** Data from the audits shows excellent performance on this requirement, with the mean of 98% for this review period. *See data in the facility's findings section below*.

In addition, the Hospital also included in its revised clinical chart audit tool, at indicator # 2, instructions to ensure that where applicable, auditors are evaluating whether the clinical formulation includes a summary of the progress made on objectives that address behaviors targeted in the IBI and PBS plans. ***See Clinical Chart Audit Tool, Tab # 8.*** Finally, all psychiatrists have completed PBS training, and the PBS team leader continues to train new employees. Updated PBS data shows:

PBS Training for New Employees (3/1/11-2/29/12)

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*
Medical (NPs and phlebotomist)	4	3	3	**75**	**75**
Psychiatry residents	10	10	10	**100**	**100**
Dental and Chaplain residents	6	6	5	**100**	**83**
Nursing - RN	85	85	85	**100**	**100**
Nursing -LPN	1	1	1	**100**	**100**
Nursing - RA	1	1	1	**100**	**100**
Psychologists and psychology trainees	20	20	20	**100**	**100**
Social work	3	3	3	**100**	**100**
Other	5	5	5	**100**	**100**
Total	**135**	**134**	**133**	**99**	**99**

** Percentage of those who passed competency exam out of the total number of employees required for training.*

See Tab # 33 PBS Training curricula and data

2. Ensure that the present status section of the case formulation clearly addresses the efficacy and status of behavioral guidelines/PBS plans.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Ongoing. The Hospital addressed this recommendation by amending its clinical chart audit tool, at indicator # 2 to include specific instructions to auditors to asses if the present status section of the clinical formulation includes, if applicable, a summary of the progress made on objectives that address behaviors targeted in the IBI or PBS plans. ***See Clinical Chart Audit Tool, instructions, indicator # 2, Tab # 8.*** This change became effective in September 2011. This requirement is also monitored through the psychiatric update audits.

Facility's Findings:

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	245	247	247	244	235	236	**245**	**242**
n	28	30	32	29	35	33	**29**	**31**
%S	11	12	13	12	15	14	**12**	**13**
%C # 1 Does the Update adequately address the significant developments in the individual's clinical status since the last Update?	93	100	100	97	94	100	**98**	**97**
%C # 7 Does the plan section of the Update reflect the diagnoses, mental status examination results, response to treatment, and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	97	100	100	94	100	**98**	**98**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

This requirement was added to the clinical chart audit during the current review period.

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 2 Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs.	81	82	100	78	89	88	**74**	**86**

N = Total number of IRP reviews scheduled
n = number audited

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Targeted sample size is 22 reviews per month (2 per unit) ***Tab # 2 CLINICAL CHART AUDIT RESULTS*** **Analysis/Action Plans:** Data from the psychiatric update shows continued high performance. The Hospital will continue to audit this through the psychiatric update audit. Data from the clinical chart audit shows improved performance on this indicator, with a mean at 86% (up from 74%) during the last review period. Audits will continue.
V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.	
V.A.3	provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;	
V.A.4	consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	
V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Recommendations:** 1. If this indicator does not quickly meet or exceed the 90% threshold, it will be important for the hospital to determine the obstacles to timely completion of scheduled IRP conferences and takes steps to remove those obstacles. SEH Response: The data on the timeliness of IRPs improved marginally during this review period, from a mean of 86% to 87%. Audit findings are now reviewed during the clinical administrators meetings and at the clinical leadership meetings. The timeliness of the house's IRPs is also being discussed with clinical administrators during their one to one supervision with the Director of Clinical Operations and was added to their performance plan objectives. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following

<table>
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<tr><td></td><td></td><td>information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See below.

Facility's Findings:

<table>
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<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. #1 The IRP was reviewed and revised as per IRP required schedule (at day 30, day 60 and every 60 days thereafter)</td><td>88</td><td>88</td><td>100</td><td>83</td><td>79</td><td>88</td><td>86</td><td>87</td></tr>
</table>
N = Total number of IRP reviews scheduled
n = number audited
Targeted sample size is 22 reviews per month (2 per unit)
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data shows marginally improved performance on this indicator. Audits will continue and the trend monitored.</td></tr>
<tr><td>B</td><td>Integrated Treatment Teams</td><td></td></tr>
<tr><td></td><td>By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:</td><td></td></tr>
<tr><td>V.B.1</td><td>where possible, individuals have input into their treatment plans;</td><td></td></tr>
<tr><td>V.B.2</td><td>treatment planning provides timely attention to the needs of each individual, in particular:</td><td></td></tr>
<tr><td>V.B.2.a</td><td>initial assessments are completed within 24 hours of admission; (exclude psychiatry)</td><td>Recommendations:

1. Continue to monitor the timeliness of the initial disciplinary assessments during this review period. Present a summary of the aggregated monitoring data in the progress report, including comparative data and by analysis of low compliance with plans of correction, as indicated.

SEH Response: See data below. (The District and DOJ agreed data need not be presented for initial psychiatric assessments.)</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2. Same as in VI.A.1 to VI.A.5.

SEH Response: See VI.A.1, VI.A.2 and VI.A.5. (Sections VI.A.3 and A.4 are no longer requirements that are being monitored.)

Facility's Findings: Per the Agreement with DOJ, the Hospital is only reporting data relating to nursing, social work and psychology initial assessments.

COMPREHENSIVE INITIAL NURSING ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	38	29	35	**36**	**36**
n	8	10	6	7	28	7	**8**	**11**
%S	18	26	19	18	97	20	**21**	**33**
%C. #1. Initial nursing assessments are completed within 8 hrs of admission*	88	60	83	86	29	43	**67**	**65**

N = Number of admissions during the month
n = number audited
* Note that for the period of September through December 2011, the entire CINA was completed within 8 hours. Beginning in January 2012, CINA Part A was the only portion that was required to be completed within 8 hours. The CINA Part A new form and new procedure were introduced to staff in January 2012.
Tab # 3 CINA AUDIT RESULTS

INITIAL PSYCHOLOGICAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	7	10	8	10	9	7	**7**	**9**
%S	16	26	26	26	31	20	**19**	**24**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	100	100	88	100	100	100	**88**	**98**
%C # 1 (Part B) If Part B completed within 12 days of admission?	100	80	100	83	40	50	**42**	**75**

N = Number of admissions during the month
n = number audited-target is 20% sample (Audit sample plan)
Tab #18 IPA AUDIT RESULTS

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>n</td><td>9</td><td>7</td><td>8</td><td>8</td><td>6</td><td>7</td><td>7</td><td>8</td></tr>
<tr><td>%S</td><td>20</td><td>18</td><td>26</td><td>21</td><td>21</td><td>20</td><td>20</td><td>21</td></tr>
<tr><td>%C # Completed within 5 days of admission</td><td>89</td><td>57</td><td>88</td><td>88</td><td>100</td><td>71</td><td>86</td><td>82</td></tr>
</table>
N= Number of admissions during the month
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 28 SOCIAL WORK AUDIT RESULTS

Analysis/Action Plans: The timeliness of social work initial assessments fell slightly during this review period, largely affected by poor performance in October and February, but leadership believes these are aberrations and not a trend. The social work supervisors will continue to audit this requirement and address issues with individual social workers as they arise. The social work initial assessment form in Avatar was redesigned and became live in mid January 2012. It is also expected to improve the timeliness of initial assessments.

During this review period, the Chief Nurse Executive resigned and a new CNE, Clotilde Vidoni-Clark was appointed. Dr. Vidoni-Clark made additional changes to the CINA to address issues identified by the DOJ nurse reviewer in the November 2011 visit, within the parameters of a Part A to be completed within 8 hours and a Part B to be completed within 24 hours. The new form was piloted for about 45 days beginning in early January 2012, and is in Avatar development as of the writing of this report. In the meantime, the form is available on a shared drive, is printed and available in a designated binder on the unit, until scanned into FileNet on the business day immediately following admission. Timeliness of the CINA is monitored at this time through the CINA audits. With these changes it is not surprising that the timeliness of the initial assessment completed by nursing fell during this review period as staff are still getting used to the new process. Nursing continues to believe the timeliness of the CINA will improve with use of the two part form, especially once it is included in Avatar. Nursing will continue to monitor this requirement through the CINA audits.

Psychology improved its completion of Part A of the IPA, going from 88% during the last review period to 98% during this review period; completion of Part B of the IPAs also improved from 42% to 75% during this period. Psychology filled three vacancies in October 2011, but a position became vacant when a staff psychologist was promoted to Psychology Training Director in February 2012. It currently has 16 staff psychologists, 1 neuropsychologist, 1 PBS Team Leader, a Training Director, the Director of Psychology, and one vacancy for which recruitment is in the early stages. In the meantime, Psychology will continue to monitor this requirement through the IPA audits.
</td></tr>
<tr><td>V.B.2.b</td><td>initial treatment plans are completed within 5 days of admission; and</td><td></td></tr>
<tr><td>V.B.2.c</td><td>treatment plan updates are performed consistent with treatment plan meetings.</td><td></td></tr>
<tr><td>V.B.3</td><td>individuals are informed of the purposes and major side effects of medication;</td><td></td></tr>
<tr><td>V.B.4</td><td>each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	addressed, monitored, reported, and documented;	
V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Recommendations:** 1. Continue to provide data regarding documentation of the review and assessment by the Director of Psychiatric Services of individuals who reach high risk triggers/thresholds. SEH Response: Ongoing. During this rating period, the Director of Psychiatric Services continued to review the cases of many of those individuals who reach high risk indicators. ***See Tab #46, Tracking Reports for High Risk Indicators.*** To date, 28 of 33 (85%) cases have reviews with progress notes completed by the Director of Psychiatric Services in the record. 2. Same as in XII.E.2. SEH Response: See XII.E.2.
V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	
V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Recommendations:** 1. Same as in V.B.4, V.E.3, V.E.4 and V.E.5. SEH Response: Same as in V.E.3. Please note that V.B.4, V.E.4 and V.E.5 are no longer active requirements. 2. Same as in section VIII. SEH Response: See section VIII. 3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated. SEH Response: See below. **Facility's Findings:** **CLINICAL CHART AUDIT RESULTS**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	275	244	234	214	198	201	**221**	**228**
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%S	7	8	8	10	11	9	**9**	**8**
%C. #2. Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition and changing needs.	81	82	100	78	89	88	**74**	**86**

N = All IRP reviews scheduled in the review month
n = number audited
Target Sample is 2 per unit
Tab # 2, CLINICAL CHART AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
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N	245	247	247	244	235	236	**245**	**242**
n	28	30	32	29	35	33	**29**	**31**
%S	11	12	13	12	15	14	**12**	**13**
%C # 7 Does the plan section of the Update reflect the diagnoses, mental status examination results, response to treatment and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	97	100	100	94	100	**98**	**98**

N = Census as of end of month, less month's admissions
n = number audited
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital modified its clinical chart audit tool to focus on certain aspects of treatment planning as recommended by DOJ consultants. Data from the clinical chart audits show improved performance in modifying treatment regimens, from 74% mean during the last review period to an 86% mean during this review period.

The Hospital in June 2011, modified its Psychiatric Update audit tool to reduce the number of indicators while still focusing on key aspects of clinical care; the tool has not been changed since that time. Also, in April 2011**,** the Hospital modified the Psychiatric Update Assessment Form in Avatar in an effort to improve documentation around response to treatment and progress. The Psychiatric Update now requires psychiatrists to address medication response, to assess whether the psychiatric condition is generally improving, unchanged or worsening, to include a narrative describing their overall assessment/changes in symptoms and functional condition since the last assessment, to document whether the individual is progressing toward treatment goals and to describe that progress. The Psychiatric Update audits show high levels of compliance on this requirement. These audits will continue.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>V.B.8</td><td>an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and</td><td></td></tr>
<tr><td>V.B.9</td><td>to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart.</td><td>Recommendation:

1. Present information regarding any significant modifications in current self-assessment tools, including changes in the monitoring indicators and sample sizes as well as the status of implementation during the review period.

SEH Response: Audits continuing or beginning during this review period include IRP observation audits, clinical chart audits, therapeutic progress note audits, CIPA audits, psychiatric update audits, IPA (Psychology) audits, psychology risk assessment audits, psychology evaluation audits, PBS audits, initial rehabilitation services assessment audits, SWIA audits, SW update audits, CINA audits, nursing update audits, seclusion and restraint audits, discharge record review audits, transfer audits, substance abuse Intervention audits, emergency involuntary medication audits, history and physical audits, medical transfer audits, TLC group leader observation audits and the post - discharge services audits completed by MHA. Many of the audit tools were changed during the last two review periods based upon input from the DOJ reviewers. Below is a summary table.

<table>
<tr><th>AUDIT RESULTS</th><th>AUDIT STATUS</th><th>CHANGES IN AUDIT TOOLS/SAMPLE SIZE SINCE LAST REVIEW</th></tr>
<tr><td>IRP observation audit</td><td>Ongoing throughout review period. Target is 1 per unit per month. There are 11 units.</td><td>Sample size was reduced during prior review period to 1 per unit. Tool was modified in Summer 2011 to eliminate three indicators that addressed requirements that are no longer actively monitored, including that team is led by psychiatrist, team identifies someone who is responsible for scheduling IRPs and that individuals have input into treatment plans. No changes during this review period (September 2011 to February 2012)</td></tr>
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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Clinical chart audit	Ongoing through review period. Target is 2 per unit per month. Audits were completed for each month during this review period.	Tool and instructions were modified in June 2011 to eliminate indicators and/or collapse some indicators, in order to focus on addressing violence and discharge planning. For example, indicators around content of clinical formulations were collapsed; instructions were added to indicator # 2 to assess whether the clinical formulation addresses IBIs or PBS plans and to indicator # 3 to assess content of present status in clinical formulation. Instructions were modified in indicator # 4 and # 5 to broaden review of objectives or interventions. At the end of the prior review period (March 2011 through August, 2011), the Hospital decided that for the current review period (September 2011 to February 2012) it would include again two indicators that had been eliminated - - one relating to writing of objectives and the other relating to nursing interventions (indicated as # 7 and # 8 on the tool in Tab #8). There is no data for these indicators for the prior review period, but data is available for the current review period which began in September 2011. In January 2012 it added a question around signature of the IRPs for billing purposes.
		Therapeutic progress note audit	Target is 1 note per group leader and individual therapist per four months.	Frequency of audit was modified to include 1 note per group leader every four months beginning with the March 2011 to August 2011 review period. Tool was slightly modified in March 2011 to correct grammar in question 6 but no changes were made during the current review period (September 2011 through February 2012).
		CIPA audit	Ongoing throughout review period. Target is 20% of monthly admissions.	From March 2011 through June 2011, there were no changes to the tool. Tool was modified effective July 2011. Numerous questions were removed or consolidated and questions were reordered to improve flow. The changes to the tool are reflected in the audit results. No further changes were made to the tool during the current review period.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Psychiatric Update audit tool	Ongoing through the review period. Target is 2 reviews per unit psychiatrist.	From March through June 2011 there were no changes to the tool. Effective in July 2011, however the tool was substantially modified, with questions eliminated, or consolidated, and the questions were reordered to improve the flow. Changes to the tool are reflected in the audit results.
		Initial History and Physical Audits	Target is 20%	No changes to the tool.
		Medical transfer audits	Target is 20%	No changes to the tool. However, due to issues in Avatar with the printing of the form which, in some cases, makes the form impractical to be used for every emergency transfer, the auditors are also auditing a transfer note completed on a medical consultation form in lieu of the medical transfer form, but apply the same standards to whichever form is used.
		Co-occurring disorder audit	Target is 10%	During the prior rating period (March 2011 through August 2011) question # 5 relating to discharge criteria was eliminated as the information is collected in other audits. No further changes were made.
		Psychiatry TD audit tool	Ongoing for review period. Target is each case of TD diagnosis every six months.	Tool updated January 2011. No additional changes since that time. During the March through August 2011 review period, the Medical Director suspended the audits to ensure every individual in care had an AIMS test within the past 12 months. Audits are now underway for those with a TD diagnosis.
		Psychology IPA audits	Ongoing for review period. Target is 20%.	No change to tool.
		Psychology Risk Assessment	Ongoing for review period. Target is 1 per psychologist who completes them.	No change to tool, except a question was added beginning with June 2011 audits to track communication of results to team. No other changes to tool.
		Psychology Evaluation	Ongoing for review period. Target is 1 per psychologist who completes them.	No change to the tool, except a question was added beginning with June 2011 audits to track communication of results to team.
		IBI/PBS Plan Audit tool	At least a 50% sample	No changes to the tool.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		BI Progress Note Audit	New tool, 20% sample	New tool was created and audits began in summer 2011 to assess if behavioral intervention-related progress notes were being completed consistent with policy.
		Neuropsychology assessment audits	Ongoing during review period.	Tool revised to eliminate specific questions and to add other questions. Question was added beginning in June 2011 to audit delivery of report to treatment teams. Audit results indicate which questions were added and deleted.
		Initial Rehabilitation Assessment audit tool	Ongoing for review period. Target is 20%.	No changes to the tool.
		SWIA audit tool	Ongoing for review period. Target is 20%.	Tool was substantially revised during previous review period (March 2011 through August 2011) with input from DOJ consultant. Seven questions were eliminated and 14 questions were added. The new questions provide an increased focus on quality of assessment and treatment recommendations. Changes to the tool are reflected in the audit results. Tool was modified in February 2012 and then updated again effective March 2012 to reflect new assessment form in Avatar.
		SW Update audit tool	Ongoing review period. Target is 1 per social worker.	Tool was substantially revised during prior review period (March 2011 – August 2011). Four questions were eliminated and 20 were added. The new questions ensure the tool tracks the revised instructions to completing the SW Update and focus on assessment of changes or lack thereof in the individual and updates relating to discharge planning. Changes to the tool are reflected in the audit results. Tool was modified in February 2012 and then updated again effective March 2012 to reflect new assessment form in Avatar.
		Emergency Involuntary medication audits	Audits began in October 2010. Target is 20%.	No change in tool during this review period.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		CINA audits (Part A and Part B)	Ongoing for review period. Target is 20%.	Old tool was used through December 2011. New tool was developed based upon revised CINA that was effective in January 2012. New audit tools for Part A and Part B were developed and implemented for January 2012 CINAs to reflect the new form, so only two months of data are available on the currently used form.
		Nursing Update audits	Ongoing for period. Target is 2 per unit.	Old tool was used through December 2011. New tool was developed and implemented in February 2012 to reflect new Update form.
		Change in Physical Status (SBAR) Audit Tool (Nursing)	Beginning February 2012	New audit tool created to review nursing notes around change in physical status
		RN Transfer to ER/Hospital Audit Tool	Beginning February 2012	New audit tool created to review nursing notes around transfers from SEH to ER or hospital
		RN Transfer from ER/Hospital to SEH	Beginning February 2012	New audit tool created to review nursing notes around transfers from ER or hospital to SEH
		Nursing Medication and Insulin Administration Audits	Target is 1 observation per nurse per 6 months	No change in tool.
		Seclusion and restraint audit	Target is 50% of cases.	Tool was simplified during last review period to track only the remaining requirements of the Settlement Agreement. No changes were made during this review period (September 2011 to February 2012).
		Discharge record audit tool	Ongoing. Target is 10%. Sample was modified to exclude pretrial forensic individuals here for competency exams.	During the prior review period, tool was simplified to track only the remaining requirements of the Settlement Agreement. No changes were made during the current review period (September 2011 – February 2012).
		Inter-unit transfer audit tool	Ongoing. Target is 20%.	No change in tool during this review period.
		Group facilitator observation audit tools (separate tools for process groups and curriculum based groups)	Ongoing. Target is one per group leader twice per year.	During prior review period, Hospital went from one tool to two new tools, one to be used in observing process groups and one for use in curricula based groups. No changes were made during this review period (September 2011 through February 2012).
		DMH post discharge audits	Monthly	No changes to the tool.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>2. Streamline the indicators within some of the auditing tools to simplify the auditing process without reducing its value (provisional tools that streamline auditing of the Comprehensive Psychiatric Assessment and the Psychiatric Updates were discussed with this expert consultant on-site).

SEH Response: Completed for psychiatry audits (CIPA and Update), clinical chart audit, IRP observation audit, social work audit and some of the psychology audits. The group observation monitoring forms were modified substantially. See above chart.</td></tr>
<tr><td>V.C.</td><td>By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:</td><td></td></tr>
<tr><td>V.C.1</td><td>be derived from analyses of the information gathered including diagnosis and differential diagnosis;</td><td></td></tr>
<tr><td>V.C.2</td><td>include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;</td><td>Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility’s Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>18</td><td>19</td><td>19</td><td>21</td><td>21</td><td>18</td><td>21</td><td>19</td></tr>
<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. #3 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge, whenever possible.</td><td>88</td><td>94</td><td>94</td><td>95</td><td>86</td><td>94</td><td>86</td><td>92</td></tr>
</table>
N = All IRP reviews scheduled in the review month</td></tr>
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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>n = number audited
** Sample size 2 per unit (22)
See Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data shows significant improvement on this requirement and the mean is now above 90%. This reflects that the Hospital, through its internal mentors and external consultants, provided targeted coaching with clinical administrators on presentation of present status and discharge planning, establishment of discharge criteria and identification of discharge barriers. The Hospital will continue the monthly clinical chart audits to identify areas and/or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. See Tab # 8 Clinical Chart Audit Tool and Feedback Form</td></tr>
<tr><td>V.C.3</td><td>include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;</td><td></td></tr>
<tr><td>V.C.4</td><td>consider biochemical and psychosocial factors for each category in Section V.C.2., supra;</td><td></td></tr>
<tr><td>V.C.5</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;</td><td></td></tr>
<tr><td>V.C.6</td><td>enable the treatment team to reach determinations about each individual's treatment needs; and</td><td>Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
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<tr><td></td><td></td><td>
<table>
<tr><td>%C. # 2 Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs.</td><td>81</td><td>82</td><td>100</td><td>78</td><td>89</td><td>88</td><td>74</td><td>86</td></tr>
<tr><td>%C. #3 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge, whenever possible.</td><td>88</td><td>94</td><td>94</td><td>95</td><td>86</td><td>94</td><td>86</td><td>92</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean is not available from prior review period; question posed inter-rater reliability issues that have since been resolved with changed instructions.
** Sample size 2 per unit (22)
See Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data shows improved performance on both of the related indicators. The Hospital provided additional training in February 2011, to address issues around completion of the present status section of the clinical formulation and also is providing coaching around the writing of the clinical formulation and IRPs. The clinical chart audit feedback form through which auditors can provide specific comments directly to the teams – what was good and what could be improved, with suggestions on how to improve the IRP related documents- - is now being used by most auditors.
See Tab # 8 Clinical Chart Audit Feedback Form
</td></tr>
<tr><td>V.C.7</td><td>make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.</td><td>
Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
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</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C. # 3. The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge, whenever possible: 88 | 94 | 94 | 95 | 86 | 94 | **86** | **92** N = All IRP reviews scheduled in the review month n = number audited * Mean reflects only two months of audit results for the prior review period ** Sample size 2 per unit (22) ***See Tab# 2 CLINICAL CHART AUDIT RESULTS*** **Analysis/Action Plans:** The data shows significant improvement from the last review period in addressing discharge related issues in the clinical formulation and the mean on this indicator is above 90%. During the prior review period (March through August 2011) , the IRP manual was revised to provide additional examples and guidance in planning for nursing home placements of individuals in care to include examples of objectives/interventions. Nurse managers also were trained on the development of nursing objectives and interventions. Staff were provided training around discharge planning, and social workers received training around discharge planning for those with co-occurring disorders. ***See Tab # 1 IRP Training Summary.*** The clinical chart audits will continue and the data will be monitored to determine if additional actions are needed.
V.D.	By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols 'to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	
V.D.1	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on, the individual's strengths and address the individual's identified needs;	**Recommendations:** 1. Develop and implement corrective actions to address the process deficiencies in medical and nursing care outlined above. Include an update regarding the status of implementation of the facility's policies and procedures regarding provision of medical care and seizure management. SEH Response: Over the past two review periods, the Hospital undertook a number of steps to improve medical and nursing care, with a focus on earlier identification of changes in physical status as well as improving services to those with seizure disorder diagnoses. First, the Hospital has reorganized the Division of Medical Affairs and created three "clusters" of related units, with assigned general medical officers and nurse practitioners. The three clusters include an admissions cluster of three units, supported by one general medical officer and two nurse practitioners; a chronic care cluster, supported by one general

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		medical officer (available in the evenings since individuals in this cluster attend the TLCs) and two nurse practitioners available on day shift; and a geriatric cluster, with a general medical officer and two nurse practitioners. The medical practitioners rotate sick call coverage each day, with a goal of ensuring all members of the team have some degree of familiarity with each individual in care, although each will also have a caseload. A supervisory nurse practitioner was also appointed. The Hospital also continues its morbidity reviews and discussions. In August 2011 two cases were reviewed, one involving an individual in care with colon cancer and a second involving an individual with hyponatremia. Issues reviewed by the Committee during this rating period include policies for vaccines for flu and Hepatitis B and an examination of the Hospital's diagnosis and/or treatment of coronary artery disease. Recommendations from the Committee include 1) ensuring that women over the age of 60 and men over the age of 50 with a diagnosis of diabetes are on a daily low dose of baby aspirin; 2) individuals over 45 should have annual EKG; 3) Individuals should be referred as appropriate for an exercise stress test based upon an individual analysis of risk factors (family history, hypertension, dyslipidemia, diabetes, sedentary life style, etc) and 4) Beta blocker therapy is recommended for all individuals without medical contraindications for use in established CAD. Findings will be shared with all physicians and with nurse managers and recommendations emanating from the Committee will be tracked in the Hospital's recommendations tracking database. Mock code blues were also conducted with increased frequency; since early June, 23 mock code blues were held, across all shifts and most units. Results were presented to Morbidity and Mortality Committee in April 2012 and show areas in which improvement is needed. ***See Tab #125 Mock Code Blue Data.*** Corrective actions include revising the mock code audit tool, identifying clear expectations for running mock codes, and conducting regular audits of crash carts, among others The Hospital created a format for a progress note to be completed by general medical officers or nurse practitioners upon an individual's ***return*** from a community hospital for treatment or evaluation. ***See Tab # 59 Reassessment by Medical Practitioner Upon Return from Community Provider format.*** The format is designed to ensure SEH staff review the results of the evaluation/treatment provided in the community, are familiar with the results of any testing or laboratory work completed by the provider, review the medications provided and targeted symptoms and make appropriate recommendations for the individual's plan of care. The format started being used October 1, 2011 although some doctors only completed the requisite progress note for returns from hospital stays, but not ER visits. That has been clarified as of March 2012. The form will be turned into an Avatar form but now the information is included in a progress note in Avatar. During the review period, there also continued to be an issue with the printing of the Physician's Transfer ***to*** ER/Hospital form; the issue is that there are no time parameters for lab results and medication orders, so that the printing often involves one hundred or more pages, and may not be completed by the time the individual is ready for transport to the ER. As a result, at times the physicians have been using the medical consultation form as a transfer note and include recent lab results and medications, but are still expected to address all sections of the Transfer To ER/Hospital form in the medical consultation note. Audits around history and physicals and medical transfers completed by medical practitioners continue and in February 2012 nursing began audits of RN assessments relating to change in physical status, RN Transfer to ER notes and RN receipt of Individual in care from ER notes. ***See data below***. Medical Affairs also began auditing for the note reassessing an individual in care upon return from the ER or Hospital. ***See Tab # 60 Medical Transfer Audit Form*** Nursing also conducted medication and insulin administration observation audits of staff and all staff. ***See Tab # 103 Medication and Insulin Administration Audit Results***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Effective January 2012 Nursing revised and implemented use of a new form titled RN Change in Physical Status (SBAR). ***See Tab #87 SBAR RN Assessing Change in Physical Condition Form, RN Transfer Out form and RN Return to SEH form.*** Under the procedure and form, nursing staff shall assess individuals in care to identify changes in physical/medical status. The new form is designed to provide a structure for the collection of data in order to inform diagnosis and treatment. The form is used in documenting acute changes in an individual's physical condition. The form is not yet in Avatar but is being completed and scanned in FileNet. Nursing likewise updated its forms around Transfer to ER/Hospital and Return from ER/Hospital which also were implemented in January 2012. ***See Tab # 87 Nursing Forms*** The Hospital continues its implementation of a medical care procedure around insulin administration to standardize practice around diabetes management. ***See Tab # 80 Insulin Administration Protocol; Tab # 97 Nursing Procedure - Insulin Administration.*** Under the new procedure, individuals requiring insulin more than once daily will be placed on short acting insulin and prn Lantus using a specific protocol. ***See Tab # 80 Insulin Administration Protocol.*** The Hospital is also developing a scope of work to contract with a diabetic educator to work with staff around diabetes management issues, write procedures and train staff. The Hospital is implementing its seizure management policy, and nursing is using the updated seizure observation form. ***See Tab #49 Seizure Management Policy and Form.*** The form is in the queue for Avatar development, but as of September 1, 2011, it began being used and hard copies will be scanned into FileNet. The prior version of the seizure observation form in paper format also can be found in FileNet. The Hospital also modified its procedures around notification of laboratory results as there has been progress with the lab interface with Quest Diagnostics. Lab results are now transmitted electronically to the lab from Quest and from there are electronically transferred to Avatar. Results go to the ordering physicians, and laboratory staff continue to notify the ordering doctor by phone call of abnormal results. In the event the lab staff cannot reach the physician, the Director of Psychiatric Services or the Director of Medical Services is notified. 2. Provide a summary of any significant modifications in current training, mentoring and coaching regarding the formulation of Foci/Objectives/ Interventions. SEH Response: Training has not been modified in any significant fashion. Training on the IRP process continues to be part of new employee orientation and an outside nursing consultant (Sally Garrett) completed recovery training for nursing staff and will be training on developing IRP nursing objectives and interventions during Spring 2012. Mentoring and coaching continues through IRP observations and clinical chart audits and use of the clinical chart audit feedback form, and training consultants are continuing to work with those units for which issues have been identified. The IRP manual was modified only slightly since September 2011; it is available on the intranet and two hard copies are on each unit with the clinical administrators and nurse managers. 3. Continue to monitor each requirement in V.D.1 to V.D.6 based on an adequate sample. Present a summary of the aggregated monitoring data, including comparative data and analysis of low compliance with plans of correction, as indicated.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See data below. V.D.6 was removed at the agreement of the parties so information is not provided on this requirement. In addition, per the recommendation of DOJ to review the audit tools to remove/consolidate indicators, the Hospital modified the clinical chart audit tool. During the March through August 2011 review period, instructions were modified in new indicators # 2, #3, #4 and # 5 so that now these indicators assess several requirements within the modified Agreement. For example, indicator # 4 includes within its scope an assessment of whether the IRP includes interventions that address treatment and rehabilitation and # 5 includes an assessment of goals as well as objectives, which eliminated several indicators from the prior tool. However, beginning with September 2011 audits, the Hospital again included two indicators that had been eliminated - - one relating to writing of objectives and the other relating to nursing interventions (indicated as # 7 and # 8 on the new tool in Tab # 10). Thus, while there is data for this review period, there is no data for these indicators during the prior review period.

4. Provide a summary outline of any significant changes in the number and types of groups offering cognitive remediation and substance use education.

SEH Response:

Cognitive Remediation Therapies/Groups May 11		**Cognitive Remediation Therapies/Group Aug 11**		**Cognitive Remediation Therapies/Group March 2012**	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
213	912	243	1042 (936 enrolled)	245	956 (901 enrolled)

Co-occurring Disorder Therapies/Groups May 11		**Co-occurring Disorder Therapies/Groups Aug 11**		**Co-occurring Disorder Therapies/Groups March 2012**	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
59	345	60	353	56	318

See ***Tab # 141 for additional information around group capacities.***

The TLCs continue to offer comprehensive cognitive programming, which includes an online cognitive skill building program for those with mild cognitive impairments, a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. ***See Tab # 141 Cognitive Groups Capacity Comparison.*** Groups for those with cognitive impairments are provided by rehabilitation services, co-occurring disorders, nursing, TLC staff, social work, psychiatry, consumer affairs, chaplaincy, and psychology. Schedules are individualized based upon the individual's diagnosis, IPA results, level of functioning, clinical formulation summary, IRP group guide and the needs and choices of the individual. Substance abuse treatment also continues, with a comprehensive array of groups that reflect the individual's stage of change; the readiness ruler assessment was repeated in September 2011 for each individual in care, and adjustments

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

made in their groups based upon the results of the reassessment. On February 29, 2012, the Readiness Ruler was repeated again and adjustments will be made to individuals' schedules based upon the results. Capacity of the groups decreased slightly because of a lower census and to decrease the size of the groups to reflect best practices.

Beginning in September 2011, the TLC Intensive implemented modified programming around competency for trial to include a weekly mock trial and 2-3 competency groups per day (except Wednesday when the mock trial is held). Additional changes were made in programming on the transitional side to expand transitional services for those preparing for discharge. The Therapeutic Learning Center continues to enhance groups focusing on community integration. The "Warming Up to New Possibilities" group, led by Consumer Affairs, began monthly trips into the community, utilizing public transportation. In March 2012, the "Spiritual Home" group began monthly trips to visit various religious institutions to assist individuals in establishing religious affiliations and community support. Rehabilitation Services and Social Work collaborated to begin a Travel Training Program (which began in March 2012) to teach skills for travel on the bus and metro-rail system throughout the city. Occupational Therapy has begun community living skills groups for individuals in pre-trial status on the Intensive TLC to enhance independent living skills.

As a result of focus group meetings throughout the hospital, new groups were created in September 2011 to address gender specific issues for women. The groups focus on women's health, self-care, grooming, and relationships. See VII for additional information. In addition, a women's advisory council was started and meets twice monthly.

Facility's Findings:

HISTORY AND PHYSICAL AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	11	9	10	10	2	2	**7**	**7**
%S	24	24	32	26	7	6	**26**	**15**
%C. # Timely completion	100	89	100	100	100	100	**100**	**98**
%C. # 1 Subsections on basic information completed	82	100	100	100	100	100	**100**	**95**
%C. # 2 Part II of H & P includes completed past medical history	82	100	100	90	100	100	**100**	**93**
%C. # 3 Immunization section is complete	82	100	90	90	100	100	**100**	**91**
%C. # 4 H & P includes complete and appropriate description of review of systems	82	100	100	100	100	100	**100**	**95**
%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings	82	100	100	100	100	100	**100**	**95**
%C. # 6 Neurological section is completed	82	100	100	100	100	100	**100**	**95**
%C. # 7 Cranial nerve section is completed	82	100	100	100	100	100	**100**	**95**
%C. # 8 Assessment section is completed and includes synthesis of relevant findings	82	100	100	100	100	100	**100**	**95**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.	82	100	100	100	100	100	**100**	**95**

N = Total monthly admissions
n = number audited
See Tab# 52 HISTORY AND PHYSICAL AUDIT RESULTS

MEDICAL TRANSFER AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	21	31	25	14	19	19	**22**	**22**
n	3	0	10	7	3	5	**4**	**5**
%S	14	0	40	50	16	26	**16**	**18**
%C. # 1 Subsections on basic information completed	100		90	100	100	100	**86**	**96**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses	100		80	100	100	100	**90**	**93**
%C. # 3 Reason for medical transfer is clearly indicated on the form	100		90	100	100	100	**95**	**96**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.	100		90	100	100	100	**95**	**96**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings	100		90	100	100	100	**100**	**96**
%C. # 6 All the most recent lab results were provided	100		80	71	33	100	**100**	**79**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted	100		80	100	100	100	**100**	**93**
%C. # 8 The allergy section is completed fully and accurately	100		10	29	33	100	**67**	**43**
%C. # 9 The form includes a brief description of current behavior and responses to treatment	33		60	86	100	100	**43**	**75**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer	67		80	71	100	100	**95**	**82**
%C. # 11 There is a progress note upon the individual's return that includes an analysis of information from the medical facility and an appropriate response by the physician/nurse practitioner.	100		100	100	100	100	**100**	**100**

N = Total number of medical transfers
n= number audited
See Tab # 62 MEDICAL TRANSFER FORM AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19	**n/a**	**19**
n						7	**n/a**	**7**
%S						37	**n/a**	**37**
%C. # 1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?						100	**n/a**	**100**
%C # 2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?						86	**n/a**	**86**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?						100	**n/a**	**100**
%C #4 Is the assessment of systems completed and synthesized?						100	**n/a**	**100**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?						100	**n/a**	**100**
%C #6 Does the assessment include auscultation, etc?						86	**n/a**	**86**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?						57	**n/a**	**57**
%C #8 Was the level of urgency consistent with the clinical presentation?						43	**n/a**	**43**
%C #9 Was the course of physical status change adequately described?						86	**n/a**	**86**
%C #10 Was the individual's response to alternative interventions documented?						100	**n/a**	**100**
%C # 11Were changes from the baseline adequately identified and described?						100	**n/a**	**100**
%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?						71	**n/a**	**71**

N=Number of transfers to ER/Hospitals
n=number audited
* Data not available for prior review period

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RN TRANSFER TO ER/HOSPITAL FORM AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19		**19**
n						7		**7**
%S						37		**37**
%C. # 1 Was the form complete, signed and dated?						71		**71**
%C. # 2 Is the medical/physical reason for transfer to the ER clearly stated/described?						86		**86**
%C. # 3 Are all supporting medical data included, i.e., vital signs, blood glucose, height, weight, etc.?						14		**14**
%C. # 4 Is there a detailed description of the individual in care's current behavioral and cognitive status?						43		**43**
%C. # 5 If the current behavior or cognitive status is a change from normal presentation, is there a description of how it is different?						0		**0**
%C. # 6 Are "At Risk For /Special Conditions" (both existing and new) indicated and consistent with the individual's clinical picture? (If none known, is the box checked?)						86		**86**
%C. # 7 Is there a description of the individual's communication needs, including any significant findings?						86		**86**
%C. # 8 If applicable, were Special instructions to Enhance Health Care provided?						100		**100**
%C. # 9 Is there evidence that all applicable documents were completed/attached?						100		**100**

N=ER transfers for month
n=number audited
* Data not available for prior review period

RN TRANSFER FROM ER DEPARTMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19		**19**
n						6		**6**
%S						32		**32**
%C. # 1 Is the form completed, signed and dated?						83		**83**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C. # 2 Are vital signs documented?						100		**100**
		%C. # 3 If the vital signs are outside the known parameters, is there evidence that the General Medical Officer was consulted?						100		**100**
		%C. # 4 If the individual in care reports pain or the RN observes signs of possible pain, was a Pain Assessment Form completed?						0		**0**
		%C. # 5 Is there evidence of a completed focused physical assessment including a review of the system related to why the individual in care was initially transferred to the general medical facility?						83		**83**
		%C. # 6 Is there evidence of review of the discharge diagnosis, treatment and care recommendations from the transferring facility?						83		**83**
		%C. # 7 Is completion of identification of new risks consistent with the RN's assessment of the individual's current physical status and the medical problems for which the individual was treated?						83		**83**
		%C. # 8 If applicable, is there completion of any additional risk assessment forms/tools?						0		**0**
		%C. # 9 Did the registered nurse summarize the assessment findings that have implications for nursing interventions, addressing immediate physical and psychiatric care and treatment?						17		**17**
		%C. #10 Were objectives identified and immediate nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area 1) (if indicated by assessment)?						0		**0**
		%C #11 Were objectives identified and immediate nursing interventions developed consistent with identified Medical/Physical Health (IRP Focus Area 11)?						50		**50**
		N= ER transfers for month n=number audited * Data not available for prior review period								

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		%C. # 5 The team revised the focus of hospitalization, objectives as appropriate to reflect the individual's changing needs.	94	94	100	68	68	71	**77**	**82**
		%C. # 2 Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs.	81	82	100	78	89	88	**74**	**86**

N = All IRP reviews scheduled in the review month
n = number audited
* No data available from prior period
** Sample size 2 per unit (22)
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data shows improvement in the quality of the goals and objectives during this rating period although neither indicator is yet showing performance at the 90% level. As noted, in September 2011, additional training was provided to clinical administrators and nurse managers around developing goals and objectives, with a focus on medical needs. The IRP manual was updated during the prior review period to provide additional examples of medically – related objectives and interventions. Changes during this period were relatively minor and include taking out the requirements of an IIRP and the 14 days IRP, updated audits and adding clarifying language around updating present status section of the clinical formulation to address focus areas, objectives and interventions specifically. Nursing is expected to have additional training during the Spring 2012 around development of nursing objectives and interventions. Audits will continue and additional steps will be identified if needed.

V.D.2 provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);

Recommendations:

1. Same as above.

SEH Response: Same as above. Please note this indicator was combined with a related indicator from the prior audit tool as reflected in the relevant instructions.

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 4 The IRP has interventions that related to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective.	100	94	100	95	100	100	**95**	**98**

N = All IRP reviews scheduled in the review month
n = number audited
** Sample size 2 per unit (22)
Tab # 2, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data shows that performance related to this requirement continued above the 90% level for the second straight review period. Trainings offered in February 2011 targeted development of goals and objectives and interventions. In September 2011, the Acting Director of Clinical Operations and the Assistant Director of Nursing met with the clinical administrator and nurse manager from each house to provide training on linking the nursing update with the IRP, and on what information from the nursing update is needed to update the IRP. Also during the prior review period, an outside consultant (Dr. Manikem) met with various clinical administrators to answer questions and provide coaching around risk factors, clinical formulation development, and the writing of the focus statement, objectives and interventions. Additionally, he conducted training in September 2011 with clinical administrators on developing objectives and interventions for those with seizure disorders, cognitive disorders, risk factors, and changing objectives and interventions. ***See Tab # 1, IRP Training Materials.*** Coaching in writing IRPs and clinical formulations also is continuing and a nursing consultant will be working with nursing around the development of nursing objectives and interventions (an RFP is expected to be announced in April 2012). This requirement of the Agreement will be monitored through the ongoing clinical chart audits and additional action steps will be identified and implemented if needed.

V.D.3 write the objectives in behavioral and measurable terms;

Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. #7. The IRP includes objectives written in behavioral and measurable terms	83	68	79	71	95	94	*	**82**

N = All IRP reviews scheduled in the review month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n = number audited * Indicator was not included for prior review period ** Sample size 2 per unit (22) ***Tab # 2, CLINICAL CHART AUDIT RESULTS*** **Analysis/Action Plans:** Data suggests additional improvement is needed in meeting this requirement on a consistent basis, although the trend in the last two months of the review period suggests training and coaching efforts are becoming effective. Audits will continue but given the recent trend, no additional actions (other than the hiring of a nursing consultant to train on the writing of nursing objectives and interventions) have been identified at this time.
V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Recommendations:** 1. Same as above. SEH Response: Same as above. 2. Maintain current level of performance in the proper documentation of IRP interventions. SEH Response: Ongoing. See data below. 3. Determine the barriers to the completion of better Therapeutic Progress Notes by nursing staff and develop appropriate corrective action plan. Maintain the gains in proper Therapeutic Progress Note completion by the other disciplines. SEH Response: Improvement in rate of completion of therapeutic progress notes continues; nursing made a significant improvement in the rate of completion and in auditing the therapeutic progress note. One strategy that was implemented was to schedule documentation time for nurses covering groups at the TLCs; this seems to have positively impacted nursing documentation in both TLCs. Additionally, the number of groups provided by nursing staff also was decreased during the prior period. Finally, during the rating period, only 4 RNs were group leaders (this has been increased to 6 beginning March 2012 and they are provided documentation time during their work day to complete this note). 4. Continue to monitor this requirement and present aggregated monitoring data including comparative data and analysis of low compliance with plans of correction, as indicated. Supporting documents should be provided. SEH Response: See data below **Facility's Findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 4. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective.	100	94	100	95	100	100	**95**	**98**

N = All IRP reviews scheduled in the review month
n = number audited
** Sample size 2 per unit (22)
Tab # 2 CLINICAL CHART AUDIT RESULTS

THERAPEUTIC PROGRESS NOTE AUDIT RESULTS

	Mar~ Aug Mean	Sep~Feb Mean
N	**142**	**138**
n total # of group leaders with notes audited	**70**	**138**
Clinical administrator	**5**	**11**
Nursing	**9**	**17**
Psychiatry	**13**	**33**
Psychology	**13**	**27**
Rehabilitation Services	**18**	**24**
Social work	**11**	**13**
TLC staff	**2**	**14**
%S	**49**	**100**
%C. #1 Completed timely (all disciplines)	**93**	**97**
%C #2 Is the number of session scheduled indicated (all disciplines)?	**100**	**100**
%C #3 Is the number of sessions attended indicated (all disciplines)?	**100**	**100**
%C #4 Is the number of sessions attended equal to the number of sessions scheduled (all disciplines)?	**58**	**60**
%C #5 If applicable, is there a specific reason why numbers (attended versus scheduled) are not identical (all disciplines)	**90**	**84**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C #6 Is the intervention (group name or individual therapy noted and is description of individual's participation level present and informative (all disciplines) **96** **96** N= total number of group leaders n= total group leaders with notes audited. ***Tab #34 THERAPEUTIC PROGRESS NOTE AUDIT RESULTS*** **Analysis/Action Plans:** As reflected by the clinical chart audits, performance on this requirement remains at a high level. Trainings previously offered that targeted development of goals and objectives and individual engagement were effective, and personal coaching in writing IRPs and clinical formulations is continuing. Additional training was provided in September 2011 on developing and modifying objectives and interventions for those with seizure disorders, cognitive disorders, and risk factors to reinforce the improved practice. A nursing consultant is being hired to assist with training nursing staff on development of nursing objectives and interventions. The Hospital implemented the revised therapeutic progress note audit beginning March 2011 and continuing through this review period. ***See Tab # 38 Therapeutic Progress Note Audit Tool and Instructions and Tab # 34 Therapeutic Progress Note Audit Results.*** The revised tool tracks whether the progress note is timely, tracks the individual's attendance, reflects the group name, assesses whether the reasons for nonattendance (if applicable) is reflected in the note and assesses whether the note is descriptive and informative concerning the individual's participation level. Data shows overall high levels of compliance with most indicators, including those relating to the quality of the note. All group leaders had a least one note audited during this review period.
V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and	**Recommendations:** 1. Continue to track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. SEH Response: The Hospital continues to struggle to produce accurate data on attendance at treatment due to significant issues with the Avatar module relating to treatment scheduling; the Avatar module for tracking group scheduling and attendance is cumbersome and unmanageable at this time. Although during this rating period a management report was available, data was not entered for the entire review period due to the multiple data entry requirements and unexplained system errors. The Hospital does not expect that all individuals will be able to be engaged in 20 hours of treatment from admission; under the IRP Manual it is recognized that it could take up to 60 days for an individual in care to be able to be engaged in 20 hours of treatment per week. Further, there are some individuals in care for who 20 hours of treatment is too much regardless of their length of stay. Available data is reported below. As a result of the continued challenges with Avatar, the Hospital's Director of Statistics and Reporting is working with the TLC directors to design an Access database that will more easily track hours attended and scheduled and will have the capacity to produce needed data. The system should be completed by the time of the site visit and can be demonstrated to DOJ at that time; additional data should also be available by the time of the visit.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2. Continue with current plan to analyze group assignment and attendance based on cohorts defined by length of stay.

SEH Response: The Avatar management report has been modified to track attendance by length of stay of more than 30 days for all units except 1E; individuals in care from that unit are included once they reach the 60th day of admission. The new system being designed will also permit data to be presented by length of stay.

3. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

Facility's Findings: The Hospital during this review period created a management report that tracks hours scheduled and hours attended based upon information in Avatar and looks at individuals with a LOS of 30 days or longer, or 60 days for those on Unit 1E. The data reflect TLC and unit based groups. However, data based on a 30 day LOS show:

Hours of Mall Groups SCHEDULED (Feb 2012)

Hours	2/1		2/8		2/15		2/22		Mean	Mean (%)
N	228	100%	226	100%	229	100%	230	100%	228	100%
0 Hours	22	10%	15	7%	19	8%	18	8%	19	8%
0.1-5 Hours	19	8%	22	10%	21	9%	22	10%	21	9%
6-10 Hours	11	5%	11	5%	10	4%	12	5%	11	5%
11-15 Hours	7	3%	11	5%	24	10%	13	6%	14	6%
16-19 Hours	22	10%	19	8%	82	36%	22	10%	36	16%
20+ Hours	147	64%	148	65%	73	32%	143	62%	128	56%

N - Individuals with LOS over 30 days and over 60 days for unit 1E

Hours of Mall Groups ATTENDED (Feb 2012)

(Feb 1, 2012 - Feb 28, 2012)

Hours	2/1		2/8		2/15*		2/22		Mean	Mean (%)
N	228	100%	226	100%	229	100%	230	100%	228	100%
0 Hours	26	11%	19	8%	78	34%	23	10%	37	16%
0.1-5 Hours	31	14%	33	15%	99	43%	37	16%	50	22%
6-10 Hours	21	9%	24	11%	39	17%	22	10%	27	12%
11-15 Hours	29	13%	32	14%	11	5%	36	16%	27	12%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

16-19 Hours	*34*	**15%**	*41*	**18%**	*2*	**1%**	*53*	**23%**	***33***	**14%**
20+ Hours	*87*	**38%**	*77*	**34%**	*0*	**0%**	*59*	**26%**	***56***	**24%**

N - Individuals with LOS over 30 days and over 60 days for unit 1E
* Holiday during this week.

This data is lower than during the prior review period, reflecting a holiday and missing attendance sheets. Specifically, during the last review period, 68% of IICs were scheduled for 20 hours or more of treatment, and 28% attended 20 hours or more of treatment, compared with 56% and 24% respectively for this review period.

See Tab # 39 Treatment Hours Report

As noted, beginning with April 2012, data around treatment hours scheduled and completed will be available through the Access database and the Hospital will no longer rely on Avatar for this data.

The Hospital is also reviewing interventions through the clinical chart audit.

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 4. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective.	100	94	100	95	100	100	**95**	**98**

N = All IRP reviews scheduled in the review month
n = number audited
** Sample size 2 per unit (22)
Tab # 2, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The Hospital continues to review available treatment data by individual's length of stay. For hours scheduled, the mean during this rating period shows that 56 % of individuals in care were scheduled for 20 or more hours per week (compared with 68% last review period), and that an additional 16% were scheduled for 11 -19 hours per week compared with 6% during the prior review period. For the attendance data, the mean shows that 24% attended 20 hours or more of treatment each day, and that an additional 14% attended 16 -19 hours of treatment. This compares with 28% attending 20 hours or more of treatment per week for the previous review period. Treatment Services continues to believe the data does not reflect actual treatment hours attended. It is believed part of the issue remains the very cumbersome data entry process required to track the data in Avatar. Because of overall dissatisfaction with Avatar, the Hospital is creating its own tracking system using ACCESS; it is in testing now, and should be completed by the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		site visit with data from the Access database available at that time. The Hospital continues to work with the "unengaged" population in an effort to improve their involvement in treatment with some success. ***See Tab # 50 Status Report of the Treatment of Unengaged Individuals in Care.*** The most recent list (March 2012) includes 35 individuals, 13 of whom were added in February 2012. The list includes 14 from the prior list who are making progress in their level of engagement. The remaining 8 are having their programming retooled, or are in the process of assessment relating to development or modification of medication or behavioral interventions. The clinical chart audit shows a high level of performance in formulating objectives and in tying the interventions to objectives. See V.D.4. Coaching of clinical administrators continues, and all were provided training in September 2011 around developing and updating IRPs and objectives and interventions for special populations such as those with seizure disorders, cognitive disorders, or risk factors. Effective September 2011 and with some additional modifications in March 2012, the TLCs refined its programming in two key areas. On the TLC Intensive, programming around competency to stand trial was substantially changed. Individuals in care here for competency issues will now participate in new programming that includes two to three groups per day (M, T, Th and Fr) and a weekly mock trial (W). On the TLC Transitional, there is expanded and revised discharge focused programming. This includes increased participation by peer transition specialists and new involvement by Consumer Affairs, Social Work and Chaplaincy Departments. Social work has updated the curriculum for each of its groups to be more focused on skill development that will improve transition to the community, Chaplaincy is working to establish linkages with individuals in the community to improve community support and is taking IICs on community trips to various churches or spiritual centers, and Consumer Affairs is working with those reluctant to leave the hospital to help establish community linkages. Finally, group leaders have been provided training on working with the cognitively impaired and how to facilitate curriculum based groups. ***See Tab # 131 Group Training Information.***
V.D.6	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	
V.E.	By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:	
V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Recommendations:** Continue to monitor each requirement (V.E.1 through V.E.3) based upon an adequate sample. Present a summary of the

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
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aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.

SEH Response: See data below.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>18</td><td>19</td><td>19</td><td>21</td><td>21</td><td>18</td><td>21</td><td>19</td></tr>
<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. #5 The team revised the focus of hospitalization, objectives as appropriate to reflect the individual's changing needs.</td><td>94</td><td>94</td><td>100</td><td>68</td><td>68</td><td>71</td><td>77</td><td>82</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period indicated reflects only two months of audits
** Sample size is two per unit
Tab # 2, CLINICAL CHART AUDIT RESULTS

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>213</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>11</td><td>8</td><td>10</td><td>11</td><td>11</td><td>11</td><td>16</td><td>10</td></tr>
<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C. # 7 Team bases progress reviews/revisions recommendations on clinical observation and data.</td><td>100</td><td>100</td><td>90</td><td>100</td><td>100</td><td>100</td><td>96</td><td>98</td></tr>
</table>
N = IRP reviews scheduled
n = number audited
Tab # 7 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: The data shows improved performance in revising objectives as an individual's needs changes with a mean over 90% for the review period. Additional training was provided in September 2011 focused on special populations, and coaching and audits will continue. No further action is needed.
</td></tr>
<tr><td>V.E.2</td><td>monitor, at least monthly, the goals; objectives, and interventions identified in the plan for effectiveness in producing the</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>desired outcomes;</td><td></td></tr>
<tr><td>V.E.3</td><td>review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;</td><td>
Recommendations:

1. Same as in V.E.1.

SEH Response: See V.E.1.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>N</td><td>18</td><td>19</td><td>19</td><td>21</td><td>21</td><td>18</td><td>21</td><td>19</td></tr>
<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. # 6. Review the goals, objectives and interventions more frequently if there are clinical relevant changes in the individual's functional status or risk factors.</td><td>100</td><td>100</td><td>100</td><td>71</td><td>100</td><td>100</td><td>87</td><td>94</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
* The mean for the prior review period indicated reflects only two months of audit data
** Sample size target is 2 per unit per month
Tab # 2, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data shows excellent performance in meeting this requirement, and the trend shows improvement, as staff become more familiar with and focused on those individuals who meet the high risk triggers of the Hospital's policy. The Hospital implemented its High Risk Tracking and Review Policy in March 2011 which was modified in March 2012 (modifications include clarifying language on some process issues and modification of some of the time frames in the policy). Under the Policy, treatment teams are required to monitor individuals in care and notify the PID where an individual meets one or more of 16 categories of behavioral or medical risk indicators. Expectations include updating the risk factors as part of the present status section of the clinical formulation as well as developing interventions to address the risks. In addition, the Hospital is continuing the monitoring of three or more UIs in a thirty day period. The Risk Manager continues to notify treatment teams and the Director of Psychiatric Services or Director of Medical Services, among others, when an individual has three or more major unusual incidents in a thirty day period. The Director of Psychiatric Services or Director of Medical Services or designee consults with the treatment team, reviews the chart and actions of the treatment team, and makes recommendations in the chart concerning actions for the team to consider. PID also periodically reviews the clinical formulations and IRPs of a sample of cases involving those on the high risk lists to determine if they have been updated to reflect the high risk status and is providing feedback to specific teams around findings. As of March 22, 2012, 97 individuals in care are on at least one "high risk" list. Twenty eight individuals have been removed from the list during this period. Of the 97, 34 had one or more behavioral risks identified, 5 had one
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		or more medical risks identified, and 58 had both behavioral and medical risks identified. Eighty eight of the 97 on the list have IRPs that address all high risks which have been identified for the IIC. Fifteen individuals as of February 29, 2012, met criteria for clinical consultation team review, and of those, all have been held. ***See Tab # 128 Summary of High Risk Data.***
V.E.4	provide that the review process includes an assessment of progress related to discharge; and	
V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.	**MENTAL HEALTH ASSESSMENTS**	
	By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	
A	**Psychiatric Assessments and Diagnoses**	
VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Recommendations:** 1. Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. SEH Response: See VI.A.2, VI.6.a, VI.A.6.d. Note that Sections VI.A.3 to VI.A 5 are no longer active, nor are VI.A.6.b or VI.A.6.c and VI.A.7. 2. Continue to monitor the timeliness and content of psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction. SEH Response: Ongoing. The Hospital is completing monthly audits of the Comprehensive Initial Psychiatric Assessment (CIPA) and the Psychiatric Update. ***See Tab # 13 CIPA Audit Tool/instructions and Tab # 16 Psychiatric Update Audit Tool/instructions.*** Both audit tools were revised substantially effective July 2011 as reflected in section V.B.9 and in the audit results. Essentially, a number of related indicators were combined and the indicators are now more quality-based. 3. Streamline the auditing indicators within the CIPA and Psychiatric Update auditing tools to simplify the auditing process without reducing its value. SEH Response: Completed. ***See Tab # 13 CIPA Audit Tools and # 16 Psychiatric Update Tools.*** **Facility's findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

COMPREHENSIVE INITIAL PSYCHIATRIC ASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	45	38	31	39	29	35	**36**	**36**
n	11	9	8	7	6	9	**8**	**8**
%S	24	24	26	18	21	26	**23**	**23**
%C Was CIPA completed in a timely manner	100	100	100	86	100	100	**100**	**98**
%C # 1 Was the individual's chief complaint reflected in the CIPA?	91	89	100	100	100	100	**100**	**96**
%C # 2 Does the CIPA include history of presenting illness?	100	100	100	100	100	100	**100**	**100**
%C # 3 Did the Assessment include a thorough review of past psychiatric history that included at a minimum information from prior treatment settings (i.e. medications, interventions, r/s history, hx of medication compliance) and information about adverse and therapeutic reactions to medications?	100	100	100	100	100	100	**100**	**100**
%C # 4 Was medical history obtained?	100	100	100	100	100	89	**100**	**98**
%C # 5 Did the assessment include description of patient's family, social and developmental history	91	89	100	100	100	100	**100**	**96**
%C #6 Is each section of the mental status examination completed?	100	100	100	100	100	89	**100**	**98**
%C # 7 Was the risk assessment section completed and include an appropriate plan to manage risks?	100	100	100	100	100	100	**100**	**100**
%C #8 Do the diagnoses reflect current clinical data and differential diagnoses?	100	100	100	100	100	89	**94**	**98**
%C #9 Does the plan section of the CIPA reflect the dx, MSE, results of risk assessment and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	100	100	100	100	100	**100**	**100**
%C #10 Was an AIMS test administered?	100	100	100	100	100	100	**100**	**100**
%C # 11 If the assessment was completed by a psychiatric resident or trainee, is there a note from the attending psychiatrist that includes documentation that the individual was seen, examined and the case discussed with the resident or trainee?	100	100	100	100	100	100	**100**	**100**

N = Admissions during the month
n = number audited- target is 20% sample per month
Tab # 14 CIPA AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

PSYCHIATRIC UPDATE AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	245	247	247	244	235	236	**245**	**242**
n	28	30	32	29	35	33	**29**	**31**
%S	11	12	13	12	15	14	**12**	**13**
%C Timely Completed?	79	87	78	76	83	97	**94**	**83**
%C #1 Does the Update adequately address the significant developments in the individual's clinical status since the last Update?	93	100	100	97	94	100	**98**	**97**
%C # 2 Is each subsection of the MSE complete and accurate?	100	100	100	100	91	94	**98**	**97**
%C #3 Are the appropriate adverse reactions noted in the relevant subsection with respect to treatment with FGA or SGA anti-psychotics?	89	80	84	88	85	83	**97**	**85**
%C #4 Is polypharmacy (≥2 or more anti-psychotics or ≥4 or more psychotropics) correctly identified and is there an adequate rationale provided	96	100	100	100	97	79	**89**	**96**
%C #5 Were risk assessment subsections completed and include an appropriate plan to manage risks?	100	100	100	100	94	100	**99**	**99**
%C #6 Do the diagnoses reflect current clinical data and differential diagnoses?	100	100	100	100	94	100	**100**	**99**
%C #7 Does the plan section of the Update reflect the diagnoses, mental status examination results, response to treatment and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	97	100	100	94	100	**98**	**98**
%C # 8 If the assessment was completed by a psychiatric resident or trainee, is there a note from the attending psychiatrist that includes documentation that the individual was seen, examined and the case discussed with the resident or trainee?	100	100	67	100	36	100	**57**	**77**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data shows that the CIPAs continue to be completed in a timely manner and show high performance in all indicators. The Psychiatric Update audits show a decline in timely completion, from a mean of 94% in the prior review period to a mean of 83% during the current review period. The only other indicator that declined relates to whether appropriate adverse reactions were noted, but other indicators held steady or increased. In the CIPA audits, all indicators are above the 90% threshold. Similarly, the audits show good quality in the content of Psychiatric Update. Six of 9 indicators from the Psychiatric Update audits were rated at 90% or higher.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>In an effort to sustain high performance and improve performance in those areas where needed, the Hospital will continue its monthly audits of the CIPA and the Psychiatric Update. Changes were made in CIPA during the prior review period to improve the clinical flow of the document and improve content by adding text boxes where needed, changing titles of tabs and to make some sections consistent with counterparts in the Psychiatric Update (i.e., risk assessment and mental status examination), which likely contributes to the excellent performance in the CIPA during this review period. See also VI.A.2, VI.A. 4, VI.6.a, VI.A.6.d, and VI.A.7. The Director of Medical Affairs and Director of Psychiatric Services will continue to monitor performance and work with individual physicians as needed.</td></tr>
<tr><td>VI.A.2</td><td>By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;</td><td>Recommendations:

1. Same as VI.A.1.

SEH Response: See VI.A.1.

2. Continue to monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on an adequate sample. Present a summary of the aggregated monitoring data including the comparative data and analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: Ongoing. Risk Assessment is monitored through the CIPA audits and the IPA audits, consistent with the Audit Sample plan. See Tab # 30 Audit Sample plan; Tab # 13 CIPA Audit Tool; Tab # 17, IPA Audit Tool/Instructions.

3. Present comparative data (mean %C for each indicator in current review period vs. last review period).

SEH Response: See below data.

Facility’s findings:

<table>
<tr><th colspan="9">COMPREHENSIVE INITIAL PSYCHIATRIC ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>45</td><td>38</td><td>31</td><td>39</td><td>29</td><td>35</td><td>36</td><td>36</td></tr>
<tr><td>n</td><td>11</td><td>9</td><td>8</td><td>7</td><td>6</td><td>9</td><td>8</td><td>8</td></tr>
<tr><td>%S</td><td>24</td><td>24</td><td>26</td><td>18</td><td>21</td><td>26</td><td>23</td><td>23</td></tr>
<tr><td>%C #7 Risk assessment completed</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = Number of admissions in the month
n = number audited- target is 20% sample per month
Tab # 14 CIPA AUDIT RESULTS</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">INITIAL PSYCHOLOGY ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>45</td><td>38</td><td>31</td><td>39</td><td>29</td><td>35</td><td>36</td><td>36</td></tr>
<tr><td>n</td><td>7</td><td>10</td><td>8</td><td>10</td><td>9</td><td>7</td><td>7</td><td>9</td></tr>
<tr><td>%S</td><td>16</td><td>26</td><td>26</td><td>26</td><td>31</td><td>20</td><td>18</td><td>24</td></tr>
<tr><td>% C Timeliness of IPA Part A</td><td>100</td><td>100</td><td>88</td><td>100</td><td>100</td><td>100</td><td>88</td><td>98</td></tr>
<tr><td>%C #A7a Assess (screen) violence risk</td><td>100</td><td>100</td><td>88</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td></tr>
<tr><td>#A7b Assess (screen) suicide risk</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>97</td><td>100</td></tr>
<tr><td>#A8a Findings violence risk</td><td>100</td><td>100</td><td>88</td><td>90</td><td>100</td><td>100</td><td>100</td><td>96</td></tr>
<tr><td>#A8b Findings suicide risk</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>94</td><td>100</td></tr>
</table>
N = Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 18 IPA AUDIT RESULTS

Analysis/Action Plans: CIPA audits continue to show excellent performance on completion of risk assessments. Similarly, the audits show high levels of performance around assessing risk in the IPA, with a mean in all categories at or above 90%. Further, timeliness of Part A of the IPAs significantly improved during this review period, from a mean of 88% to 98%. Audits will continue.
</td></tr>
<tr><td>VI.A.3</td><td>By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;</td><td></td></tr>
<tr><td>VI.A.4</td><td>By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;</td><td></td></tr>
<tr><td>VI.A.5</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;</td><td></td></tr>
<tr><td>VI.A.6</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that:</td><td></td></tr>
<tr><td>VI.A.6.a</td><td>Clinically supported, and current assessments and diagnoses are provided for each individual</td><td>Recommendations:

1. Same as in VI.A.1 and VI.A.3.

SEH Response: Same as in VI.A.1, and VI.A.3. See those subsections for related data.

Analysis/Action Plans: See VI.A.1 to VI.A.3.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments:	
VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and	
VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Recommendations:** 1. Same as in VI.A.1 through VI.A.6.a and VI.6.c. SEH Response: See VI.A.1 through VI.A.6.a and VI.6.c. **Analysis/Action Plans:** See VI.A.1 through VI.A.6.a and VI.6.c.
VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	
B.	Psychological Assessments (these assessments may be completed by psychologists or graduat students, in psychology under the supervision of psychologists.)	
VI.B.1	By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all	**Recommendations:** 1. Fill the five vacancies in the Psychology Department. SEH Response: The Psychology Department filled all line positions during the rating period, but in January 2012 one psychology staff member was promoted to be Psychology Training Director. Her position is in the early stages of recruitment. As of the writing of this report, the Department has 17 psychologists, 1 neuropsychologist, 1 PBS leader, a Training Director and the Director, for a total staff of 20 plus the vacancy.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	settings), and personality assessments.	2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's findings:**

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	45	38	31	39	29	35	**36**	**36**
n	7	10	8	10	9	7	**7**	**9**
%S	16	26	26	26	31	20	**19**	**24**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	100	100	88	100	100	100	**88**	**98**
%C # 1 (Part B) If Part B completed within 12 days of admission?	100	80	100	83	40	50	**42**	**75**

N = Number of admissions
n = number audited-target is 20% sample (Audit sample plan)
Tab # 18, IPA AUDIT RESULTS

RISK ASSESSMENT PEER REVIEW AND AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	1	1		1	3	1	**3**	**1**
n	1	1		1	1	1	**2**	**1**
%S	100	100		100	33	100	**73**	**71**
%C # 1 a 30 days or less from date of referral to date of acknowledgement in referral	100	100		100	100	100	**100**	**100**
%C #1 b 60 days or less from date of acknowledgement to date of report	100	100		0	100	100	**100**	**80**
%C # 16 There is a progress note in Avatar documenting delivery of report and feedback to the referral to the referral source.*	N/A	N/A		N/A	0	0	**100**	**0**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* New indicator in June, 2011
Tab #26 PSYCHOLOGICAL, NEUROPYSCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	6	4	1	2	4	5	**3**	**4**
n	4	3	1	2	1	1	**2**	**2**
%S	67	75	100	100	25	20	**70**	**55**
%C # 1a 30 days or less from referral to date of acknowledgment in referral database?	100	100	100	100	100	100	**86**	**100**
%C # 1b 60 days or less from acknowledgment to date of report?	100	100	100	100	100	100	**83**	**100**
%C # 13b Date the evaluation is discussed with the recovery team is listed	N/A	N/A	N/A	N/A	N/A	N/A	**80**	**N/A**
%C # 14 Progress note in Avatar documenting delivery of report	25	100	100	50	100	100	**100**	**64**

N= Number of referrals in the month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab #26 PSYCHOLOGICAL, NEUROPSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

NEUROPSYCHOLOGICAL AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	2	1	2	2	2	2	**2**	**2**
n	2	1	2	2	2	2	**2**	**2**
%S	100	100	100	100	100	100	**91**	**100**
%C #1 Completed within 45 days of referral							**50**	
%C # 1a Acknowledged within 30 days of referral?	100	100	100	100	50	100	**100**	**91**
%C #1b 60 days or less from date of acknowledgement to date of report	100	100	50	50	100	100	**88**	**82**
%C # 11 There is a progress note in Avatar documenting delivery of report and feedback to the referral to the referral source.	50	100	0	50	100	100	**100**	**64**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 26 PSYCHOLOGICAL, NEUROPSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital is providing the full range of psychological evaluations and the quality remains high. See VI.B generally for additional data reflecting other indicators from audits. Some minor changes were made to the audit tools or instructions during the prior review period, but no changes were made during this review period. The audit instructions relative to the IPA Part B were modified in August 2011 to reflect the fact that in many cases, individuals in care were not willing to participate in the assessments within the 12 day time frame, but that psychologists were attempting to complete the exams in a timely fashion. The second change was to the psychological evaluation, risk

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>assessment and neuropsychological tool effective with the June 2011 audits. A question was added to the audits to determine if there was documentation that the report was communicated to the team.

The data shows improvement in the timeliness of most types of psychological evaluations. For example, data from the IPA Part A show that timeliness improved significantly during this review period over the prior review period (from 88% to 98%), and Part B improved from 42% to 75%, the timeliness of psychological evaluations improved from 83% to 100%, timeliness of risk assessments was at 80% using the revised hospital policy timeframes, and timeliness of neuropsychological evaluations fell slightly from 88% to 82%. Performance on documentation of communication of results of the various psychological examinations is not at the anticipated level.

The Hospital continued its efforts to fill the vacant psychology positions, and all were filled by October 2011, although with a promotion, one vacancy was created in late January 2012; the backfill of that position is underway. The Director of Psychology will continue to monitor the timeliness of the audits and will modify assignments as needed.</td></tr>
<tr><td>VI.B.2</td><td>By 24 months from the Effective Date hereof, all psychological assessments, shall:</td><td></td></tr>
<tr><td>VI.B.2.a</td><td>expressly state the purpose(s) for which they are performed;</td><td></td></tr>
<tr><td>VI.B.2.b</td><td>be based on current, and accurate data;</td><td></td></tr>
<tr><td>VI.B.2.c</td><td>provide current assessment of risk for harm factors, if requested;</td><td>Recommendations:

1. Maintain current level of practice.

SEH Response: Level of practice maintained.

2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

Facility findings:

<table>
<tr><th colspan="9">RISK ASSESSMENT PEER REVIEW AND AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>1</td><td>1</td><td></td><td>1</td><td>3</td><td>1</td><td>3</td><td>1</td></tr>
<tr><td>n</td><td>1</td><td>1</td><td></td><td>1</td><td>1</td><td>1</td><td>2</td><td>1</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td></td><td>100</td><td>33</td><td>100</td><td>73</td><td>71</td></tr>
</table></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		% C # 13 a Summary/discussion that integrates all the data gathered into a clear clinical picture is present: 100 100	100 100 100 **100** **100** %C #13 b Referral question is answered: 100 100	100 100 100 **100** **100** %C # 13c Conclusions about the patient's risk status are stated?: 100 100	100 100 100 **100** **100** %C # 13 d Conclusions and risk management (including any treatment) recommendations flow naturally from risk factors identified in the report: 100 100	100 100 100 **64** **100** %C #13 e Clinician distinguishes between strategies for addressing stable and acute risk factors: 100 100	100 100 100 **100** **100** %C #13 f If possible, clinician describes how the risk factors link into known or possible offense processes for this individual: 100 100	100 100 100 **100** **100** N= Number of risk assessment referrals in month n = number audited-target is 1 per psychologist (Audit sample plan) ***Tab # 26 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS*** **Analysis/Action Plans:** Data shows high performance, with improved performance on indicator # 13 d. Audits will continue and psychology will monitor data and trends. No other actions are required.
VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment, and	
VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	
VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	
VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	
VI.B.5	By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results	**Recommendations:** 1. Quickly determine a method to ensure that the results of psychological evaluations are both communicated to the treatment team and meaningfully responded to by that team, perhaps in the team psychologist's progress note. SEH Response: Since mid June 2011, psychologists have been writing a progress note in Avatar documenting delivery of

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	for diagnosis and treatment.	the reports and the provision of feedback to the referral source. The various psychological audits are now tracking this as well. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's findings:**

RISK ASSESSMENT PEER REVIEW AND AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	1	1		1	3	1	**3**	**1**
n	1	1		1	1	1	**2**	**1**
%S	100	100		100	33	100	**73**	**71**
%C # 16 There is a progress note in Avatar documenting delivery of report and feedback to the referral source.	N/A	N/A		N/A	0	0	**100**	**0**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 26 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

PSYCHOLOGICAL EVALUATION PEER REVIEW AND AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N	6	4	1	2	4	5	**3**	**4**
n	4	3	1	2	1	1	**2**	**2**
%S	67	75	100	100	25	20	**70**	**55**
%C # 13b Date that the evaluation is discussed with the recovery team is listed.	N/A	N/A	N/A	N/A	N/A	N/A	**80**	**N/A**
%C # 14 Progress note in Avatar documenting delivery of report	25	100	100	50	100	100	**100**	**64**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* Data from prior review period reflect only two months as the indicator was added with July 2011 audits
Tab # 26 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Beginning in late June 2011, because unit based staff were reluctant to complete the Acknowledgement of Receipt and Recommendations of the IPA/Psychological Evaluation Form, the Department of

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Psychology stopped using the form and instead required psychologists to write a note in the record documenting that the results of the evaluation were communicated to the IRP teams. In addition, psychological audits were changed in late June 2011 to begin to track whether there was documentation that the results of the assessments were shared with the teams. Data shows variable performance on this indicator and the Director of Psychology is reminding staff of this requirement. Additionally IRP observation data shows significant improvement in the attendance of psychologists at the IRP, from 77% during the last review period to 90% during this review period. ***See Tab # 7, IRP Observation Audit results.*** This also ensures that psychologists are working with teams to interpret results of evaluations and recommend next steps for the individuals in care.
VI.C	Rehabilitation Assessments	
VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.	
VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	
VI.C.2.a	be accurate as to the individual's functional abilities;	
VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	
VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	
VI.C.2.d	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	
VI.C.3	By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	rehabilitation assessment.	
VI.D	By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.	**Recommendations:** 1. Continue with current corrective action plan. SEH Response: Ongoing. The Social Work Department continues to implement the strategic action plan submitted to DOJ in July 2011. Turning first to the staffing related action steps, all social worker vacancies were filled effective August 15, 2011 until resignations in February, 2012. One of those positions was filled effective March 26, 2012, and the second candidate declined an offer, so recruitment for one vacancy is underway. Attendance of social workers at IRP conferences during this review period improved from a mean of 83% for the prior period to a mean of 97% during this review period. In addition, effective in February 2012, the social work initial assessment and social work update forms in Avatar were redesigned and all social work staff were trained on the new forms using actual cases. The revised forms include updates to the portions of the assessments around discharge planning and were designed to improve the clinical flow of the assessments' discharge planning sections. Audit tools and instructions were then updated to reflect the new forms, although there is only one month of data (February) reflecting the use of the new forms. Data for audits also show improved performance in inviting community case workers (improved from 87% to 94%) and family (improved from 84% to 88%) to IRP conferences. ***See Tab # 7 IRP Observation Audit Results.*** The Social Work Department implemented the CAP action steps related to training. Social workers were provided training around discharge issues and in the completion of the initial social work assessment and social work updates using the new forms. During this training, emphasis was placed on the development and linkages of social work-related objectives and interventions, and how the new forms are more clearly linked to the IRP. Other trainings for social work staff during this review period included ACEDS training and retraining with the DMH's Housing Department around housing options and requirements. Training is planned for Spring 2012 with DC Department of Health around assisted living issues. The social workers also attended a two day social security benefits training offered by DMH that focused on how discharge planning, including such topics as understanding what benefits and services are available to the individuals in care as they work towards outplacement and once outplaced. In this training, social workers learned the rules and allowances for job training and working with a disability, applying for the various types of benefits and how to obtain timely approvals for benefits. Finally, in December 2011 social workers were provided training around discharge planning for those individuals with substance abuse related diagnoses. ***See Tab # 1 IRP Training Summary and Examples.*** Weekly meetings with the MHA and the Community Integration Team continue. In addition, beginning in September 2011, the TLC Transitional modified its program to improve discharge-related programming, and social work modified its curricula for discharge-related groups to increase the focus on building practical skills needed by individuals in care when they return to the community. The Therapeutic Learning Center continues to enhance groups focusing on community integration. The "Warming Up to New Possibilities" group, led by Consumer Affairs, has begun monthly trips into the community, utilizing public transportation. In March 2012, the "Spiritual Home" group began monthly trips to visit various religious institutions to assist individuals in establishing religious affiliations and community support. Rehabilitation Services and Social Work have collaborated to begin a Travel Training Program to teach skills for travel on the bus and

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

metro-rail system throughout the city. Occupational Therapy has begun community living skills groups for individuals in pre-trial status on the Intensive TLC to enhance independent living skills. As a result of focus group meetings throughout the hospital, new groups were created in September 2011 to address gender specific issues for women. The groups focus on women's health, self-care, grooming, and relationships. A women's advisory council was formed and meets twice monthly.

Finally, to ensure continued progress is made, social work has implemented the action steps related to audits and are sharing audit results with individual workers during their 1:1 supervision, which are also presented at the monthly social worker meetings as described in the July CAP.

2. Quickly align the prompts in AVATAR for the SWIA so that they are congruent with the actual information being documented in each section of the assessment.

SEH Response: Completed in two phases. Social work and the Avatar team updated the "light bulbs" for both the SWIA and the Update to improve clarity for workers about what should go in each section while work was completed on revising the forms in Avatar. Revisions to the forms were completed in early 2012, and the revised forms became effective in Avatar in February 2012.

3. Continue to present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	9	7	8	8	6	7	**7**	**8**
%S	20	18	26	21	21	20	**20**	**21**
%C # Completed within 5 days of admission	89	57	88	88	100	71	**86**	**82**
%C # 3a SW has reviewed other sources of information such as old records, initial psych assessment etc	67	43	38	100	100	86	**77**	**70**
%C # 3b Review of the individual's history is satisfactory and includes benefits, medical developmental, psychiatric, social history, and substance abuse history.	100	100	100	100	100	100	**98**	**100**
%C # 4a Identifies whether there is a discrepancy or note and if SWIA includes resolution of discrepancy	78	100	100	N/A	N/A	100	**93**	**85**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #4b If discrepancy is not resolved, the SWIA documents a plan to resolve the discrepancy.	50	N/A	100	N/A	N/A	100	**100**	**75**
		%C # 5 Documents the presenting problem in the individual's own words, one's perceived strengths, their own goals for treatment and discharge.	100	100	100	100	100	100	**97**	**100**
		%C # 6a Describes the individual's strengths and limitations	100	100	88	100	100	100	**98**	**98**
		%C #6b Has recommendations/interventions that are clinical and specific such as "SW will meet to discuss various housing options three times a week""	44	57	50	100	100	86	**75**	**71**
		%C #6c Identifies a group for the individual to participate in, if applicable	60	67	80	100	100	100	**100**	**85**
		%C #6d Overall assessment includes discussion of individual's goals and feelings about community placement	89	86	100	100	100	100	**77**	**96**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 28 SOCIAL WORK AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	247	247	247	244	235	236	**244**	**243**
n	15	12	13	12	12	10	**11**	**12**
%S	6	5	5	5	5	4	**4**	**5**
%C Timely completions	47	100	85	67	92	90	**97**	**78**
%C # 1a Indicates contact with family, significant other and/or guardian	93	100	100	80	100	90	**88**	**94**
%C #1b Indicates the family's, significant other's and/or guardian's support towards individual's progress and discharge plan	57	90	89	89	100	75	**85**	**81**
%C #2a Documents observable/measurable objectives	60	100	77	83	92	80	**75**	**81**
%C # 2b Documents frequency and where progress or lack of progress is	27	50	69	58	33	60	**59**	**49**
%C #2c Documents who is responsible for the intervention and what will be addressed or taught	60	75	85	67	92	80	**79**	**76**
%C # 2d Documents individual's progress to objectives and interventions	60	92	92	83	100	90	**73**	**85**
%C #2e Documents next steps	67	92	69	92	100	80	**83**	**82**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 2f Documents if the individual has made progress, the objective and/or intervention has been revised to move the individual toward discharge	27	0	0	50	67	50	**58**	**38**
		%C # 2g In case of an individual who has not made progress on an objective since the previous update, there is clinical documentation stating the reason for continuing with current objective and intervention	17	82	64	70	83	88	**44**	**64**
		%C #3a Documents in the individual's own words their expressed goal	77	82	83	83	82	80	**85**	**81**
		%C # 3b Documents the individual's perception of progress related to treatment and discharge planning	75	91	100	100	91		**74**	**91**
		%C # 4a The individual's strengths and limitations are described	67	100	92	100	92	70	**89**	**86**
		%C # 4b Documents the individual's current behaviors and functioning	87	100	92	100	100	90	**100**	**95**
		%C # 5a Includes anticipated placement for individual (specific or generic)	80	83	92	92	83	100	**90**	**88**
		%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	58	62	83	67		**86**	**69**
		%C # 5c Includes discharge plan (what steps SEH staff, CSA etc will do to assist with discharge) and provides an update	80	83	77	83	92		**83**	**83**
		%C # 5b Identifies if the individual has any barriers to discharge or anticipated placement	93	83	92	100	100	100	92	95
		%C #5c Discharge criteria and discharge plan review is present and updated.	60	58	62	67	67	100	52	68
		%C # 6a There is identifying information regarding the community support worker/CSA	100	100	100	100	100	100	100	100
		%C # 6b Documents the dates the CSA was notified of the IRP	60	50	45	50	63	63	56	55
		%C # 6c Description of case manager's/CSA's involvement in discharge planning and contact with individual	82	100	100	100	100	75	**87**	**93**
		%C #6d Identifies resources needed for discharge, as needed for the individual in care (such as benefits, housing needs, employment plans, day activities, spiritual needs, substance abuse services, and any other recommended services)	73	100	100	100	100		**81**	**94**
		%C # 6e Documents a recommendation for groups if applicable	40	63	60	73	88		**56**	**62**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N= Census at end of month less admissions n = number audited-target is 1 per social worker (Audit sample plan) ***Tab # 28 SOCIAL WORK AUDIT RESULTS*** See Also Chapter VII for specific indicators around discharge planning. **Analysis/Action Plans:** Data from the audits show continued improvement in social work practice in completing both initial and assessment updates which reflect the actions taken by social work leadership to improve its performance. First, social work implemented modified "light bulb" instructions in Avatar to provide additional guidance to staff in completing the social work initial assessment and the social work update. It also worked with Avatar to modify the SWIA and SW Update forms themselves, which went live in February 2012. Audit tools were then modified again to reflect the new forms. This second set of revisions to social work forms and audit tools were implemented for February audits; however, it is too early to assess if the revised forms have had the desired effect. Of the 20 indicators in the social work initial assessment audit tool, 12 are above 90%, 4 are above 80% and others have significantly trended upward in the last few months of the rating period. (There were two months when the timeliness of the SWIA fell, but leadership believes these were aberrations and not a trend. With respect to the social work updates, performance has not improved to the same extent as the SWIA, but the Director believes that the updates were more affected by the deficiencies in the assessment form itself, which was corrected in February 2012. Other action steps included training for social work staff who, supported by the consultants, jointly reviewed and completed a social work initial assessment using a specific case. The Director of Social Work and the Assistant Director repeated this model for training on the new update using a series of mini-sessions, where updates for actual cases were completed with coaching from social work leaders. Additional examples of good discharge objectives and interventions were also provided during these sessions. See also response to recommendation # 1 of this section for more information about training. Social work supervisors are implementing several strategies to continue the positive trend. An assistant supervisory social worker was named, and each supervisor is assigned to supervise specific individual social workers and audit their work, with periodic cross-checking to insure inter-rater reliability. Audit results are shared with social workers as a group as well as individually during 1:1 supervision, and coaching is provided as needed. Social work will continue to monitor performance using the new tools and forms and will take other actions if needed.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td colspan="3">VII. DISCHARGE PLANNING AND COMMUNITY INTEGRATION</td></tr>
<tr><td></td><td>Taking into account the limitations of court-imposed confinement and public safety, SER, in coordination and conjunction with the District of Columbia Department of Mental Health (“DMH”) shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.</td><td></td></tr>
<tr><td>VII.A</td><td>By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:</td><td>Recommendations:
Implement and monitor the current strategies and audits in the CAP.

SEH Response: Ongoing. The Hospital is continuing its IRP observation and Clinical chart audits as well as the discipline and discharge audits. See Tab # 2 Clinical Chart Audit Results, Tab # 7 IRP Observation Audit Results, Tab # 28 Social Work Audit results and Tab # 54 Discharge Audit results. The Director of Social Work shares the results of all the audits with staff during their monthly meetings, and also is working with individual workers as needed to address issues identified through the audits. Training provided during this review period included ACEDS training, mini-sessions on completing the social work update, discussion of additional examples for discharge related objectives and interventions, and retraining around housing options. Other training included discharge planning for those with co-occurring disorders and training about social security benefits and discharge planning. See VI.D for more information.

In addition, the Director of Social Work worked with Avatar to modify the social work assessment forms (both the initial assessment and the social work update) to improve the focus on discharge planning from the time of admission. These were implemented in February 2012; the audit tools were modified to reflect the new forms, but most of the audits and data reflect the prior versions of the forms. See Tab # 27 SWIA Audit form and # 29 Social Work Update Audit tool (all versions used during this rating period).

CIT meetings continue weekly, and some CSAs are now attending twice per month. There seems to be progress in that many CSAs are more engaged in the discharge planning process and, for those whose level of care is CRF placement, there is a clear goal of placement within three weeks of a level of care being obtained.

Facility’s findings:

<table>
<tr><th colspan="9">SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>45</td><td>38</td><td>31</td><td>39</td><td>29</td><td>35</td><td>36</td><td>36</td></tr>
<tr><td>n</td><td>9</td><td>7</td><td>8</td><td>8</td><td>6</td><td>7</td><td>7</td><td>8</td></tr>
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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%S	20	18	26	21	21	20	**20**	**21**
		%C # 5 Documents the presenting problem in the individual's own words, one's perceived strengths, and own goals for treatment and discharge	100	100	100	100	100	100	**97**	**100**
		%C # 6a Describes the individual's strengths and limitations	100	100	88	100	100	100	**98**	**98**
		%C # 6b Has recommendations/interventions that are clinical and specific	44	57	50	100	100	86	**75**	**71**
		%C # 6c Identifies a group for the individual to participate in, if applicable	60	67	80	100	100	100	**100**	**85**
		%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	89	86	100	100	100	100	**77**	**96**
		%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**93**	**100**
		%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	86	**95**	**98**
		%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	67	71	88	100	100	100	**93**	**87**
		%C # 7d Description of discharge barriers	100	100	100	100	100	100	**98**	**100**
		%C # 7e Includes goals as they relate to functional, psychiatric, behavioral, medical and legal status	100	100	100	100	100		**100**	**100**
		%C # 8a There is identifying information regarding the Community support worker/CSA	100	100	100	100	100	100	**97**	**100**
		%C # 8b Documents the dates the CSA was notified of the IRP	33	33	43	75	67	100	**34**	**57**
		%C # 8c Identifies resources needed for discharge, as needed for the individual in care (i.e. benefits, housing etc)	100	100	100	100	100		**95**	**100**

N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
* New indicator this review period

Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	213	198	201	**221**	**228**
n	11	8	10	11	11	11	**16**	**10**
%S	4	3	4	5	6	5	**7**	**591**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 8 SEH shall provide the individual the opportunity beginning at the time of admission and continuously throughout the individual's stay, to be an active participant in the discharge planning process, as appropriate	100	100	100	91	91	100	**93**	**97**

N = All IRP reviews scheduled in the month
n = number audited
** Sample size target is 2 per unit (Audit Sample plan)
Tab # 7 IRP OBSERVATION AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 3 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible? (# 10 old tool)	88	94	94	95	86	94	**86**	**92**
%C # 4 The IRP has interventions that relate to each objective specifying who will do what, within what timeframe, to assist the individual to meet his /her needs as specified in the objective.	100	94	100	95	100	100	**95**	**98**

N = IRP reviews scheduled during month
n = number audited
* Removed from clinical chart audit
** Sample size target is 2per unit (Audit sample plan)
Tab # 2 CLINICAL CHART AUDIT RESULTS

DISCHARGE MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	17	24	12	14	16	13	**20**	**16**
n	3	4	3	3	4	4	**5**	**4**
%S	18	17	25	21	25	31	**24**	**22**
%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?	100	100	100	100	100	100	**96**	**100**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C # 21 Identified individual to assist with interventions.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C # 22 Timeframes and duration for completion of interventions</td><td>100</td><td>100</td><td>100</td><td>67</td><td>50</td><td>75</td><td>93</td><td>80</td></tr>
</table>
N = All discharges of individuals in care with civil or NGBRI legal status in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As the various audit results show, the Hospital continues to improve the effectiveness of discharge planning from the time of admission. In addition to training provided to clinical administrators and social workers during the last review period, social workers also participated in trainings specifically addressing completion of the SWIA and the completion of the Social Work Update. The instructions for each of the social work assessments were updated, and in February, 2012, revised SWIA and SW Updates went live in Avatar; changes to the forms focused on the discharge related sections and on improving the linkages of objectives and interventions relating to discharge in the IRPs. Social workers were provided with examples of discharge criteria and discharge plans to assist workers and teams in addressing discharge issues; the examples are more aligned with the revised social work forms. Social workers also had a dedicated training focused on discharge planning for those with co-occurring disorders. See Tab # 1 IRP Training Material Discharge Documentation examples. Social work completed a number of other trainings including a two-day training around social security benefits and the related application process, and training on use of the LOCUS system. They also were retrained about housing options and were trained on use of the ACEDS system to check the benefits status of individuals in care. Finally a training with the Department of Health around assisted living options for individuals in care is scheduled for Spring 2012.

The Hospital will continue with its discipline and discharge audits to identify areas of strengths and areas in need of improvement.
</td></tr>
<tr><td>VII.A.1</td><td>those factors that likely would result in successful discharge including the individual's strengths, "preferences, and personal goals;</td><td>Recommendation:

See VII.A

SEH Response: See VII.A

Analysis/Action Plans: See VII.A.</td></tr>
<tr><td>VII.A.2</td><td>the individual's symptoms of mental illness or psychiatric distress;</td><td></td></tr>
<tr><td>VII.A.3</td><td>barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the</td><td>Recommendations:

1. The hospital should continue providing opportunities for the hospital and community to collaborate.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	extent that they are known; and	

SEH Response: The Hospital and Division of Integrated Care are continuing to collaborate around discharge issues through weekly meetings, and some CSAs are attending twice monthly. A number of CSAs are more engaged in the process and placements are being identified more quickly with everyone being more engaged in the discharge process. The Hospital and DMH are also working to identify training needs and DMH and other departments have provided training to Hospital social workers and in some cases direct access to community related databases.

2. The hospital and DMH should identify and resolve specific administrative/paperwork barriers to discharge.

SEH Response: The Hospital and DMH are working closely to address administrative and paperwork barriers to discharge. During this review period, several steps were taken. Social workers were trained on and now utilize the ACEDs system which allows them to access social security benefits and Medicaid information. They were trained on the LOCUS system, which has improved their understanding of an individual in care's level of care needs. This reduces the Hospital's dependence on administrative support from the Department with respect to many discharge activities. Social workers also received refresher training with DMH's Housing Department around housing options and also are scheduled for training with DOH around assisted living options for our individuals in care.

2. SEH Corrective Action Plan, Action Steps should be implemented and monitored.

SEH Response: Ongoing.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	9	7	8	8	6	7	**7**	**8**
%S	20	18	26	21	21	20	**20**	**21**
%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**93**	**100**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	86	**95**	**98**
%C # 7c Includes discharge plan (what SEH, CSA etc will take to assist with discharge)	67	71	88	100	100	100	**93**	**87**
%C # 7 d Identifies if the individual has any barriers to discharge to anticipated placement (old tool #9)	100	100	100	100	100	100	**98**	**100**

N= Number of admissions in the month
n = Target is 20% of admissions
Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	247	247	247	244	235	236	**244**	**243**
n	15	12	13	12	12	10	**11**	**12**
%S	6	5	5	5	5	4	**4**	**5**
%C # 5a Includes anticipated placement for individual (specific or generic)	80	83	92	92	83	100	**90**	**88**
%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	58	62	83	67		**86**	**69**
%C # 5c Includes discharge plan (what steps SEH staff, CSA etc will do to assist with discharge) and provides an update	80	83	77	83	92		**83**	**83**
%C # 5d Identifies if the individual has any barriers to discharge to anticipated placement (# 6 from prior tool)	93	83	92	100	100	100	92	95
%C #5e Discharge criteria and discharge plan review is present and updated.	60	58	62	67	67	100	52	68

N= Census at end of month less month's admissions
n = number audited-target is 1 per social worker(Audit sample plan)
* New indicator this review period
Tab # 28 SOCIAL WORK UPDATE AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 3 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible? (# 10 in prior tool)	88	94	94	95	86	94	**86**	**92**

N = All IRPs scheduled in the review month
n = number audited. Target sample is 2 per unit
Tab # 2 CLINICAL CHART AUDIT RESULTS

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">Census and 30-Day Readmissions*</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>Individuals in Care – Daily Average</td><td>290</td><td>282</td><td>286</td><td>279</td><td>275</td><td>269</td><td>289</td><td>280</td></tr>
<tr><td>Discharges</td><td>41</td><td>43</td><td>38</td><td>34</td><td>48</td><td>28</td><td>37</td><td>39</td></tr>
<tr><td># 30-day Readmissions</td><td>2</td><td>6</td><td>0</td><td>3</td><td>2</td><td>2</td><td>n/a</td><td>2.5</td></tr>
<tr><td>% 30-day Readmissions</td><td>4.9</td><td>14.0</td><td>0.0</td><td>8.8</td><td>4.2</td><td>7.1</td><td>n/a</td><td>6.5</td></tr>
</table>
*National Public Rate (NPR) of 30-day readmission: 7.8%, NASMHPD Research Institute, December 2010
Rehospitalization data from February discharges is not yet available.
See Tab # 43 PRISM Report

Analysis/action steps: Average daily census continued to decline; the average daily census was 278 in August 2011 and 269 in February 2012. This has been accomplished with a 30 day rehospitalization rate that falls below the national public rate and reached 0.0% for individuals discharged in November 2011 in this review period.

In addition, social work and the clinical chart audits show an improving trend around identifying discharge barriers and improving IRPs to address these issues, which should continue with the new Avatar forms. The SWIA audits showed that 100% of SWIAs audited included barriers to discharge and identified resources needed for discharge. This also was an area of strength in the Social Work Update audits, and 95% of cases identified barriers to discharge (indicator # 5d). As noted, training for social workers and clinical administrators around discharge planning was held during the prior review period with a focus on the linkages between the social work update and the completion of the discharge sections of the clinical formulation. Changes were made to the SWIA and Social Work Update forms in Avatar that are also expected to improve the quality of the social work assessments and how workers address discharge barriers. This will continue to be monitored through the identified audits, and additional actions will be taken as needed.
</td></tr>
<tr><td>VII.A.4</td><td>the skills necessary to live in a setting in which the individual may be placed.</td><td>
Recommendations:

1. Continue to implement and monitor the SEH Corrective Action Plan.

SEH Response: Ongoing. See prior discussion on implementation of CAP.

Facility’s findings:
<table>
<tr><th colspan="9">SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>45</td><td>38</td><td>31</td><td>39</td><td>29</td><td>35</td><td>36</td><td>36</td></tr>
<tr><td>n</td><td>9</td><td>7</td><td>8</td><td>8</td><td>6</td><td>7</td><td>7</td><td>8</td></tr>
<tr><td>%S</td><td>20</td><td>18</td><td>26</td><td>21</td><td>21</td><td>20</td><td>20</td><td>21</td></tr>
<tr><td>%C # 6a Describes the individual’s strengths and limitations</td><td>100</td><td>100</td><td>88</td><td>100</td><td>100</td><td>100</td><td>98</td><td>98</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 6b Has recommendations/interventions that are clinical and specific?	44	57	50	100	100	86	**75**	**71**
%C # 6c Identifies a group for the individual to participate in, if applicable	60	67	80	100	100	100	**100**	**85**
%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	89	86	100	100	100	100	**77**	**96**
%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**93**	**100**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	86	**95**	**98**
%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	67	71	88	100	100	100	**93**	**87**
%C # 7d Description of discharge barriers	100	100	100	100	100	100	**98**	**100**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
* New indicator for this review period
Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. # 3 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible	88	94	94	95	86	94	**86**	**92**

N = All IRPs scheduled in the review month
n = number audited. Target sample is 2 per unit
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Steps: See VII.A.1 through A.3.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>VII.B</td><td>By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.</td><td></td></tr>
<tr><td>VII.C</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:</td><td>
Recommendations:

1. Continue to implement and monitor the Corrective Action Plan.

SEH Response: Ongoing. See prior description of progress on implementing CAP and data below.

2. Focus social work staff and individual social work supervision meetings on developing specific clinical SW interventions.

SEH Response: Ongoing. As noted previously, the Director of Social Work and her assistant director provide 1:1 supervision with staff and use various tools to strengthen the development of clinical social work interventions. Either the Director or her assistant director attends most of the 7 day IRPs for individuals who are readmitted within 30 days of discharge. Audit results are shared with workers as a group, and supervisors also meet with staff and review with the worker his or her specific audit results. When the new Avatar forms went live, the social work leadership conducted a series of mini-trainings (mandatory for workers) where each worker had to complete a form using a real case, while others watched and participated. Finally, additional examples of objectives and interventions were shared with social work staff.

Facility's findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>213</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>11</td><td>8</td><td>10</td><td>11</td><td>11</td><td>11</td><td>16</td><td>10</td></tr>
<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C Data fields: Family Member invited?</td><td>100</td><td>67</td><td>100</td><td>100</td><td>100</td><td>78</td><td>84</td><td>88</td></tr>
<tr><td>%C Data fields: Community support worker invited</td><td>88</td><td>100</td><td>100</td><td>90</td><td>90</td><td>100</td><td>87</td><td>94</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month)
See Tab # 7 for IRP OBSERVATION AUDIT RESULTS

<table>
<tr><th colspan="9">SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>45</td><td>38</td><td>31</td><td>39</td><td>29</td><td>35</td><td>36</td><td>36</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	9	7	8	8	6	7	**7**	**8**
%S	20	18	26	21	21	20	**20**	**21**
%C # 6a Describes the individual's strengths and limitations	100	100	88	100	100	100	**98**	**98**
%C # 6b Has recommendations/interventions that are clinical and specific?	44	57	50	100	100	86	**75**	**71**
%C # 6c Identifies a group for the individual to participate in, if applicable	60	67	80	100	100	100	**100**	**85**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
* New indicator for this review period
Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	247	247	247	244	235	236	**244**	**243**
n	15	12	13	12	12	10	**11**	**12**
%S	6	5	5	5	5	4	**4**	**5**
%C # 5a Includes anticipated placement for individual (specific or generic)	80	83	92	92	83	100	**90**	**88**
%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	58	62	83	67		**86**	**69**
%C # 5c Includes discharge plan (what steps SEH staff, CSA etc will do to assist with discharge) and provides an update	80	83	77	83	92		**83**	**83**
%C # 5d Identifies if the individual has any barriers to discharge to anticipated placement (# 6 from prior tool)	93	83	92	100	100	100	92	95
%C #5e Discharge plan review is present and updated.	60	58	62	67	67	100	52	68

N= Census at end of month less month's admissions
n = number audited-target is 1 per social worker(Audit sample plan)
* New indicator this review period
Tab # 28 SOCIAL WORK UPDATE AUDIT RESULTS

Analysis and Action Plan: See subcells below.

VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Recommendations:** 1. See VII.C

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
SEH Response: See VII.C.

2. Maintaining progress should result in substantial compliance at the next visit.

SEH Response: No response needed.

Facility's findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>24</td><td>12</td><td>14</td><td>16</td><td>13</td><td>20</td><td>16</td></tr>
<tr><td>n</td><td>3</td><td>4</td><td>3</td><td>3</td><td>4</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>%S</td><td>18</td><td>17</td><td>25</td><td>21</td><td>25</td><td>31</td><td>24</td><td>22</td></tr>
<tr><td>%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>96</td><td>100</td></tr>
</table>
N = All discharges of civil or NGBRI legal status to the community in the month
n = number audited
Target sample is 20%
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: Audit results suggest performance improved in ensuring measurable interventions regarding the individual's discharge considerations, with a mean of 100%. Audits will continue to monitor performance on this requirement.
</td></tr>
<tr><td>VII.C.2</td><td>the persons responsible for accomplishing the interventions; and</td><td></td></tr>
<tr><td>VII.C.3</td><td>the time frames for completion of the interventions.</td><td></td></tr>
<tr><td>VII.D</td><td>By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.</td><td>
Recommendations:
1. Implement and monitor the Corrective Action Plan.

SEH Response: Corrective Action Plan is being implemented and monitored. See Corrective Action Plan.

2. Continue to monitor and take affirmative steps to analyze the admission and readmission rates by legal category.

SEH Response: The Hospital monitors admission and readmission rates through the monthly PRISM report and yearly
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
trend analysis. Data by legal status is available in the PRISM and Trend Analysis reports, data tables. See Tab # 41 FY 11 Trend Analysis and Tab # 43 PRISM report. The data suggests that the census “creep” in August and September was not a trend, but more of an aberration as the average daily census has declined to 269 in February 2012. The Director of Social Work or her Assistant attend the 7 day IRPs for those persons readmitted within 30 days.

Facility’s findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>24</td><td>12</td><td>14</td><td>16</td><td>13</td><td>20</td><td>16</td></tr>
<tr><td>n</td><td>3</td><td>4</td><td>3</td><td>3</td><td>4</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>%S</td><td>18</td><td>17</td><td>25</td><td>21</td><td>25</td><td>31</td><td>24</td><td>22</td></tr>
<tr><td>%C. # 23 Is there evidence of adequate assistance in transitioning prior to discharge?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>96</td><td>100</td></tr>
</table>
N = All discharges of individuals in care with civil and NGBRI legal statuses in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: The Hospital continues to implement the revised TLC programming and curricula to have a far more robust offering around support for transitioning to the community. The Therapeutic Learning Center continues to enhance groups focusing on community integration. The “Warming Up to New Possibilities” group, led by Consumer Affairs, began monthly trips into the community, utilizing public transportation. In March 2012, the “Spiritual Home” group began monthly trips to visit various religious institutions to assist individuals in establishing religious affiliations and community support. Rehabilitation Services and Social Work have collaborated to begin a Travel Training Program that began in March 2012 to teach skills for travel on the bus and metro-rail system throughout the city. Occupational Therapy has begun community living skills groups for individuals in pre-trial status on the Intensive TLC to enhance independent living skills. As a result of focus group meetings throughout the hospital, new groups were created in September 2011 to address gender specific issues for women. The groups focus on women’s health, self-care, grooming, etc. Finally, Social Work continues to enhance its curricula to provide more in-depth lessons on distinct components of discharge planning (e.g., money management, understanding your benefits, etc.).

Audits show performance consistently about the 90% mark during both the prior and current review periods. This is further supported by the Hospital’s low 30 day rehospitalization rate which was at 0% for those discharged in July 2011 and November 2011, and well below the national public rate of 7.84%. The Hospital will continue with monthly audits.
</td></tr>
<tr><td>VII.E</td><td>Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual</td><td>
Recommendations:

1. Implement and monitor the Corrective Action Plan.

SEH Response: Ongoing. The Hospital is implementing and monitoring the CAP.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	for the services, and the discharge of the individual.	2. Target the areas of identification of substance abuse services and outpatient appointments in discharge planning trainings and individual SW coaching. SEH Response: Social workers received training from the Hospital's in house substance abuse expert in December 2011 around identification of substance abuse services for outpatients. ***See Tab # 1 IRP Training Summary*** This was also reviewed with social workers during the mini-sessions held to train on the new Avatar forms. **Facility findings:**

DISCHARGE MONITORING AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	17	24	12	14	16	13	**20**	**16**
n	3	4	3	3	4	4	**5**	**4**
%S	18	17	25	21	25	31	**24**	**22**
%C. # 6 Is there documented evidence of active collaboration with a CSA?	100	100	100	100	100	100	**92**	**100**
%C. # 7 Was the outpatient psychiatrist identified?	67	100	67	50	100	75	**84**	**78**
%C. #8 Was the outpatient/community support worker identified?	100	100	100	100	100	100	**96**	**100**
%C. # 9 Was the next outpatient (medication or therapy) appointment date indicated?	67	100	67	100	100	50	**85**	**78**
%C. # 12 Was the exact type of day services or employment indicated?	100	100	100	100	100	100	**100**	**100**
%C. # 13 Were the type and location of substance abuse/addiction services indicated?	n/a	100	n/a	100	100	100	**85**	**100**
%C. # 14 If the individual has an active Axis III diagnosis, were ongoing medical needs identified?	100	100	100	100	100	100	**89**	**100**
%C. # 15 Was housing secured?	100	100	100	100	100	100	**92**	**100**
%C. # 16 Was the individual's benefit information completed?	100	100	100	100	100	100	**96**	**100**
%C. # 17 Were any other specialized services identified?	100	100	100	100	100	100	**100**	**100**
%C. # 18 Was the discharge plan of care signed by the individual or his/her legal representative?	100	100	67	67	100	100	**89**	**90**
%C. # 19 Was a copy of the discharge plan of care given to the individual or the individual's family or legal representative?	100	100	100	100	100	100	**89**	**100**

N = All discharges in the month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n = number audited ***Tab # 54 DISCHARGE AUDIT RESULTS*** **Analysis/Action Plans:** See VII.A. Audits show significant improvement on most indicators, with a slight decline in performance on two indicators (whether OPD psychiatrist was identified; was the next outpatient appointment identified). It should be noted that the audits did not include a review of discharges of pretrial patients since the Hospital does not control the timing or circumstance of the discharge. Discharge audits will continue. Social work supervisors, as well as the other discipline directors, will review data monthly to identify systemic issues or trend among individual practitioners.
VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	
VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at· discharge; and	
VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.	**SPECIFIC TREATMENT SERVICES**	
VIII.A	Psychiatric Care	
	By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	
VIII.A.1	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	
VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	
VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;	
VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	
VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Recommendations:** 1. Same as in VI.A.1 and VI.A.7. SEH Response: See VI.A.1 and VI.A.7. 2. Improve the risk benefit analysis, as part of the psychiatric update, to justify continued treatment of new generation antipsychotic medications for individuals suffering from a variety of metabolic disorders. SEH Response: Effective with the July 2011 audits, the Hospital revised its CIPA and Psychiatric Reassessment audit tools to consolidate indicators and to restructure the audits to look for more analysis and critical thinking by treating psychiatrists around high risk issues. In the revised Psychiatric Reassessment audit tool there are now three questions (#3, # 4 and #7) that address adverse reactions and high risk medication practices, including evaluating the rationale for polypharmacy or use of new generation antipsychotics for persons suffering from a variety of metabolic disorders, among other high risk practices. The instructions prompt the auditor to consider the rationale, whether it is consistent with the medication guidelines and whether it specifically addresses the risks versus benefits of any high risk regimen. The audit tools track the revised Psychiatric Update form that includes sections on medication response, pertinent laboratory

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

results, medication side effects, polypharmacy or use of benzodiazepines in high risk groups. Data from these audits will be used to address practice issues with psychiatrists as a group as well as with individual psychiatrists.
As previously reported, the Hospital held a Grand Rounds in January 2011 titled "Metabolic Syndrome and Mental Illness" in January 2011. The learning objectives included reviewing metabolic syndrome criteria and prevalence, discussion of the association of metabolic syndrome with mental illness and a review of guidelines for metabolic monitoring for patients on anti-psychotic medication. Other grand rounds that focused on treatment included "Seizure Disorders in Psychiatric Institutions", "Challenges of Treating a Patient in Manic Episode" and "Treatment for Schizophrenia, Current Limitations and Future Strategies". ***Tab # 67 Grand Rounds Schedule.***

See also V.D.1 for discussion of insulin administration protocol.

Finally, the Hospital is continuing its efforts to contract with a diabetes educator who will review protocols and revise them as needed and work with physician and nursing staff around diabetes management issues. A scope of work is being developed.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	11	9	8	7	6	9	**8**	**8**
%S	24	24	26	18	21	26	**23**	**23**
%C # 9 Does the plan section of the CIPA reflect the diagnosis, mental status examination results, results of risk assessment and does it include an appropriate rationale for prescription of any high risk medication regimen? (Indicator effective July 2011)	100	100	100	100	100	100	**100**	**100**

N= Number of admissions
n= 20% sample per audit plan
Tab # 14 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	245	247	247	244	235	236	**245**	**242**
n	28	30	32	29	35	33	**29**	**31**
%S	11	12	13	12	15	14	**12**	**13**
%C # 3 Are the appropriate adverse reactions noted in the relevant subsection with respect to tx with FGAs or SGAs anti-psychotics?	89	80	84	88	85	83	**97**	**85**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 4 Is polypharmacy (≥ 2 more anti-psychotics or ≥ 4 or more psychotropics) correctly identified and is there an adequate rationale?	96	100	100	100	97	79	**89**	**96**
%C # 7 Does the plan section of the Update reflect the diagnosis, mental status examination results, response to treatment and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	97	100	100	94	100	**98**	**98**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital continues to implement the redesigned CIPA and Psychiatric Update. The "current treatment" section of the Psychiatric Update includes questions around whether the individual is experiencing side effects, with a specific prompt around weight gain or BMI > 25. In addition, the Update asks whether there has been any change in medication and if so, what and why, whether the benefits of medication prescribed and risks and/or side effects have been discussed with the individual and requires a summary of that conversation. The Psychiatric Update also requires the psychiatrist to address the use of restraint or seclusion or STAT medications in the context of whether medication changes may be in order.

Overall, the data suggests continuing improvement in documentation around high risk medication practices. Data from the revised audit tool shows excellent performance, although the indicator relating to assessment of adverse reactions is below the 90% threshold. The audits will continue and will monitor whether psychiatrists are documenting the rationale underlying medication choices and the risks/ benefits; this is especially true around use of STAT medications and long term use of benzodiazepines or other high risk practices. The Medical Director/designee will identify practitioner issues through the audits and will review the documentation expectations during his monthly meetings with psychiatrists.

VIII.A.1.e

assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;

Recommendations:

1. Same as in V.B.5, VI.A.2.and VI.A.7.

SEH Response: See V.B.5, VI.A.2. Please note that VI.A.7 is no longer an active section of the Agreement.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	45	38	31	39	29	35	**36**	**36**
n	11	9	8	7	6	9	**8**	**8**
%S	24	24	26	18	21	26	**23**	**23**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 7 Were the risk assessment subsections completed, and include an appropriate plan to manage risks?	100	100	100	100	100	100	**100**	**100**

N= Number of admissions
n= number audited. Target is 20%
Tab # 14 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	245	247	247	244	235	236	**245**	**242**
n	28	30	32	29	35	33	**29**	**31**
%S	11	12	13	12	15	14	**12**	**13**
%C # 5 Were the risk assessment subsections completed, and include an appropriate plan to manage risks?	100	100	100	100	94	100	**99**	**99**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The audit results suggest excellent performance around completion of risk assessments. The Medical Director shares audit results with the psychiatrists; he will continue to work with psychiatrists around the quality of documentation.

In addition, the Hospital is tracking high risk behaviors or medical conditions through the High Risk Indicator Event System and High Risk Indicator Tracking and Review Policy. There are two pertinent aspects to the system that address this DOJ requirement. First, the Hospital continues to monitor those individuals involved in 3 or more major UIs in a 30 day period; the Risk Manager notifies the treatment team, the PBS Team Leader and the Director of Psychiatric Services when an individual has a third major incident within a 30 day period. The treatment team has seven days to address the issue, and write a note in the record, and thereafter the Director of Psychiatric Services reviews the record and makes additional recommendations to the team if needed, or if no additional recommendations are needed, so indicates in the medical record. ***See Tab # 46, Risk Indicator Tracking Summary List.*** This is tracked through a database maintained in PID.

Second, the Hospital, effective March 2011, began implementing the High Risk Indicator Tracking and Review Policy. ***See Tab # 129 High Risk Indicator Tracking and Review Policy.*** Under the policy, eight categories of behavioral high risks and eight categories of medical high risks were identified and individuals in care who meet the criteria are now identified and tracked until removed from the lists. The policy provides for three levels of interventions, including the first level by the IRP teams, a second level of review by the Director of Psychiatric Services (or designee) of any individual who meets a high risk threshold and a third level clinical consultation team (CCT) which reviews any individual who meets the high risk threshold more than once in a six month period, remains on the list more than six months, or requires placement on a list for the second time in a six month period unless recommended deferred by the Director of Psychiatry. (The policy was updated in March 2012; some of the criteria for removal from the high risk have been changed to permit removal after

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		four months instead of six months.) PID tracks the compliance with the policy, and also reviews a sample of records to determine if risk is reflected in the IRP documentation following placement on the list. As of the writing of the previous report, there were 95 individuals on one or more lists; 25 individuals are no longer on any lists. Eleven individuals met the qualifications for a CCT and all had them. For the current review period, there were 97 individuals on one or more lists; 28 individuals are no longer on any lists. Seventeen individuals were determined to be in need of a CCT and 15 of those had them (two were determined not to be in need of them at the time the CCTs were scheduled.)
VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	
VIII.A.1.g	documentation of reasons for complex pharmacological treatment;	
VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	
VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	
VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	
VIII.A.2.a.i	Clinically justified	
VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	
VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	
VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	
VIII.A.2.a.v	evaluated for side effects; and	
VIII.A.2.a.vi	documented.	
VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	
VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	laboratory studies needed for use of classes of medications in the formulary;	
VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of· PRN uses;	
VIII.A.2.b.iii	establish a system for the pharmacist to communicate drug alerts to the medical staff; and	
VIII.A.2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Recommendations:** 1. Implement corrective actions to address under-reporting of ADRs. SEH Response: The Hospital continues to monitor ADR reporting through it Pharmacy and Therapeutics Committee and continues to work with physicians around the importance of reporting ADRs, but strategies to date have not proven to be wholly effective. The Hospital in early Summer, 2011 launched a Six Sigma review of ADRs and MVR, which began with a review of data and was followed by audit of records to assess the degree of underreporting. Six data sets were identified as possible indicators of ADRs or MVs, and then cases that fell within these data sets during the month of April 2011 were reviewed by a psychiatrist and the Chief Pharmacist, to determine if the records suggested ADRs or MVRs. Audit results suggest a significant number of ADRs and MVs go unreported. ***See Tab # 47 Six Sigma ADR/MVR audit findings.*** Data sets included ADR tracer drugs given as a PRN with ADR indication, medication side effect or ADR indicated in psychiatric update, discontinued with ADR indication, med change/discontinuation with reason documented, med change/discontinued with no reason documented, missing medication administrations that might be related to ADR). Essentially, audit findings suggest that in the month of April, 2011, 23% of individuals in care *may* have experienced ADR symptoms in April, 2011, of which only 9% were reported as ADRs. (None of the ADR cases detected through the review were severe – 76% of the possible ADRs would fall within the mild category, and remainder fall within the moderate category.)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

With respect to the MVR, a similar analysis was conducted. Data sets included "discontinued with duplicate order indication", "missing medication administration that might be related to MV", "medication administration on hold, no reason documented", "med administration missing and no reason documented", "likely duplicate orders", "missing medications reported". Reviewers' findings suggested that 100 individuals in care, or 32% experienced some type of medication variance during April, 2011 with an estimated reporting rate of, at most, 20%. Outcomes for most of the unreported MVR appear to be in the potential category - - 71% in the potential categories.

In addition, the six sigma team conducted interviews (in 2010) with clinicians to identify barriers to reporting, which included 1) lack of understanding or disagreement on the need for reporting; 2) fear of punitive actions for revealing errors; 3) burden of paperwork in reporting; 4) lack of understanding of ADR/MV. The six sigma team presented the findings to the Pharmacy and Therapeutics Committee in September 2011 and made preliminary recommendations. The Committee recommended, among other things, that the audit results be presented to medical officers and nurses, that it be investigated as to whether some kind of alert could be generated in the Avatar system of a possible ADR/MV if specific orders are entered and that modifying the reporting process for some types of ADRs or MV be considered. In addition, Pharmacy was asked to determine if they could run a daily or weekly report on new orders for specific medications as a way to prompt improved reporting. This was followed up at the October 2011 Pharmacy and Therapeutics Committee meeting. In addition, a management report that provides an additional mechanism to identify possible adverse reactions was developed and is being tested. The report tracks changes in medication that include a listed reason of adverse reaction, and will allow managers to follow up with psychiatrists and medical practitioners as needed to determine actual ADRs.

2. Continue to provide summary data regarding Adverse Drug Reactions (ADRs) including:

a) Total number of ADRs reported during the review period (specify dates) compared with the number during the previous period (specify dates);

Total Number of Reported ADRs by Month								
Previous Review Period	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**July-11**	**Aug-11**	**Total**	**Mean**
Current Review Period	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**		
Previous	11	6	10	2	4	9	**42**	**7.0**
Current	8	3	9	5	3	3	**31**	**5.2**

Tab # 76 Pharmacy and Therapeutics Committee Data

b) Classification of ADRs by probability category (doubtful, possible, probable and definite) compared with the number during the previous period;

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Probability of ADRs

Probability	Previous Period / Current Period	Mar-11 / Sep-11	Apr-11 / Oct-11	May-11 / Nov-11	Jun-11 / Dec-11	July-11 / Jan-12	Aug-11 / Feb-12	Total	Mean
Doubtful	Previous	0	0	1	1	0	0	2	0.3
	Current	1	0	1	0	0	0	2	0.3
Possible	Previous	4	3	7	0	2	2	18	3.0
	Current	2	0	3	2	1	2	10	1.7
Probable	Previous	7	2	2	1	2	7	21	3.5
	Current	5	2	5	3	2	1	18	3.0
Definite	Previous	0	1	0	0	0	0	1	0.2
	Current	0	1	0	0	0	0	1	0.2

c) Classification of ADRs by severity category (mild, moderate and severe) compared with the number during the previous period;

Severity of ADRs

Severity Level	Previous Period / Current Period	Mar-11 / Sep-11	Apr-11 / Oct-11	May-11 / Nov-11	Jun-11 / Dec-11	July-11 / Jan-12	Aug-11 / Feb-12	Total	Mean
Mild (0)	Previous	3	2	3	0	2	3	13	2.2
	Current	1	0	4	0	0	0	5	0.8
Moderate (1~2)	Previous	8	4	7	2	2	6	29	4.8
	Current	7	3	5	5	3	3	26	4.3
Severe (3~5)	Previous	0	0	0	0	0	0	0	0.0
	Current	0	0	0	0	0	0	0	0.0

Outcome of Reaction

Result	Sep	Oct	Nov	Dec	Jan	Feb	Total	Mean
Recovered/resolved Completely	4	1	8	5	3	2	23	3.8
Recovered/resolved with sequelae	0	0	0	0	0	0	0	0.0
Recovering/resolving	0	0	0	0	0	0	0	0.0
Not recovered/not resolved*	3	0	0	0	0	0	3	0.5
Fatal	0	0	0	0	0	0	0	0.0
Unknown	1	1	1	0	0	1	4	0.7

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

* This data is as of the end of the month, not as of the writing of the report

Reporter Discipline								
Result	Sep	Oct	Nov	Dec	Jan	Feb	**Total**	**Mean**
Nurse	0	0	0	0	0	0	**0**	**0.0**
Pharmacist	0	1	1	0	0	0	**2**	**0.3**
Medical	2	0	0	1	0	1	**4**	**0.7**
Psychiatrist	6	2	8	4	3	2	**26**	**4.2**

d) Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;

SEH Response: No ADR met the category, and thus no intensive case analysis was completed.

e) Clinical information regarding each ADR that was classified as "not recovered and/or unresolved;"

SEH Response: No ADR met the category as of the writing of this report.

f) Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:
   i) Date of the ADR;
   ii) Brief Description of the ADR;
   iii) Outline of ICA findings and recommendations; and
   iv) Outline of actions taken in response to the recommendations.

SEH Response: No ADR met the category, and thus no intensive case analysis was completed.

g) Analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.

SEH Response: See a) and response to recommendation # 1 above. ***See also Tab # 76 Pharmacy and Therapeutics Committee Monthly report***

3. Continue to provide summary of Drug Utilization Evaluation (DUE)s during the review period, including the following information.

   a) Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.
   b) Date of each DUE;

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		c) Description of each DUE including methods used; d) Outline of each DUE's recommendations; and e) Outline of actions taken in response to the recommendations. f) Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns. SEH Response: The Hospital completed two DUEs during this review period and completed the first phase of an additional DUE. ***Report Tab # 69 Drug Use Evaluations.*** The first DUE involved a review the status of the assessment and treatment of individuals with Hepatitis C at the Hospital; guidelines were implemented in 2010 and this was a review of the implementation of the guidelines. The DUE revealed that as of December 20, 2011 there were 51 individuals, or 19% of the census, with a diagnosis of Hepatitis C. All but two individuals (they declined) had viral load (VL) results; 9 had non-detectable VLs and one of the nine was post-treatment non-detectable VL. Ten IICs had viral loads between 43 and 1 M, 25 had VL between 1M-10M and 5 had VL greater than 10M. Twelve individuals had reported liver biopsy results; of these, 8 were reported as stage I disease, 3 as stage II and 1 as stage III. Two IIC without liver biopsy results were found to have liver masses through imaging studies. Nine IICs have refused to be evaluated by specialists and one declined treatment after a stage I finding through biopsy. Two IICs with stage I disease by biopsy were awaiting treatment, one individual with stage II was treated and VL decreased significantly, and twelve IICs were referred to specialists. Recommendations from the DUE include that regular conferences be held to review status of treatment of those IICs with Hepatitis C and that given the clusters of refusals of evaluation and treatment on certain houses, the reasons for declining treatment be reviewed to determine if a health teaching initiative might be useful. A second DUE reviewed use of nicotine replacement therapy four years after the Hospital became a smoke free campus. The goal of the DUE was to study the prevalence of nicotine dependence among IICs, their motivation to quit and the current practices in the use of nicotine replacement therapy (NRT). Information for the DUE was obtained from the diagnoses screens in Avatar, the results of the Readiness Ruler used by the TLCs and pharmacy with respect to use of NRT. The study concluded that the range of prevalence of nicotine dependence for IICs is between 21% and 37%, which is somewhat lower than might be expected. The data from the Readiness Ruler showed that most IICs with nicotine dependence are at lower motivational levels to quit smoking and that curricula at the TLCs appropriately reflect this status. The DUE also looked at the type of NRT used at the Hospital, with only the patch, gum and lozenge in the formulary. As a result of the DUE, changes were made to the formulary so that the patch and lozenge (most frequently used NRT) are standard formulary items but that gum and inhaler will be available as a special non-formulary request. Finally, the DUE concluded that given the low level of smoking contraband suggests most IIC are receiving adequate treatment to address nicotine craving. ***Report Tab # 69 Drug Use Evaluations.*** A third DUE was begin and phase I was completed. This DUE reviewed medications that were utilized to manage agitation or disruptive behavior and if the psychopharmacological management adheres to best practice standards. The DUE reviewed STAT medication use for the first 8 months of 2011. During this period, there were 884 episodes involving 179 IICs, of which 104 resulted in a Code 13 being called. The first phase of the DUE revealed that mono-therapy was the most frequent type of treatment modality with only one agent being employed in 54% of the cases in which medication was ordered; antipsychotic medication alone was used in 24% of the cases, benzodiazepines alone used in 26% of cases and diphenhydramine in 3% of cases. Haldol was the most commonly used anti-psychotic used in mono-therapy. As for

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

combination therapy, the most frequent combination was an antipsychotic and benzodiazepine combination. Of the 595 cases in which medication was ordered, the DUE found that it was the same medication as the routine medication in 58% of cases and a different antipsychotic in 42% of cases. Best practice standard suggests that an oral atypical anti-psychotic agent is the first choice in managing agitation in patients with schizophrenia and bipolar disorders, but the use of haldol and lorazepam is still a common practice across the country, as is the practice here. These findings will be presented to the P and T Committee and a second phase is planned, with additional data analysis and a phase three which will look at prescribing patterns on physicians on call versus those of attending physicians.

4. Improve mechanisms to capture medication variances, including potential variances;

SEH Response: See response to recommendation # 1 above.

5. Continue to provide data regarding medication variance reporting including:

a) Total number of actual and potential variances during the review period compared with numbers reported during the previous period;

Total Number of Reported Medication Variances by Month								
Previous Review Period	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**July-11**	**Aug-11**	**Total**	**Mean**
Current Review Period	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**		
Previous	8	20	14	19	16	13	**90**	**15.0**
Current	10	12	14	7	8	5	**56**	**9.3**

See Tab # 76 MVR SUMMARY REPORTS

b) Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual, with totals during the review period compared with the last review period;

Number of Medication Variances by Type									
	Sep	Oct	Nov	Dec	Jan	Feb	**Total**	**Mean-P**	**Mean-C**
Administering	0	1	0	0	0	3	**4**	**0.8**	**0.7**
Dispensing	2	2	0	2	1	0	**7**	**1.5**	**1.2**
Monitoring	0	0	0	0	0	0	**0**	**0.0**	**0.0**
Prescribing	6	8	10	4	7	0	**35**	**11.7**	**5.8**
Procurement	0	0	3	1	0	0	**4**	**0.0**	**0.7**
Transcribing/Documenting	2	1	0	0	0	0	**3**	**0.7**	**0.5**
Other/NA	0	0	1	0	0	2	**3**	**0.5**	**0.5**

** A medication variance incident may be categorized in more than one type.*

See Tab # 76 MVR SUMMARY REPORTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Classification by Outcome Category								
	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
Potential - A	0	0	2	0	0	0	**1.7**	**0.3**
Potential - B	7	4	7	3	6	3	**11.7**	**5.0**
Potential Subtotal	*7*	*4*	*9*	*3*	*6*	*3*	***13.3***	***5.3***
Actual - C	3	8	5	4	2	1	**1.2**	**3.8**
Actual - D	0	0	0	0	0	1	**0.5**	**0.2**
Actual - E	0	0	0	0	0	0	**0.0**	**0.0**
Actual - F	0	0	0	0	0	0	**0.0**	**0.0**
Actual - G	0	0	0	0	0	0	**0.0**	**0.0**
Actual - H	0	0	0	0	0	0	**0.0**	**0.0**
Actual - I	0	0	0	0	0	0	**0.0**	**0.0**
Actual Subtotal	3	8	5	4	2	2	**24**	**4.0**
# of ICA Complete*	*0*	*0*	*0*	*0*	*0*	*0*	***0.0***	***0.0***

** ICA (Intensive Case Analysis) is required for MVs with outcome E through I.*

See Tab # 76 MVR SUMMARY REPORTS

c) Number of variances by critical breakdown point with totals during the review period compared with the last review period;

Number of Medication Variances by Critical Breakdown Point									
	Sep	Oct	Nov	Dec	Jan	Feb	Total	Mean-P	Mean-C
Administering	0	1	0	0	0	3	4	**0.8**	**0.7**
Dispensing	2	2	0	2	1	0	7	**1.5**	**1.2**
Monitoring	0	0	0	0	0	0	0	**0.0**	**0.0**
Prescribing	6	8	10	4	7	0	35	**11.7**	**5.8**
Procurement	0	0	3	1	0	0	4	**0.0**	**0.7**
Transcribing/Documenting	2	1	0	0	0	0	3	**0.5**	**0.5**
Other/NA	0	0	1	0	0	2	3	**0.5**	**0.5**

See Tab # 76 MVR SUMMARY REPORTS

d) Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved;

SEH Response: No critical case analyses were required this period.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		e) Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; Also provide summary outline of each analysis including the following: i) Date of the variance; ii) Brief description of the variance; iii) Outline of ICA findings and recommendations; and iv) Outline of actions taken in response to the recommendations SEH Response: No critical case analyses were required this period. f) Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances; SEH Response: ***See Tab # 73 Pharmacy and Therapeutics Committee Minutes.*** The Committee reviews each month the Medication Variance Reporting data, as well as a synopsis of each reported medication variance. The information is summarized in the minutes, and a more full description of each medication variance case is handed out and reviewed at each meeting. In addition, the Committee, in September 2011 reviewed the preliminary findings of the six sigma review. This was reviewed again during the March 2012 meeting. g) Evidence of corrective actions to address patterns and trends identified in medication variances. SEH Response: The Hospital continues to focus on medication variances involving missing medication administration documentation. Each month, a report is prepared by the Office of Statistics and Reporting concerning aspects of ADR and MVR data which is submitted to the Pharmacy and Therapeutics Committee. ***See Tab # 76 Pharmacy and Therapeutics Committee Monthly Report.*** The Hospital has undertaken a six sigma analysis to better understand the scope of the issues around underreporting as well as the issues that are contributing to the underreporting. The Hospital is also continuing to monitor medication administration documentation and the data is now reported to Pharmacy and Therapeutics Committee as well. During this review period, the percentage of missing documentation has fallen from 0.36% in August, 2011 to 0.33 % in February, 2012. The percentage of nurses with no missing documentation was 57 % in August 2011 and was 61% in February 2012. (In February 2012 33% percent missed documentation in 1-10 doses, and only 6% had between 10 and 50 doses with missed documentation.) Information is tracked by unit and by nurse. ***See Tab # 76 P and T Committee Data and Tab # 90 Medication Administration Documentation Data Report.*** 6. Provide data regarding mortality reviews of all unexpected deaths during the review period. Ensure completion of an external review of all unexpected mortalities and integration of results of the independent external medical mortality review and post-mortem examinations in the final level interdisciplinary review in a timely manner. SEH Response: The DMH Mental Health Authority continues to act as the independent external reviewer of mortalities. Its recommendations are presented to the Performance Improvement Committee and are tracked by the Performance Improvement Department. During this review period, there were three deaths of inpatients. ***See Tab # 130 Mortality reports.*** All Hospital mortality reports were recently finalized and submitted to DMH for review.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		7. The facility's mortality review process must be revised to ensure that risk factors that may be contributing to the mortality are addressed in a systematic and interdisciplinary manner. SEH Response: Completed. The Patient Death and Sentinel Event policies were revised during the prior review period. ***See Tab # 78 Mortality Review Policy; Tab # 122 Sentinel Event Policy.*** The changes in the Mortality Review policy include but are not limited to broadening the definition of unexpected/unanticipated death, adding language to clarify the purpose of a mortality review (to establish what happened, how it happened and why it happened, so that recommendations can be made and actions taken to minimize or prevent a recurrence), and to identify proposed risk reduction recommendations and issues for performance improvement. No changes were made during this period.
VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units	
VIII.A.4	SEH shall ensure that individuals in need are - provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	
VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	
VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	
VIII.A.4.c	integrate psychiatric and behavioral treatments.	
VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.	
VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	
VIII.A.7	By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.	
B	Psychological Care	
	By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological support and services to individuals who require such services.	
VIII.B.1	By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	
VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected. to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;[2]	**Recommendations:** 1. Quickly initiate an audit for the presence and quality of the psychologist progress note that is to be written following an individual in care reaching a threshold/trigger for behavioral review. SEH Response: This is being completed as part of a qualitative audit by the PBS Team Leader and was begun in July 2011. The PBS Team leader reviews the team psychologist's progress note and decision to initiate or not to initiate an IBI. Information will be available during the site visit. 2. Quickly initiate an audit of the psychology progress notes required for individuals in care who are recipients of any type of behavioral intervention, including IBIs. SEH Response: Ongoing. In June 2011, Psychology began auditing progress notes relating to behavioral interventions and the team psychologist's progress note marking the decision to initiate or not initiate an IBI. ***See Tab # 20 IBI Progress Note Audit and Audit Results.*** The audit tool includes 8 indicators and reviews for the presence and content of the progress notes. See data below. 3. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below.

[2] Psychology uses a combination of peer review and supervisory audits. PBS plans, neuropsychology reports, progress notes and IBIs are audited by the Director of Psychology. IPAs are reviewed through peer reviews. The Risk Assessments and Psychological Evaluations are part peer review and part audits. Progress note audits are supervisory audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's findings:

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	45	38	31	39	29	35	**36**	**36**
n	7	10	8	10	9	7	**7**	**9**
%S	16	26	26	26	31	20	**19**	**24**
%C #B- 2 (Part B) Behavioral intervention screening	100	100	100	100	100	100	**100**	**100**
%C # B- 3 (Part B) Behavioral observations	100	67	100	100	100	100	**100**	**93**
%C # B- 5b (Part B) Behavioral plan appropriateness	67	100	100	100	100	100	**100**	**96**

N = Monthly admissions
n = number audited-target is 20% sample (Audit sample plan)
Tab # 18 IPA AUDIT RESULTS

BEHAVIORAL INTERVENTION PROGRESS NOTE AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	8	2	2	4	5	7	**10**	**5**
n	6	2	2	4	5	7	**4**	**4**
%S	75	100	100	100	100	100	**38**	**93**
%C # 1 Progress notes list the reporting period	100	100	100	100	100	100	**87**	**100**
%C # 2 Progress notes report on the occurrence of target behaviors	100	100	100	100	100	100	**100**	**100**
%C # 3 Progress notes comment on changes in the occurrence of the target behaviors	100	100	100	100	100	100	**100**	**100**
%C # 4 Progress notes provide analysis of the staff's preventions/interventions as guided by the IBI/PBS plan or behavior guidelines	100	100	100	100	100	100	**93**	**100**
%C # 5 Progress notes provide assessment of effectiveness of the IBI, Guideline or Plan	100	100	100	100	100	100	**87**	**100**
%C # 6 Progress notes provide recommendations/plan for modifications to the IBI, Guideline or Plan	100	100	100	100	100	100	**93**	**100**
%C # 7 Progress notes are written on schedule as indicated in the IBI through the first 8 weeks OR at frequency indicated at the initial 8 week review	100	100	100	100	80	100	**87**	**96**
%C #8 Number of missing progress notes over the review period.	100	100	100	100	80	100	**80**	**96**

N=Number of individuals in care with BI
n=number audited
Tab # 20 BI PROGRESS NOTE AUDIT TOOL AND RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis and Action Plan: Data shows high rates of compliance in completing the behavioral screens in the IPA Part B, so no specific actions will be taken. Behavioral Intervention Progress Note audit shows performance on all indicators over 90% mark. These audits will continue.
VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual, had in their development, and the system for earning reinforcement;	
VIII.B.1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not ,the use of aversive contingencies;	
VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	
VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Recommendations:** 1. Maintain current practice. SEH Response: Current practice maintained. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's Findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

BEHAVIORAL INTERVENTIONS AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	1	3	2	4	1	5	**3**	**3**
n	1	2	2	4	1	5	**3**	**3**
%S	100	67	100	100	100	100	**89**	**94**
%C. #1. The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms	100	100	100	100	100	100	**100**	**100**
%C #2. Appropriate data collection methods are used	100	100	100	100	100	100	**100**	**100**
%C #3. A structural assessment is completed	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
%C #4. A functional assessment is completed	N/A	N/A	N/A	N/A	N/A	100	**100**	**100**
%C #5. The target maladaptive behavior is described in terms of its predisposing, precipitating, and perpetuating factors	100	100	100	100	100	100	**100**	**100**
%C #6. A baseline estimate of the behavior is presented in terms of objective measures (e.g., rate, frequency, duration, severity, intensity).	100	50	0	100	100	100	**75**	**80**
%C #7. At least one hypothesis is generated from the assessment data	100	100	100	100	100	100	**100**	**100**
%C #8. Behavioral interventions are directly related to the hypothesis	N/A	100	100	100	100	100	**100**	**100**
%C #9. Appropriate interventions are developed if the target maladaptive behavior is to be made irrelevant	N/A	100	100	100	100	100	**100**	**100**
%C #10. Appropriate interventions are developed if the target maladaptive behavior is to be made inefficient	100	100	100	100	100	100	**100**	**100**
%C #11. Appropriate interventions are developed if the target maladaptive behavior is to be made ineffective	N/A	N/A	100	100	100	100	**100**	**100**
%C #12. Behavioral interventions do not use aversive contingencies	100	100	50	100	100	100	**100**	**93**
%C #13. The behavioral intervention plan is revised as clinically indicated by outcome data	N/A	N/A	N/A	75	100	100	**100**	**90**
%C #14. Should the individual engage in the target maladaptive behavior, the staff know how to respond to it in an effective manner	100	100	100	100	100	100	**81**	**100**

N = Individuals referred for behavioral interventions
n = number audited

Tab # 84 BEHAVIORAL INTERVENTIONS AUDIT RESULTS.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: The data above reflect audits of IBIs, behavioral guidelines and plans in place. The data shows that behavioral plans, IBIs and guidelines generally are of excellent quality and that trends show performance meets or exceeds the 90% target on all but one indicator, and performance on this indicator improved from the prior review period. Based upon the data, no additional actions will be taken, but audits will continue and corrective actions will be taken if indicated.</td></tr>
<tr><td>VIII.B.1.f</td><td>ensure that there are adequate number of psychologists for each unit, where needed- with experience in behavior management, to provide adequate assessments and behavioral treatment programs.</td><td>Recommendation:

Increase by five FTEs the staffing of the psychology department

SEH Response: The Hospital in August 2011 received the authority to fill the three vacant psychology positions and backfill a fourth. There were not five positions as indicated in the recommendation. One position cannot be filled until resolution of a federal lawsuit. The other position was used previously to hire another psychologist. The positions were advertised in September 2011 and the positions were filled. As of the writing of this report, one new vacancy exists as the incumbent was promoted to Director of Psychology Training. That position is in early stages of recruitment.</td></tr>
<tr><td>VIII.B.2</td><td>By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.</td><td>Recommendation:

Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below. Please note that during the prior review period, the Hospital began implementation of two new tools to assess the quality of group facilitation. One tool is to be used in evaluating facilitators of curricula based groups, and the other for use in evaluating facilitators of process groups. See Tab # 106 Group Facilitator Monitoring Forms There are five ratings per indicator; excellent, good, acceptable, needs improvement and poor.

Facility's findings:

<table>
<tr><th colspan="5">CURRICULUM BASED GROUP FACILITATOR MONITORING AUDIT RESULTS</th></tr>
<tr><th></th><th colspan="2">Percent Compliance*</th><th colspan="2">Average Score</th></tr>
<tr><th></th><th>Prior</th><th>Current</th><th>Prior</th><th>Current</th></tr>
<tr><td>N =# of group leaders all type of groups</td><td>142</td><td>141</td><td></td><td></td></tr>
<tr><td>n= number observed curricula based groups</td><td>54</td><td>73</td><td></td><td></td></tr>
<tr><td>%C. # 1 Leader starts and ends group on time and is prepared for session (has lesson plan, handouts and necessary materials/props)</td><td>89</td><td>88</td><td>4.3</td><td>3.9</td></tr>
<tr><td>%C #2. Leader demonstrates familiarity with the lesson plan and can explain how the lesson is integrated in the overall curriculum and how the current lesson fits with the overall learning objectives.</td><td>87</td><td>92</td><td>4.3</td><td>4.1</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT				
		%C #3. Leader identifies group agenda and maintains focus on agenda for the full session.	87	96	4.1	4.2
		%C #4. Leader's presentation style is engaging and effective.	91	99	4.3	4.2
		%C #5. Directions, objectives and other information is provided in a clear manner.	91	94	4.3	4.1
		%C #6. Leader utilizes positive instructional techniques.	89	97	4.1	4.2
		%C #7. Leader uses reality orientation, sensory stimulation, and other therapeutic techniques appropriately.	93	100	4.2	4.0
		%C #8. Leader presents information in a manner appropriate to the functional level of group members.	94	97	4.4	4.3
		%C #9. Leader tests and evaluates participants' understanding through questions, role play or other means and provides opportunities for participants to practice skills learned in group.	92	94	4.2	4.1
		%C # 10 All group leaders appeared to be at the appropriate cognitive and/or functional level for the group.	89	92		
		%C # 11 Individuals' Treatment Goals/objectives are linked with group objectives	78	92		

***** percent compliant means rated at acceptable or above

See Tab # 106 GROUP FACILITATOR MONITORING RESULTS

PROCESS GROUP FACILITATOR MONITORING AUDIT RESULTS				
	Percent Compliance*		Average Score	
	Prior	Current	Prior	Current
N =Number of group leaders, all type groups	142	141		
n= number observed	26	20		
%C. # 1 Sets group agenda and discussed group rules	87	95	3.9	4.3
%C #2. Encouraged member self-disclosure that was relevant to the current group agenda without forcing it	92	95	4.3	4.4
%C #3. Encouraged here and now versus story-telling disclosure.	90	100	4.1	4.6
%C #4. Interrupted ill-timed or excessive member disclosure and reframed injurious feedback	89	100	3.7	4.3
%C #5. Encouraged positive feedback.	91	100	4.1	4.5
%C #6. Helped members apply in-group feedback to out of group situations.	89	93	3.9	4.5

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT				
		%C #7. Not defensive when confronted by a member and refrained from conveying personal feelings of hostility and anger in response to negative member behavior.	80	100	3.9	4.4
		%C #8. Maintained an active engagement with the group and its work.	96	95	4.6	4.6
		%C #9. Recognized and responded to the meaning of group members' comments.	96	94	4.3	4.4
		%C # 10 Either prevented or recognized and adequately responded to situations in which members felt discounted, misunderstood, attacked, or disconnected and involved members in describing and resolving conflict	90	91	4.2	4.1
		%C # 11 All group members appeared to be at the appropriate cognitive or functional level for group	76	84		
		%C # 12 Individuals/ treatment goals and objectives are linked with the group objectives	74	89		

***** percent compliant means rated at acceptable or above

See Tab # 106 GROUP FACILITATOR MONITORING RESULTS

Analysis/Action plan:

During the prior review period, the Hospital began utilizing two new tools for assessing group facilitation. One tool is used for curriculum based groups, and the second for process groups. ***See Tab # 106 Group Facilitator Monitoring Forms and Instructions and Results.*** Audits of group leaders are completed at least twice per year. The Hospital uses the audit results to identify those individuals who would benefit from additional training, and those staff will attend the "refresher" training. A 12 hours training course for group leaders continues, and during this review period, 16 additional staff completed the course, for a total of 108 staff trained. In addition, training with group leaders occurred in September 2011 on how to facilitate curriculum based groups with cognitively impaired individuals in care. Eighty four group leaders completed this training. Data from the audits show overall performance is improved for both curricula and process group leaders.

The Hospital continues to refine the TLCs to better meet the needs of individuals in care. In September 2011, the 6th Generation of the TLCs was introduced. Changes were made to the competency program in Intensive TLC to include a weekly mock trial and two to three competency groups each day (except Wednesday when there is a mock trial), and TLC, psychology and PBS team staff revisit treatment strategies for each unengaged individual every four to six months. In TLC Transitional, there was an expansion and revision of discharge focused programming. The Therapeutic Learning Center continues to enhance groups focusing on community integration. The "Warming Up to New Possibilities" group, led by Consumer Affairs, has begun monthly trips into the community, utilizing public transportation. In March 2012, the "Spiritual Home" group began monthly trips to visit various religious institutions to assist individuals in establishing religious affiliations and community support. Rehabilitation Services and Social Work have collaborated to begin a Travel

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Training Program that began in March 2012 to teach skills for travel on the bus and metro-rail system throughout the city. Occupational Therapy has begun community living skills groups for individuals in pre-trial status on the Intensive TLC to enhance independent living skills. As a result of focus group meetings throughout the hospital, new groups were created in September 2011 to address gender specific issues for women. The groups focus on women's health, self-care, grooming, and relationships and a women's advisory council was created. Tab # 55 TLC and Unit Based Group Schedules. The Hospital also continues its work with the unengaged individuals. The most recent list (March 2012) includes 35 individuals, 13 of whom were added in February 2012. The list includes 14 from the prior list who are making progress in their level of engagement. The remaining 8 are having their programming retooled, or are in the process of assessment relating to development or modification of medication or behavioral interventions. Tab # 50 Status Report; Treatment of Unengaged Individuals.</td></tr>
<tr><td>VIII.B.3</td><td>By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.</td><td>Recommendations:

1. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

2. Follow up with data indicating the level of outcome for those individuals on the intensive treatment mall who had presented with engagement issues.

SEH Response: Treatment services staff, PBS team members and representatives from the psychology department continue to monitor this group of individuals. The most recent list (March 2012) includes 35 individuals, 13 of whom were added in February 2012. The list includes 14 from the prior list who are making progress in their level of engagement. The remaining 8 are having their programming retooled, or are in the process of assessment relating to development or modification of medication or behavioral interventions. Tab # 50 Status Report; Treatment of Unengaged Individuals.

Facility's findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>11</td><td>8</td><td>10</td><td>11</td><td>11</td><td>11</td><td>16</td><td>10</td></tr>
<tr><td>%S</td><td>4</td><td>3</td><td>4</td><td>5</td><td>6</td><td>5</td><td>7</td><td>5</td></tr>
<tr><td>%C # 6 Review process includes review of progress toward discharge</td><td>90</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>94</td><td>98</td></tr>
<tr><td colspan="9">N = All IRP reviews scheduled in the month</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>n = number audited
** Sample size target is 2 per unit (Audit Sample plan)
Tab # 7 IRP OBSERVATION AUDIT RESULTS

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>24</td><td>12</td><td>14</td><td>16</td><td>13</td><td>20</td><td>16</td></tr>
<tr><td>n</td><td>3</td><td>4</td><td>3</td><td>3</td><td>4</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>%S</td><td>18</td><td>17</td><td>25</td><td>21</td><td>25</td><td>31</td><td>24</td><td>22</td></tr>
<tr><td>%C. #20 Were there measurable interventions regarding the individual’s particular discharge considerations?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>96</td><td>100</td></tr>
<tr><td>%C # 21 Identified individual to assist with interventions.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C # 22 Timeframes and duration for completion of interventions</td><td>100</td><td>100</td><td>100</td><td>67</td><td>50</td><td>75</td><td>93</td><td>80</td></tr>
</table>
N = All discharges of individuals in care with civil or NGBRI legal status in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

See VIII.B.2

Analysis/Action Plans: Continue with audits as well as the group leader training. Share audit results with discipline chiefs and Director of Clinical Operations.</td></tr>
<tr><td>VIII.B.4</td><td>By 18 months from the Effective Date hereof, SEH shall ensure that:</td><td></td></tr>
<tr><td>VIII.B.4.a</td><td>behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;</td><td></td></tr>
<tr><td>VIII.B.4.b</td><td>programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;</td><td></td></tr>
<tr><td>VIII.B.4.c</td><td>where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;</td><td></td></tr>
<tr><td>VIII.B.4.d</td><td>programs are developed and implemented for individuals with forensic</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;</td><td></td></tr>
<tr><td>VIII.B.4.e</td><td>psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;</td><td>
Recommendations:
1. Continue with present corrective action plan.

SEH Response: Corrective action plan is being implemented.

2. Continue to present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>18</td><td>19</td><td>19</td><td>21</td><td>21</td><td>18</td><td>21</td><td>19</td></tr>
<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. # 2 Treatment and medication regimens are modified, as appropriate, considering such factors as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs.</td><td>81</td><td>82</td><td>100</td><td>78</td><td>89</td><td>88</td><td>74</td><td>86</td></tr>
<tr><td>%C # 8 Ensure that each individuals IRP identifies the diagnoses, treatments and interventions that nursing and other staff are to implement etc</td><td>89</td><td>89</td><td>89</td><td>71</td><td>95</td><td>89</td><td>*</td><td>87</td></tr>
</table>
N = All IRP reviews scheduled, IRP database 9/23/10
n = number audited
* Data not available for the prior review period
Tab #2 CLINICAL CHART AUDIT RESULTS.

Analysis/Action Plan: Data from the clinical chart audit shows improvement in modifying treatment based upon an individual's response to treatment. See Tab # 2, Clinical Chart Audit Results The Hospital is continuing to provide coaching to each treatment team by IRP observers and clinical chart auditors. See Tab # 1 for IRP Training Materials and Data. This continues to be a focus for internal mentors in working with teams.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.B.4.f	clinically relevant information remains readily accessible; and	
VIII.B.4.g	staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.	
C.	Pharmacy Services	
	By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:	
VIII.C.1	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	
VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	
D	Nursing and Unit-based Services	
	SEH shall within 24 months provide medical and nursing services that shall result in SEH's residents receiving individualized services, supports, and 'therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	
VIII.D.1	The Hospital will develop and implement clinical audits and oversight to ensure changes in physical status are identified and treated.	**Recommendations:** 1. Quickly evaluate and resolve issues associated with implementation of nursing forms designed to strengthen documentation of assessments and interventions when individuals' physical status changes.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Completed. A Physical Assessment group of nurse managers and others was formed to evaluate current forms. Based upon their review, the group redesigned the Change in Physical Assessment SBAR progress note, RN transfer to ER forms and the RN Return from ER form which included reducing the duplication of documentation and also eliminated the requirement that a progress note be completed in addition to the transfer form. The related nursing procedures will be updated. The new Change in Physical Assessment form uses the SBAR format with numerous prompts to structure the substance and communication between the nurse and the doctor. Modifications were also made to the RN Transfer to ER form and the RN Return From ER form. ***See Tab # 87 SBAR RN Change in Physical Condition Assessment Form, RN Transfer Out form and RN Return Form and Instructions.***

2. Establish mechanism to monitor implementation, aggregate findings, report and resolve emerging issues.

SEH Response: Nursing developed and implemented audit forms for monitoring, identifying and resolving emerging issues for each of the three new forms. These forms were just introduced in January 2012 and thus only one month of audit data is available; additional data may be available by the time of the visit. ***Tab # 88 Audit Tool for Change in Physical Status form, Audit Tool for RN Transfer to ER/Medical Form, and Audit Tool for RN Transfer from ER/Medical Facility form.*** See data below.

3. Ensure that committee minutes accurately reflect findings from Code Blue drills and the status of actions taken to resolve identified issues.

SEH Response: Ongoing. Code blue drills data is shared with the Morbidity and Mortality Review Committee. ***See Tab # 125, Mock Code Blue data and Tab # 130 Morbidity and Mortality Committee minutes.***

Facilities Findings:

HISTORY AND PHYSICAL AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	45	38	31	39	29	35	**36**	**36**
n	11	9	10	10	2	2	**7**	**7**
%S	24	24	32	26	7	6	**26**	**15**
%C. # Timely completion	100	89	100	100	100	100	**100**	**98**
%C. # 1 Subsections on basic information completed	82	100	100	100	100	100	**100**	**95**
%C. # 2 Part II of H & P includes completed past medical history	82	100	100	90	100	100	**100**	**93**
%C. # 3 Immunization section is complete	82	100	90	90	100	100	**100**	**91**
%C. # 4 H & P includes complete and appropriate description of review of systems	82	100	100	100	100	100	**100**	**95**
%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings	82	100	100	100	100	100	**100**	**95**
%C. # 6 Neurological section is completed	82	100	100	100	100	100	**100**	**95**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 7 Cranial nerve section is completed	82	100	100	100	100	100	**100**	**95**
%C. # 8 Assessment section is completed and includes synthesis of relevant findings	82	100	100	100	100	100	**100**	**95**
%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.	82	100	100	100	100	100	**100**	**95**

See TAB # 52 HISTORY AND PHYSICAL AUDIT RESULTS

MEDICAL TRANSFER AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	21	31	25	14	19	19	**22**	**22**
n	3	0	10	7	3	5	**4**	**5**
%S	14	0	40	50	16	26	**16**	**18**
%C. # 1 Subsections on basic information completed	100		90	100	100	100	**86**	**96**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses	100		80	100	100	100	**90**	**93**
%C. # 3 Reason for medical transfer is clearly indicated on the form	100		90	100	100	100	**95**	**96**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.	100		90	100	100	100	**95**	**96**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings	100		90	100	100	100	**100**	**96**
%C. # 6 All the most recent lab results were provided	100		80	71	33	100	**100**	**79**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted	100		80	100	100	100	**100**	**93**
%C. # 8 The allergy section is completed fully and accurately	100		10	29	33	100	**67**	**43**
%C. # 9 The form includes a brief description of current behavior and responses to treatment	33		60	86	100	100	**43**	**75**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer	67		80	71	100	100	**95**	**82**
%C. # 11 There is a progress note upon the individual's return that includes an analysis of information from the medical facility and an appropriate response by the physician/nurse practitioner.	100		100	100	100	100	**100**	**100**

SEE TAB $ 62 MEDICAL TRANSFER AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19	**n/a**	**19**
n						7	**n/a**	**7**
%S						37	**n/a**	**37**
%C. # 1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?						100	**n/a**	**100**
%C # 2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?						86	**n/a**	**86**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?						100	**n/a**	**100**
%C #4 Is the assessment of systems completed and synthesized?						100	**n/a**	**100**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?						100	**n/a**	**100**
%C #6 Does the assessment include auscultation, etc?						86	**n/a**	**86**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?						57	**n/a**	**57**
%C #8 Was the level of urgency consistent with the clinical presentation?						43	**n/a**	**43**
%C #9 Was the course of physical status change adequately described?						86	**n/a**	**86**
%C #10 Was the individual's response to alternative interventions documented?						100	**n/a**	**100**
%C # 11Were changes from the baseline adequately identified and described?						100	**n/a**	**100**
%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?						71	**n/a**	**71**

N=Transfers to ER or Hospitals
n=cases audited
* Data not available for prior review period
SEE TAB # 104 RN SBAR AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RN TRANSFER TO ER/HOSPITAL FORM AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19		**19**
n						7		**7**
%S						37		**37**
%C. # 1 Was the form complete, signed and dated?						71		**71**
%C. # 2 Is the medical/physical reason for transfer to the ER clearly stated/described?						86		**86**
%C. # 3 Are all supporting medical data included, i.e., vital signs, blood glucose, height, weight, etc.?						14		**14**
%C. # 4 Is there a detailed description of the individual in care's current behavioral and cognitive status?						43		**43**
%C. # 5 If the current behavior or cognitive status is a change from normal presentation, is there a description of how it is different?						0		**0**
%C. # 6 Are "At Risk For /Special Conditions" (both existing and new) indicated and consistent with the individual's clinical picture? (If none known, is the box checked?)						86		**86**
%C. # 7 Is there a description of the individual's communication needs, including any significant findings?						86		**86**
%C. # 8 If applicable, were Special instructions to Enhance Health Care provided?						100		**100**
%C. # 9 Is there evidence that all applicable documents were completed/attached?						100		**100**

N=ER transfers for month
n=number audited
* Data not available for prior review period
SEE TAB # 104 RN TRANSFER TO AUDIT RESULTS

RN TRANSFER FROM ER DEPARTMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19		**19**
n						6		**6**
%S						32		**32**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C. # 1 Is the form completed, signed and dated?						83		**83**
		%C. # 2 Are vital signs documented?						100		**100**
		%C. # 3 If the vital signs are outside the known parameters, is there evidence that the General Medical Officer was consulted?						100		**100**
		%C. # 4 If the individual in care reports pain or the RN observes signs of possible pain, was a Pain Assessment Form completed?						0		**0**
		%C. # 5 Is there evidence of a completed focused physical assessment including a review of the system related to why the individual in care was initially transferred to the general medical facility?						83		**83**
		%C. # 6 Is there evidence of review of the discharge diagnosis, treatment and care recommendations from the transferring facility?						83		**83**
		%C. # 7 Is completion of identification of new risks consistent with the RN's assessment of the individual's current physical status and the medical problems for which the individual was treated?						83		**83**
		%C. # 8 If applicable, is there completion of any additional risk assessment forms/tools?						0		**0**
		%C. # 9 Did the registered nurse summarize the assessment findings that have implications for nursing interventions, addressing immediate physical and psychiatric care and treatment?						17		**17**
		%C. #10 Were objectives identified and immediate nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area 1) (if indicated by assessment)?						0		**0**
		%C #11 Were objectives identified and immediate nursing interventions developed consistent with identified Medical/Physical Health (IRP Focus Area II)?						50		**50**
		N= ER transfers for month n=number audited * Data not available for prior review period ***SEE TAB # 104 RN RETURN AUDIT RESULTS*** **Analysis/Action Plan:** The Hospital has undertaken a number of initiatives to address this requirement. First, in the Fall 2011, the Hospital reorganized the Division of Medical Affairs. It implemented three "clusters" of related units, with assigned general medical officers and nurse practitioners. The three clusters include an admissions cluster of									

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		three units, supported by one general medical officer and two nurse practitioners; a chronic care cluster, supported by one general medical officer (night) and two nurse practitioners; and a geriatric cluster, with a general medical officer and two nurse practitioners. The medical practitioners rotate sick call coverage each day, with a goal of ensuring all members of the team have some degree of familiarity with each individual in care, although each will also have a caseload. Medical Affairs also hired a supervisory nurse practitioner. During this period, the Hospital continued to conduct morbidity reviews. In August 2011 two cases were reviewed, one involving an individual in care with colon cancer and a second involving an individual with hyponatremia. Other issues reviewed between September 2011 and February 2012 included those related to vaccinations (flu and hepatitis B) and strategies to address coronary heart disease. Recommendations from the Committee include 1) ensuring that women over the age of 60 and men over the age of 50 with a diagnosis of diabetes are on a daily low dose of baby aspirin; 2) individuals over 45 should have annual EKG; 3) Individuals should be referred as appropriate for an exercise stress test based upon an individual analysis of risk factors (family history, hypertension, dyslipidemia, diabetes, sedentary life style, etc) and 4) beta blocker therapy is recommended for all individuals without medical contraindications for use in established CAD. Findings from the Committee are shared with all physicians and with nurse practitioners and recommendations emanating from the Committee are tracked in the Hospital's recommendations tracking database. The Committee also reviewed data reflecting mock codes held from June through February 2012. Mock code blues were also conducted with increased frequency; since early June, 23 mock code blues have been held, across all shifts and most units. ***See Tab # 125 Mock Code Blue Data See Tab # 130 Mortality/Morbidity Committee Minutes.*** A working group coordinating the Mock Code Blue drills presented recommendations to the Mortality/Morbidity Committee during its April Meeting. Among the approved recommendations include revision of the mock code audit tool, development of clear responsibility for conducting mock codes and auditing crash carts to ensure they meet expected standards. In addition, it was decided that audits of crash carts will be conducted monthly by PID with nursing. The Hospital created a format for a progress note to be completed by general medical officers or nurse practitioners upon an individual's ***return from*** a community hospital for treatment or evaluation; while this generally is being completed, not all evening or night physicians were using the format for returns from an ER (as opposed to an inpatient stay in which case it was being used) but that has since been clarified, effective March 1, 2012. The form is in queue for Avatar development ***See Tab # 59 Format for Notes by Medical Practitioner Upon Return from Community Provider.*** The "return" physician's note is designed to ensure SEH staff review the results of the evaluation/treatment provided in the community, are familiar with the results of any testing or laboratory work completed by the provider, review the medications prescribed and symptoms targeted and make appropriate recommendations for the individual's plan of care at SEH. It is being audited for as part of the medical transfer audits. At the same time, the Hospital is continue to resolve an Avatar issue with respect to the MD ***transfer to*** medical facility form which is affecting its use and for which doctors have created a work around. The form prints all lab results and all medications, and doctors are not able to provide time parameters, so the form often takes a long time to populate and to print. As a result, in many cases, doctors instead are completing the medical consultation form and printing specific lab results and medication histories in lieu of completing the Avatar transfer form, but Avatar is continuing its efforts to resolve these issues. Doctors and nurse practitioners have been instructed to ensure that if they choose to utilize the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		medical consultation form in lieu of the medical transfer form, the content of the medical consultation note should include the same content as would be included in the medical transfer form. During the review period, nursing made substantial revisions to its CINA and Nursing Update forms and began using the revised forms in a data entry format beginning January 4, 2012. ***See Tab # 22 CINA form and Tab # 24 Nursing Update form*** The forms were then tested for about 45 days and revised before being forwarded to Avatar for development. New audit tools were also developed and data reflecting the new forms is available for one to two months depending on the form. ***See Tab # 23 CINA Audit Tools and # 25 Nursing Update Audit Tools*** See audit results below. Nursing also revised its physical assessment related forms (and will be updating related procedures) to address recommendations from the nursing reviewer emanating from the November 2011 visit. Among the forms and procedures that were revised are the SBAR format progress note around Change in Physical Status form, the RN Transfer *to* ER/Hospital form, and the RN Transfer *from* ER/Hospital form. ***See Tab # 87 RN Transfer To ER Form, RN Return from ER Form and SBAR Form*** The revised SBAR Assessing Change in Physical Condition form, effective January 2012, is designed to provide a structure for the collection of data in order to inform diagnosis and treatment and to minimize duplication in documentation. The form is to be used in documenting acute changes in an individual's physical condition. The revised forms were introduced effective January 4, 2012, piloted for 45 days, and scanned in FileNet. The forms were revised based upon the pilot and are now with Avatar for development. Medical Affairs continues its audits around history and physicals and medical transfers. Data from the History and Physical Examination audits show all indicators at or above 90%. In the Medical Transfer audits reflecting the notes of the GMOs or nurse practitioners, most indicators improved from the last review period, with the exception of indicators relating to provision of laboratory results (which may be related to the Avatar issue), diagnostic impression specifying reason for transfer and completion of the allergy section. In 100% of the cases reviewed, there was a note upon the individual's return that included an analysis of information from the medical facility and an appropriate response by the physician or nurse practitioner. Nursing developed audit forms and began audits around the new three medically related nursing forms (Change in Physical Status, RN Transfer to ER/Hospital and RN Transfer from ER/Hospital). ***See Tab # 88 Audit Tools for the Change in Physical Status form, the RN Transfer to Medical Facilities and the RN Transfer From Medical Facilities Form; Tab # 104 Audit results for Change in Physical Status form, the RN Transfer to Medical Facilities and the RN Transfer From Medical Facilities Form.*** As of the writing of this report, we only have one month of data from these nursing audits but additional data will be available during the site visit. Data from the one month of nursing audits provide a baseline from which leadership can assess progress going forward. Nurse managers trained staff in the use of all the new forms, are reviewing completed forms with staff and are providing coaching on psychiatric and physical assessment and related documentation. The Hospital established a medical care procedure around insulin administration to standardize practice around diabetes management. ***See Tab # 80 Insulin Administration Protocol; Tab # 97 Nursing Procedure, Insulin Administration*** Under the new Hospital procedure, individuals requiring insulin more than once daily will be placed on short acting insulin and prn Lantus using a specific protocol. It is also seeking to contract with a qualified nurse to write procedures and train staff. Nurse managers are also observing at least one medication or insulin administration per RN every six months, and

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		data is collected. Data from the most recent observations show generally high performance in both insulin/diabetes management and medication administration. ***See Tab # 85 Medication/Insulin Administration Observation Audit Tool and data.*** The few individuals who did not meet the competency standards were retrained and retested and all met the competency. The Hospital continues its implementation of the seizure management policy, and on September 1, 2011, nursing has begun to utilize the updated seizure observation form. ***See Tab # 49 Seizure Management Policy and Observation Form.*** The form is in the queue for Avatar development, until developed, hard copies of completed forms will be scanned into FileNet. (Note that the prior version of the seizure observation form also can be found in FileNet). The Hospital implemented the interface with Quest Diagnostics during this review period. Under the interface, laboratory results are transmitted electronically to the Hospital's laboratory, which then transmit the data to Avatar. Lab personnel still notify the ordering doctor or nurse practitioner of any abnormal results, and will contact the Director of Psychiatric Services or the Director of Medical Services if they are unable to reach the ordering physician/nurse practitioner.
VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Recommendations:** 1. Resolve barriers that prevent RNs from entering relevant nursing interventions into the IIRP. Train the designated RNs to prioritize and individualize interventions. SEH Response: The Hospital discontinued use of the IIRP effective December 1, 2011. In lieu of the IIRP, effective January 3, 2012, Nursing modified the CINA (Part A and Part B) to include a nursing plan of care that addresses specifically Focus Area 1 (psychiatric/psychological) and Focus Area II (medical/physical health). In the nursing plan of care section of the CINA, the RN identifies target symptoms for both focus areas, articulates an objective and develops immediate nursing interventions. Both parts of the CINA are based upon a recovery model and the initial nursing interventions focus on the prioritized issues of psychiatric and medical conditions. The nursing plan of care is completed within the first 8 hours (CINA Part A), and updated within the first 24 hours (CINA Part B). Nurse managers were trained on the new nursing documentation forms (CINA Parts A and B) on December 20, 2012 and retrained their house staff. Instructions on completion of the forms are available on each house. The new documentation forms and instructions were incorporated into nursing orientation training effective January 3, 2012. Ninety percent of nursing staff also have completed recovery training during this review period. The Hospital is issuing an RFP that will include training on development of nursing interventions that will supplement training provided in Summer 2011. In addition, nursing staff began in late February 2012 bringing comfort plan strategies to the IRP as part of the nursing report. 2. Expedite implementation of new policies and forms including assignment sheets. Monitor implementation and make operational adjustments as indicated. SEH Response: During this review period, the following forms were revised/ developed: CINA Parts A and B, Nursing

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Update, RA Care Documentation, Advanced Instruction/Personal Comfort Planning, Change in Physical Status (SBAR), RN Transfer to ER Form, RN Return from ER Form. ***See Tab #s 22, 24 and 87*** T he forms are currently used in data entry format and then scanned into FIleNet; the forms were piloted through January and mid February to ensure they met the Hospital's needs and were referred to Avatar for development in March 2012. Guidelines for completion of the forms are available on each house. Nursing also reviewed documentation to eliminate duplication, and began conducting audits that include a focus on removing judgmental words and improving the content of the RA and RN Notes. The frequency of nursing documentation has also been modified; assessments are due weekly for the first 60 days and monthly thereafter. In addition, the nursing assignment sheet was revised and substantial coaching by an outside consultant has been provided to nurse managers around unit management including use of assignment sheets. ***See Tab # 92 Change of Shift forms and Revised assignment sheets.*** The consultant spent one half day with each of the nurse managers on his or her units to provide coaching and to assess the unit's functioning. One of the areas of focus was managing risk, (identifying IIC at risk of behavioral emergencies or risk of physical change, IICs on special observation) using in part the assignment sheets to ensure risks are addressed. The Unit assignment sheet was reviewed with the nurse managers to assist them in ensuring all functions are assigned and staff accountability is clear. Nurse managers were coached on how to explain assignments and rationales and to clarify staff expectations; nurse managers are also reviewing assignment sheets for all three shifts on a routine basis. Use of assignment sheets and issues that may emerge will be made part of particular unit quarterly reports at nurse manager meetings as appropriate. ***See Tab # 102 Nurse Managers Mentoring and Reporting Outlines.*** Change of shift report was also updated to include relevant information about risk factors and implications for specific nursing interventions in the upcoming shift in addition to the information about behavioral and physical status and attendance at and participation in TLCs. ***See Tab # 92 Change of Shift Report*** RNs are being retrained on the content of shift report and need to think critically to determine specific interventions for the upcoming shift in light of an individual's status. 3. Re-evaluate the utility of EARN. If it is retained, align EARN with recovery principles and integrate activities with established basic nursing functions, e.g., consistent assignment to work with specific individuals, integration with and implementation of IRP, integration with routine documentation requirements. SEH Response: The Hospital is evaluating how EARN could be modified to fit better with the recovery model. (To date, 85 percent of nursing staff have completed training on the recovery model, which includes both didactic and experiential components. ***See Tab # 99 Recovery Training Handout and Data.*** If EARN is retained, it will be necessary to align EARN with recovery principles and integrate activities with established basic nursing functions: e.g. consistent assignment to work with specific individuals in care; integration and implementation of IRP, and integration with routine documentation requirements. More information about the status of EARN will be available during the site visit. 4. Develop a structure and process for nursing management to analyze findings from relevant reviews, document actions to address findings, and evaluate the effectiveness of those actions. SEH Response: The CNE is working with an outside consultant to restructure nurse manager meetings. Once per month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		three to four unit nurse managers will report at a Nurse managers' weekly meeting (so each nurse manager will report once per quarter) the results of audits, identify issues generally on the unit, address environmental issues and integration of the recovery model and report actions to address issues and share results. ***See Tab # 102 Format for Nursing Quarterly Report to Nurse Managers*** In addition, beginning this Spring, nurse managers will begin to utilize a method/tool to assess the culture change (effectiveness of staff engagement and implementation of recovery principles) that is occurring on their units, the results of which will be incorporated into their quarterly reports. This will allow other nurse managers to benefit from experience and learn solutions that may be applied to similar issues on their units. Development of the relevant tool is part of the scope of work for the nursing consultant. In addition to the nurse manager reports during one nurse manager's meeting per month, one nurse manager's meeting per month will include a review of audit results, one will be dedicated to staff development and the last to the nursing office central staffing issues. 5. NMs should provide leadership for changing nursing practice culture, and report on strategies and progress in NM meetings. Consider real time coaching for NMs in conducting nursing unit meetings. SEH Response: Ongoing. All nurse managers were first to complete recovery training, and recovery training is continuing for all direct care nursing staff; to date 85 % have completed it. A nurse consultant provided four hours of on unit coaching for unit managers to include strengthening knowledge and skills for effectively implementing and mentoring staff on use of recovery principles on a unit, effective use of identified manager competencies, managing improvement processes for culture change, facilitating effective staff meetings, identifying, monitoring and analyzing indicators of quality patient care, reducing violence/seclusion/restraint and increasing and more effectively using comfort plans. ***See Tab # 102 Nurse Managers Mentoring Outline.*** Nursing will also be implementing this Spring, a tool for evaluating the effectiveness of staff engagement and implementation of recovery principles on the unit. See also # 4 above. 6. Resolve outstanding CINA issues including but not limited to: separate the current assessment into two parts: ensure that screens and assessments are differentiated as required; refine suicide screen or assessment; simplify and prioritize nursing assessment domains. SEH Response: Completed. CINA has been separated into two parts, the suicide screen has been refined and the documents have been revised to reflect new domains. The new two part CINA was introduced in a data entry format effective January 4, 2012 in a pilot phase to assess its workability. Some changes were recommended and in March 2012 the form was submitted to the Avatar team for development. Meanwhile the form is being completed in a data entry format, is printed and then scanned into FIleNet. Part A includes psychiatric and medical risk screens and Part B includes trauma, learning and strength assessments. 7. See VIII.D.11 SEH Response: See VIII.D.11. **Facility's Findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

IRP OBSERVATION MONITORING AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	275	244	234	214	198	201	**221**	**228**
n	11	8	10	11	11	11	**16**	**10**
%S	4	3	4	5	6	5	**7**	**5**
%C # Data fields Presence of RN in IRP meetings	82	100	100	100	91	100	**94**	**95**

N=All IRPs scheduled
n=number audited in the month
Tab # 7 IRP OBSERVATION AUDIT RESULTS

INITIAL NURSING ASSESSMENT AUDIT RESULTS (ORIGINAL CINA FORM)
September – December 2011

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	45	38	31	38			**36**	**38**
n	8	10	6	7			**8**	**8**
%S	18	26	19	18			**21**	**20**
Completed within 8 hours	88	60	83	86			**67**	**77**
%C #9 If assessment identified risk in any risk screens, was nature of risk described sufficiently to develop adequate nursing interventions to address risk	75	75	50	43			**89**	**62**
%C #13 If prior medical history was noted was there appropriate description of the event so that interventions could be identified if needed?	75	75	60	33			**91**	**65**
%C # 16 Did the assessment include a physical assessment of all systems	88	60	80	86			**93**	**77**
%C #17 If a positive physical assessment is noted, is there a description of the symptoms or event sufficient to develop interventions and minimize risk to patient?	50	44	60	50			**87**	**50**
%C #25 Did the record overall support the findings in the mental status examination sections?	88	90	83	71			**98**	**84**
%C # 26 Were the MSE section findings consistent with the risk assessment findings?	88	90	50	71			**98**	**77**
%C #28 Was the recovery assessment section completed?	88	90	67	29			**71**	**71**
%C #30 Do the assessments in each domain of the functional rehabilitation screens accurately reflect the record?	88	100	100	71			**86**	**90**
%C #33 Were nursing interventions developed?	100	38	83	100			**93**	**79**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT							
		%C #34 Was a nursing intervention developed for each area of risk identified in the assessment?	100	25	33	57			**73**	**55**
		%C #35 Were the nursing interventions specific and individualized and tailored to the individual's needs?	71	30	0	14			**56**	**30**
		%C #36 Were the interventions appropriate to the functional level of the individual?	86	30	17	29			**67**	**40**

N= Monthly Admissions
n= Population monitored (target is 20% sample)
Tab # 3 CINA AUDIT RESULTS

INITIAL NURSING ASSESSMENT AUDIT RESULTS Part A (NEW CINA FORM) January 2012-February 2012								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N					29	35	**N/A**	**32**
n					28	7	**N/A**	**18**
%S					97	20	**N/A**	**55**
%C #1 Were all areas of CINA-Part A completed, signed and dated within 8 hours of admission?					29	43	**N/A**	**31**
%C #2 Did assessment include the individual's explanation of reason/events leading to admission?					64	86	**N/A**	**69**
%C #3 Did assessment include a report of the individual's understanding of mental illness and what helps?					68	86	**N/A**	**71**
%C #4 Was the mental health and behavioral screening section completed and is it internally consistent?					33	71	**N/A**	**41**
%C #5 If the Psychiatric Risk Screen was positive for current thoughts/feelings of self harm or suicide, did the RN place the individual on 1:1 arms length and notify the psychiatrist?					25	100	**N/A**	**40**
%C #6 If the Psychiatric Risk Screen was positive for current thoughts of violence/harm to others, did the RN place the individual on 1:1 line of sight and call the psychiatrist?					9	25	**N/A**	**13**
%C #7 Are the implications for risk for use of seclusion and/or restraint identified?					75	100	**N/A**	**78**
%C #8 If the Fall Risk Screen was positive for one or more risk factors, did the RN complete the Fall Risk Assessment-Morse Fall Scale?					29	0	**N/A**	**25**
%C #9 If the Morse Fall Scale indicates the individual is at risk for falls, did the RN place the individual on fall precautions and notify the MD?					50	0	**N/A**	**33**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #10 If any risk factors for potential for choking were checked, did the RN place the individual on choking precautions and notify the GMO and Nutrition Services?					33	N/A	**N/A**	**33**
		%C #11 Does the completed assessment accurately identify psychiatric/behavioral and medical/physical risks?					43	29	**N/A**	**40**
		%C #12 Is completion of risk screens consistent with assessment data?					46	29	**N/A**	**43**
		%C #13 Does the completed CINA Part A reflect that the RN used all available sources for assessment including his/her own observations?					86	71	**N/A**	**83**
		%C #14 Did the Nursing Summary reflect RN review and analysis of all assessment areas?					54	29	**N/A**	**49**
		%C #15 Were objectives and interventions developed for all identified psychiatric/behavioral foci that have implications for nursing care during the next 7 days, including specific interventions for indentified violence risk, suicide risk, cognitive deficits, hyperactivity, withdrawn/isolative behavior?					43	43	**N/A**	**43**
		%C #16 Were objectives and interventions developed for all identified medical/physical foci that have implication for nursing care during the next 7 days, such as falls, choking, medical conditions?					44	71	**N/A**	**50**
		%C #17 If the individual was placed on any level of special observations, were appropriate interventions integrated into the plan of care?					32	57	**N/A**	**38**
		%C #18 Do the interventions in the plan of care reflect integration of the Comfort Plan?					21	71	**N/A**	**31**
		N=Number of admissions n=number audited ***See Tab # 3 CINA AUDIT RESULTS***								

INITIAL NURSING ASSESSMENT AUDIT RESULTS Part B (NEW CINA FORM) January 2012-February 2012								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N					29	35	**N/A**	**32**
n					26	8	**N/A**	**17**
%S					90	23	**N/A**	**53**
%C #1 Were all sections/questions of the assessment completed within 24 hours of admission?					58	63	**N/A**	**59**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #2 If the risk screen indicates the individual has a history of trauma and/or abuse/neglect, did the RN develop fn objective and intervention to minimize potential for re-traumatization while in the hospital?					15	0	**N/A**	**11**
		%C #3 Is the assessment of Learning Needs adequate to provide guidance to staff working with the individual?					85	75	**N/ A**	**82**
		%C #4 Did the RN summarize the medical/physical and psychiatric/behavioral findings that have implications for nursing care and treatment?					42	100	**N/A**	**56**
		%C #5 Was data from CINA Part A considered and integrated in assessment and development of additional objectives/interventions in Part B?					54	75	**N/A**	**59**
		%C #6 Is there evidence that additional information learned since the CINA – Part A was completed is incorporated into the Plan of Care?					31	75	**N/A**	**41**
		%C #7 Were objectives indentified and nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area I) that have implications for nursing care during the next 5 days?					38	88	**N/A**	**50**
		%C #8 Were objective identified and nursing interventions developed for Medical/Physical Health (IRP Focus Area II) that have implications for nursing care during the next 5 days?					44	75	**N/A**	**52**
		%C #9 Were the nursing interventions specific and tailored to the individual needs of the individual in care?					46	63	**N/A**	**50**
		%C #10 Were the interventions consistent with the functional level of the individual in care?					54	63	**N/A**	**56**
		%C #11 If the registered nurse was unable to complete a section of the assessment, was the reason noted?					100	N/A	**N/A**	**100**
		%C #12 Do the interventions in the plan of care reflect integration of the Comfort Plan?					35	75	**N/A**	**44**
		N=Number of admissions n=number audited * Not available from prior review period as this is new tool ***See Tab # 3 CINA AUDIT RESULTS***								

NURSING UPDATE ASSESSMENT AUDIT RESULTS (OLD UPDATE FORM) September –December 2011								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	239	254					**243**	**247**
n	10	13					**21**	**12**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%S	4	5					**9**	**5**
		%C #2 Has the advance instruction/comfort plan form been reviewed and updated	100	73					**98**	**86**
		%C # 5 Are strengths clearly described	100	95					**98**	**98**
		%C # 6 Is the current mental status carefully described	82	59					**68**	**70**
		%C # 7 Is improvement re current mental status summarized per instructions	82	59					**63**	**70**
		%C # 8 Is current safety risk indicated	100	68					**91**	**84**
		%C # 9 Is change in safety risk since last update noted	100	55					**93**	**77**
		%C # 10 Summary of current health and wellness challenges which require monitoring or treatment adequately noted	100	73					**97**	**86**
		%C # 11 Pertinent risk assessment tool ratings (falls, skin integrity, dysphagia) included	59	52					**83**	**56**
		%C # 12 Includes cognitive and perceptual/neurological symptoms if indicated	36	56					**67**	**45**
		%C # 13 Includes summary of vital signs and weight	82	55					**72**	**68**
		%C # 14 Includes pertinent changes in lab values	73	36					**56**	**55**
		%C # 15 Includes capacity for ADLS and if the individual is able to manage ADLs independently	86	82					**89**	**84**
		% C # 16 Includes progress/lack of progress and conclusion	100	64					**98**	**82**
		%C # 26 Summarizes the progress toward recovery goals	87	38					**88**	**64**
		%C # 29 Describes relationships in the milieu	86	91					**83**	**89**
		%C # 30 Describes circumstances if individual has been involved in conflicts or arguments	91	88					**60**	**90**
		%C # 32 Describes hobbies or leisure skills	73	83					**47**	**76**
		%C # 34 Notes discharge issues	100	94					**81**	**98**
		%C # 35 Notes progress or lack of progress and conclusions	100	64					**94**	**82**
		%C # 36 Describes if individual knows what nursing is doing for him and why	95	82					**92**	**89**
		%C # 37 RN summarizes progress and makes recommendations to IRP	95	82					**87**	**89**
		%C # 38 RN identifies issues not covered in focus areas or data that reflect currently inactive problems but may become issues later	95	41					**86**	**68**
		N= End of month Census less new monthly admissions n= number of updates audited								

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

See Tab# 4 NURSING UPDATE AUDIT RESULTS

NURSING UPDATE ASSESSMENT AUDIT RESULTS
January – February 2012

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						236		**236**
n						22		**22**
%S						9		**9**
%C # 1 Was the Nursing Update note completed within established timelines (every 7 days for first 60 days and every 30 days thereafter)?						95		**95**
%C #2 Was there assessment data present addressing each nursing treatment intervention?						59		**59**
%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?						68		**68**
%C # 4 Are individualized strengths identified for the individual in care?						86		**86**
%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?						17		**17**
%C # 6 Does the RN summarize the current health and wellness challenges that have implications for nursing care?						95		**95**
%C # 7 Does the RN summarize the current psychiatric/mental health challenges that have implications for nursing care?						82		**82**
%C # 8 Does the note include individual's understanding of and thoughts/feelings about the IRP?						86		**86**
%C # 9 Does the RN assessment reflect review of recent lab results and assessment tool ratings, i.e., Braden scale, Choking and Swallowing, Morse Falls Rating, etc.?						77		**77**
%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?						73		**73**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?						55		**55**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?						91		**91**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N= End of month Census less new monthly admissions
n= number of updates audited
* No data from prior review period
See Tab# 4 NURSING UPDATE AUDIT RESULTS

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N						19		**19**
n						7		**7**
%S						37		**37**
%C #1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?						100		**100**
%C #2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?						86		**86**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?						100		**100**
%C #4 Is the assessment of systems completed and synthesized?						100		**100**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?						100		**100**
%C #6 Does the assessment include auscultation, etc?						86		**86**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?						57		**57**
%C #8 Was the level of urgency consistent with the clinical presentation?						43		**43**
%C #9 Was the course of physical status change adequately described?						86		**86**
%C #10 Was the individual's response to alternative interventions documented?						100		**100**
%C #11 Were changes from baseline adequately identified and described?						100		**100**
%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?						71		**71**

N=Transfers to ER
n= cases audited

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		* No data available from prior period ***See Tab # 104 SBAR AUDIT RESULTS*** **Analysis/Action Plan:** Data shows that the attendance of the registered nurse at the IRP continues to improve exceeds the 90% threshold for the second consecutive review period. ***See Tab # 7 IRP Observation Monitoring Results.*** Data from audits were completed in the Fall 2011 using the old tools showed continued issues with the quality of initial and update assessments. Recognizing that significant improvement was needed, the CNE took several steps. First, the CINA and Nursing Updates were revised to improve the clinical flow of the documents, to establish clear priorities within the assessments and to elicit more critical thinking. She also worked with a consultant to develop a curriculum on the recovery model of care and to ensure nursing staff completed the training (85% of nursing staff have completed training). Significant focus has also occurred on understanding why nursing interventions (especially around violence and physical status) are either not being incorporated into the IRPs or not being offered by nursing staff, and how to ensure they are individualized and meaningful when they are offered and incorporated**.** Nursing staff are now bringing comfort plan interventions to the IRP conferences (beginning in March 2012) to inform the team and the IRP. In addition, the Hospital is announcing a new RFP to provide support to nursing around a number of topics, including the development of IRP interventions. Also part of the scope of work is the following: evaluation of nurse training offerings and program, developing a house recovery audit, continuing coaching for nurse managers, coaching and support on implementing the recovery model on units and the TLCs, unit organization and management coaching, consulting on development and implementation of a fall prevention program, supporting development of a nursing QA system and audits, and consulting on development of competency audit tools, among other things. As of the writing of this report, the Hospital completed two months of audits of the new the CINA form (Part A and B) using the new audit forms and one month of data from audits of the new Nursing Update form using the new audit tool. Data from the CINA Part A and Part B audits show that significant improvement is needed on almost all indicators, which is not surprising inasmuch as the two part CINA forms were only introduced in January 2012. The majority of CINA Part A and Part B indicators (20 out of 28 combined indicators) showed improvement from January to February. Similarly, data from the new Nursing Update audit shows significant improvement is needed. It is expected that the new forms, with their new flow and manner of establishing priorities will improve the quality of assessments as staff become more familiar with them. ***See Tab ## 3 CINA Audit Results and 4 Nursing Update Audit Results*** As we only have up to two months of data on the new forms and updated audit tools, it is too early to determine if the new forms have had the expected impact but more information should be available by the time of the site visit. ***See Tab #22 Revised CINA and Tab # 24 Nursing Update forms*** Nursing will continue to monitor the quality of these forms and will take actions as appropriate. In addition, utilization review specialists will complete a concurrent review on a sample of CINAs and Nursing Updates in an effort to improve documentation. The Hospital also is implementing a number of other strategies to improve nursing practice and skills; much of this review period was spent on continuing to strengthen the core competencies of nurse managers and in introducing recovery and safety care training for all nursing staff. Nurse managers were the first to complete one-day training on the Recovery Model. ***See Tab # 99 for Recovery Model Training Materials.*** Recovery training, with didactic and experiential exercises, included a review of the principles underlying a recovery- based system of care and the role staff play in sparking hope and empowering individuals in care. The training also focused staff on re-orienting deficits into perceived assets.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

In addition, all Hospital staff (including evening and night shift) were provide an overview of the culture change expected going forward, a practice that is more focused on a recovery model and preventative, trauma informed mind set. This culture change is being reinforced in several ways, including Safety Care training, and the above described recovery training. The new nurse orientation program was also redesigned. The nursing orientation program provides 6 weeks of broad overview of care and role responsibilities based on departmental standards of care. The nursing orientation for full-time and part-time nurses is designed to be completed in two separate phases. Phase I (Centralized Orientation) involves classroom preparation to include hospital and nursing trainings lasting 3 weeks. Phase II (Unit-Based Orientation) starts in week 4 and runs through week 6 when the nursing orientation is completed. The unit-based orientation follows a multi-mentoring model to include daily assigned resource nursing staff to demonstrate and work with the new employee, the QEC nurse and the nurse manager to guide the new employee through the orientation pathway. Each week the new employee meets with the resource nursing staff, QEC nurse and the nurse manager to evaluate and document progress in the orientation packet and prepares for the following week. By the end of the 6 week orientation, the nurse manager, QEC nurse and the new employee will discuss the transitioning process to full duty status pending the overall orientation performance. Finally nurse managers were provided with individual, on unit coaching around mentoring staff on implementing recovery principles, managing the improvement process for culture change, facilitating effective staff meetings, identifying, monitoring, and analyzing indicators of quality patient care, reducing violence, seclusion or restraint and increasing use of comfort plans. ***See Tab # 99 for Recovery Training Information and Data and Tab # 109 for Safety Care Training Data***

Third, as described in more details above new forms for CINA (Parts A and B), Nursing Update, Change in Physical Condition (SBAR), RN Transfer To ER/Hospital and RN Transfer From Hospital were developed and implemented. ***Tab # 22 CINA Form, # 24 Nursing Update Forms, and #87 for SBAR, Nursing Transfer Out and Return Forms*** Staff were trained on each of the new forms, and audits for the new assessment forms and new Change in Physical Status Form and RN Transfer notes are underway. ***See Tab # 23 CINA Audit forms; Tab # 25 Nursing Update Audit forms; Tab # 88 Audit forms for SBAR Change in Physical Assessment, RN Transfer Out and RN Return Notes*** Nursing also developed a form for Recovery Assistant Documentation and modified the Advanced Instruction/Comfort Plan and Pain Management Flow Record forms. The procedures relating to these new forms are being updated.

Increasing the number and ratio of RNs is critical to improved practice. The CNE developed a staffing plan that ensures a 50% RN mix and nursing care hours. ***See Tab # 86 Nursing Staffing Plan***. The Plan reflects full funding for the additional 35.5 RN positions needed to meet the 50% RN mix and nursing care hours. See section VIII.D.11 for specifics around staffing. The District made a net gain of 23 RNS since the prior visit and there are an additional 16 RNs with EOD over the next six to eight weeks. For much of the review period there continued to be delays in hiring because of an insufficient number of funded RN positions but that issue was resolved as of early April 2012, and all needed RN positions are fully funded in FY 12 through conversion of some positions and funds received by the Mayor.

Table 1: RNs hired since September 2011

Month	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New Hires	10	7	4	6	3	9	10	39
Separations	4	1	4	2	2	1	6	16
Net Gain for Month	6	6	0	4	1	8	4	23

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Table 2: Current Staffing and Funding Levels for Direct Care RNs and Supervisors

	A	B	C	D	E	F	*G*	H	I
	Total # Needed for 50% Mix and 6 NCHPPD	**Total FY 12 Funded Positions**	**Total Filled FTEs (D+E+F)**	**Total On Units***	**Total in Training**	**Total Not Available to the Units**	***Currently Vacant (B-C)***	**FY 12 Funded Vacancies**	**FY 12 Shortage in Funded positions (A-B)**
NM	N/A	14	14	14	0	0	1	0	0
RNs	199.5	199.5	147.2	122	13	12	24	35.5	0
QECs	N/A	3	3	3	0	0	0	0	0
RAs & LPNs	199.5	211	203	188	0	15	0	0	0

* It is estimated that the total number of RNs on the units by the first week in June will be 152 (based upon EOD dates and completion of the six week training although this number does not reflect separations.

Nurse managers are continuing their observations of medication or insulin administration at least once per quarter for every RN. With respect to the administration on insulin, data shows that overall, 100 % of RNS passed competency for diabetes management and insulin administration. ***See Tab # 103 Insulin and Medication Administration Observation data.*** The Hospital continues to monitor missed medication administration documentation, which continues to meet the Hospital's target rate. Most recent data shows missed documentation rate at 0.33%, with 61% of nurses with no missed documentation. ***See Tab # 103 Medication Administration Documentation Data.***

In an effort to strengthen nursing's role in IRP planning, clinical administrators and nurse managers from each treatment team met with the Acting Director of Clinical Operations and the ADON during September 2011, to develop strategies for ensuring that (1) IRPs include nursing interventions and (2) updates from nursing staff on the individual in care's progress or lack thereof as well as key changes in physical status are completed and integrated into the IRP. Additional examples of medical objectives and interventions were also added to the IRP Manual. New employees are being trained in the Hospital's IRP processes and recovery model. Further, an RFP is being issued to include training and strategies to improve the development of IRP objectives and interventions. Finally, the CNE met with all clinical administrators in March 2012 to review all the new nursing forms and expectations for nursing around IRP planning.

With respect to behavioral interventions, the PBS team is providing periodic coaching to TLC nursing staff relating to those individuals whose participation in the TLC programming is marginal, reinforcing prior PBS training. TLC staff receive the shift progress notes that include the interventions to use for specific behaviors. During this review period, in part because of the time intensity of the Safety Care training and the recovery training which impacted nursing, Collaborative Problem-solving training was suspended in the Fall 2011 but is expected to resume in April 2012. The percentage of active staff that have completed the training has fallen due to the high number of new staff; to date, 69% of non nursing clinical staff, 62 % of nursing day shift, 49 % of nursing evening shift, and 72% of night nursing shift have completed the training. ***See Tab # 66 Collaborative Problem Solving Training; Tab # 109 Safety Care Training Data.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	**Recommendations:** Implement audit tools in order to identify improvements necessary to meet the requirements of this provision. SEH Response: Ongoing. New audit forms were developed for CINA (Part A and Part B)and Nursing Update, Changes in Physical Status (SBAR), RN Transfer to ER/Hospital and RN Transfer from ER/Hospital. ***See Tab # 23 CINA Audit Form; Tab # 24 Nursing Update Audit Forms; Tab # 88 Audit Forms for Change in Physical Condition (SBAR), RN Transfer To ER/Hospital, and RN Return from ER/Hospital Audit Form.*** See also VIII.D.1 for audit results. **Analysis and action steps:** See generally response to VIII.D.1.
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Recommendations:** Continue to monitor medication administration. SEH Response: Ongoing. **Analysis/Action plan:** The Hospital continues to monitor the rate of missed documentation for routinely scheduled medications. ***Tab # 90 Medication Administration Documentation Report.*** In February 2011, 50% of nurses had no missing documentation, 42% had >1 but < 10, 8% had >10 but < 50, and 0% had more than 50 missing documentations. By August 2011, 57% of nurses had no missed documentation, 36% had between 1 and 10 missed documentations, and 7% had between 11 and 50 missed documentations. No nurses had more than 50 missed documentations. The missing documentation rate was at 0.36% in August 2011. In February 2012, 61% of nurses had no missing documentation, 33% had >1 but < 10, 6% had >10 but < 50, and 0% had more than 50 missing documentations. Information is also tracked by unit. This will continue. The Hospital policy on medication administration was updated in October 2011 to include specific language around first dose medication monitoring. In addition, nurse managers are continuing their observations of medication or insulin administration at least once every six months for every RN. With respect to the administration on insulin, data shows that overall, 100% of RNs passed competency for diabetes management and insulin administration. ***See Tab # 103 Insulin and Medication Administration observation.***
VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	
VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that	**Recommendations:** Maintain compliance.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>appropriate follow-up occurs to prevent recurrence of such errors</td><td>SEH Response: Compliance maintained. See VIII.D.4.

Missing medication administration documentation continues to be monitored. Data shows the Hospital's missing administration documentation continues to be below the .5% target, with the rate of 0.33% in February 2012, slightly improved from the 0.36% level in August 2011.</td></tr>
<tr><td>VIII.D.7</td><td>Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;</td><td></td></tr>
<tr><td>VIII.D.8</td><td>Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;</td><td>Recommendations:

1. Develop clearer expectations for RA documentation with a close eye on minimizing potential for duplication of/conflict with the RN note content.

SEH Response: Completed. A standard format for RA documentation was developed during this rating period. RA documentation will be required by day 5 following admission, weekly for the next sixty days and monthly thereafter. See Tab # 94 RA Documentation Form. The new form provides a structure for RA notes that includes strengths identified by the individual in care and staff, a review (and update if needed) of the comfort plan, addresses self-care progress, information about enrichment, leisure and social skills, and communication content during the RA and individual in care during their 1:1 sessions. Finally, the RA is asked to provide suggestions for IRP changes that would better address the needs of the individual in care.

2. See D.2.

SEH Response: See VIII.D.2.

Facility's findings:

<table>
<tr><th colspan="9">NURSING UPDATE ASSESSMENT AUDIT RESULTS (OLD UPDATE FORM)
September – December 2011 Tool</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>239</td><td>254</td><td></td><td></td><td></td><td></td><td>243</td><td>247</td></tr>
<tr><td>n</td><td>10</td><td>13</td><td></td><td></td><td></td><td></td><td>21</td><td>12</td></tr>
<tr><td>%S</td><td>4</td><td>5</td><td></td><td></td><td></td><td></td><td>9</td><td>5</td></tr>
<tr><td>%C #2 Has the advance instruction/comfort plan form been reviewed and updated</td><td>100</td><td>73</td><td></td><td></td><td></td><td></td><td>98</td><td>86</td></tr>
<tr><td>%C # 5 Are strengths clearly described</td><td>100</td><td>95</td><td></td><td></td><td></td><td></td><td>98</td><td>98</td></tr>
<tr><td>%C # 6 Is the current mental status carefully described</td><td>82</td><td>59</td><td></td><td></td><td></td><td></td><td>68</td><td>70</td></tr>
<tr><td>%C # 7 Is improvement re current mental status summarized per instructions</td><td>82</td><td>59</td><td></td><td></td><td></td><td></td><td>63</td><td>70</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 8 Is current safety risk indicated	100	68					**91**	**84**
		%C # 9 Is change in safety risk since last update noted	100	55					**93**	**77**
		%C # 10 Summary of current health and wellness challenges which require monitoring or treatment adequately noted	100	73					**97**	**86**
		%C # 11 Pertinent risk assessment tool ratings (falls, skin integrity, dysphagia) included	59	52					**83**	**56**
		%C # 12 Includes cognitive and perceptual/neurological symptoms if indicated	36	56					**67**	**45**
		%C # 13 Includes summary of vital signs and weight	82	55					**72**	**68**
		%C # 14 Includes pertinent changes in lab values	73	36					**56**	**55**
		%C # 15 Includes capacity for ADLS and if the individual is able to manage ADLs independently	86	82					**89**	**84**
		% C # 16 Includes progress/lack of progress and conclusion	100	64					**98**	**82**
		%C # 26 Summarizes the progress toward recovery goals	87	38					**88**	**64**
		%C # 29 Describes relationships in the milieu	86	91					**83**	**89**
		%C # 30 Describes circumstances if individual has been involved in conflicts or arguments	91	88					**60**	**90**
		%C # 32 Describes hobbies or leisure skills	73	83					**47**	**76**
		%C # 34 Notes discharge issues	100	94					**81**	**98**
		%C # 35 Notes progress or lack of progress and conclusions	100	64					**94**	**82**
		%C # 36 Describes if individual knows what nursing is doing for him and why	95	82					**92**	**89**
		%C # 37 RN summarizes progress and makes recommendations to IRP	95	82					**87**	**89**
		%C # 38 RN identifies issues not covered in focus areas or data that reflect currently inactive problems but may become issues later	95	41					**86**	**68**
		N=Population in need of update n=number audited ***Tab # 4 NURSING UPDATE AUDIT RESULTS***								

NURSING UPDATE ASSESSMENT AUDIT RESULTS (NEW FORM) January – Feb 2012 Tool								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N						236		**236**
n						22		**22**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%S						9		**9**
		%C # 1 Was the Nursing Update note completed within established timelines (every 7 days for first 60 days and every 30 days thereafter)?						95		**95**
		%C #2 Was there assessment data present addressing each nursing treatment intervention?						59		**59**
		%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?						68		**68**
		%C # 4 Are individualized strengths identified for the individual in care?						86		**86**
		%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?						17		**17**
		%C # 6 Does the RN summarize the current health and wellness challenges that have implications for nursing care?						95		**95**
		%C # 7 Does the RN summarize the current psychiatric/mental health challenges that have implications for nursing care?						82		**82**
		%C # 8 Does the note include individual's understanding of and thoughts/feelings about the IRP?						86		**86**
		%C # 9 Does the RN assessment reflect review of recent lab results and assessment tool ratings, i.e., Braden scale, Choking and Swallowing, Morse Falls Rating, etc.?						77		**77**
		%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?						73		**73**
		%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?						55		**55**
		%C # 12 Does the note reflect individual in care's attendance at treatment modalities?						91		**91**
		N=Target population needing updates n=number audited ***** New audit tool so data from prior period not available ***Tab # 4 NURSING UPDATE AUDIT RESULTS*** **Analysis and Action Plan:** New audit tools for the CINA (Parts A and B) and the nursing update were developed to track the new CINA and Update forms; the revised Nursing update audit form includes indicators to assess whether the Update								

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>specifically address changes in the IIC's condition since the last Nursing Update and if the RN developed nursing objectives and interventions to address the level of progress (or lack thereof) for the psychiatric and medical focus areas. Because only one month's data is available it is too early to determine what specific actions steps are needed, although such data may be available by the site visit. Audits will continue.</td></tr>
<tr><td>9</td><td>Ensure that each individual's treatment plan identifies:</td><td></td></tr>
<tr><td>VIII.D.9.a</td><td>the diagnoses, treatments, and interventions that nursing and other staff are to implement;</td><td>Recommendation:
1. Explore and resolve factors that contribute to an absence of nursing interventions in the IRPs, especially interventions to address violence and physical health status.

SEH Response: The CINA and Nursing Update forms were revised to improve the focus on and development of nursing interventions for inclusion into the IRP. For example, both Part A and Part B of the CINA include a section in the nursing plan of care where the RN is expected to identify objectives and nursing interventions to address Focus Areas # 1 (psychiatric) and # 2 (physical health). Changes to the Nursing Update are even more significant. The Nursing Update includes sections relating to each of the IRP focus areas; the nurse is expected to summarize progress toward meeting recovery goals, assess current mental status and risk status and describe progress or lack thereof. In addition, for each focus area, the RN is expected to identify new IRP nursing interventions that will support the IIC's recovery. Additional training on developing nursing objectives and interventions is planned; an RFP for consultant services to work with staff is expected to be announced in April 2012. In addition, the CNE has a two-part process to improve documentation with an initial focus on ensuring the documentation is completed, followed by a focus on quality. Nursing education and QA will be working with nurses on the admissions unit to improve timeliness and content of documentation, and concurrent reviews will be implemented for other units, with support from the two utilization review specialists.

2. Monitor policy implementation, identify trends, take action to address trends, and monitor effectiveness of actions taken.

SEH Response: Ongoing. Audits of the CINA, and Nursing Updates were revised to reflect the changes to the forms and both audits are assessing the quality of the nursing interventions suggested by the RN. In addition, there are questions to address these in the clinical chart audits.

Facility Findings:

<table>
<tr><th colspan="9">NURSING UPDATE ASSESSMENT AUDIT RESULTS (NEW FORM)
January – Feb 2012 Tool</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td></td><td></td><td></td><td></td><td></td><td>236</td><td></td><td>236</td></tr>
<tr><td>n</td><td></td><td></td><td></td><td></td><td></td><td>22</td><td></td><td>22</td></tr>
<tr><td>%S</td><td></td><td></td><td></td><td></td><td></td><td>9</td><td></td><td>9</td></tr>
<tr><td>%C #2 Was there assessment data present addressing each nursing treatment intervention?</td><td></td><td></td><td></td><td></td><td></td><td>59</td><td></td><td>59</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?						68		**68**
%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?						17		**17**
%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?						73		**73**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?						55		**55**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?						91		**91**

N=Population due an update
n=number audited
* New audit tool so no data from prior period available
Tab # 4 NURSING UPDATE AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. #8. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms	89	89	89	71	95	89	*	**87**

N = All IRPs due in the review month
n = number audited
Sample size is two per unit (as of the writing of this report, there are 11 units)
Tab # 2 CLINICAL CHART AUDIT RESULTS

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	11	8	10	11	11	11	**16**	**10**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S	4	3	4	5	6	5	**7**	**5**
%C RN attendance at IRP	82	100	100	100	91	100	**94**	**95**
%C. #2. Each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatment	91	88	90	100	100	100	**96**	**95**

N = All IRPs scheduled in the review month
n = number audited per audit sample plan
See Tab # 7 for IRP OBSERVATION AUDIT RESULTS

See also VIII.D.2 for additional information.

Analysis/Action Plans: Nursing has developed new forms that require RNs to address objectives and develop nursing interventions that relate to each focus area of the IRP; audit forms were modified to track the new forms. As of the writing of this report, only one month of data is available but Nursing is monitoring the data closely. Actions steps will be developed once data is available**.** An RFP for additional training and support around development of objectives and interventions for nursing is expected to be announced in April 2012. See also VIII.D.9.a.

VIII.D.9.b

the related symptoms and target variables to be monitored by nursing and other unit staff; and

Recommendations:
1. See VIII.D.2, D.3, D.4, and D.9.a.

SEH Response: See VIII.D.2, VIII.D.3, VIII.D.4, and VIII.D.9.a.

2. Align audit scoring instructions to ensure monitoring of interventions that nursing staff will implement.

SEH Response: Completed. ***See Tab # 23 CINA Audit Tool and Tab # 25, Nursing Update audit tool, Tab # 8, Clinical Chart Audit Tool and Instructions, Tab # 3 CINA Audit Results and Tab #4 Nursing Update Audit Results.***

Facility's Findings:

NURSING UPDATE ASSESSMENT AUDIT RESULTS (NEW FORM) January – Feb 2012 Tool								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N						236		**236**
n						22		**22**
%S						9		**9**
%C #2 Was there assessment data present addressing each nursing treatment intervention?						59		**59**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?						68		**68**
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N=Population due an update
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Tab # 4 NURSING UPDATE AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	275	244	234	214	198	201	**221**	**228**
n	18	19	19	21	21	18	**21**	**19**
%S	7	8	8	10	11	9	**9**	**8**
%C. #8. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms	89	89	89	71	95	89	*	**87**

N = All IRPs due in the review month
n = number audited
* Not audited during prior review period
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The Hospital returned this indicator to the clinical chart audits to identify areas and or units in which additional training or coaching may be needed during the upcoming review period.

VIII.D.9.c	the frequency by which staff need to monitor such symptoms:	**Recommendation:** See VIII.D.2, 3, 4, and 9.a.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>SEH Response: See VIII.D.2, 3, 4, and 9.a.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P8</td><td>Mean-C</td></tr>
<tr><td>N</td><td>275</td><td>244</td><td>234</td><td>214</td><td>198</td><td>201</td><td>221</td><td>228</td></tr>
<tr><td>n</td><td>18</td><td>19</td><td>19</td><td>21</td><td>21</td><td>18</td><td>21</td><td>19</td></tr>
<tr><td>%S</td><td>7</td><td>8</td><td>8</td><td>10</td><td>11</td><td>9</td><td>9</td><td>8</td></tr>
<tr><td>%C. #8. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms</td><td>89</td><td>89</td><td>89</td><td>71</td><td>95</td><td>89</td><td>*</td><td>87</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
* Not audited during prior review period
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: See VIII.D.9.b.</td></tr>
<tr><td>VIII.D.10</td><td>Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:</td><td></td></tr>
<tr><td>VIII.D.10.a</td><td>actively collect data with regard to infections and communicable diseases;</td><td></td></tr>
<tr><td>VIII.D.10.b</td><td>assess these data for trends;</td><td></td></tr>
<tr><td>VIII.D.10.c</td><td>initiate inquiries regarding problematic trends;</td><td></td></tr>
<tr><td>VIII.D.10.d</td><td>identify necessary corrective action;</td><td></td></tr>
<tr><td>VIII.D.10.e</td><td>monitor to ensure that appropriate remedies are achieved;</td><td></td></tr>
<tr><td>VIII.D.10.f</td><td>integrate this information into SEH's quality assurance review; and</td><td></td></tr>
<tr><td>VIII.D.10.g</td><td>ensure that nursing staff implement the infection control program.</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>VIII.D.11</td><td>Ensure sufficient nursing staff to provide nursing care and services</td><td>

Recommendations:

1. Establish and fund positions to achieve a 50% RN skill mix and deliver 6.0 NCHPPD.

SEH Response: Ongoing. The CNE developed a new staffing plan that ensures a 50% RN mix and 6 hours of NCHPPD; this requires 199.5 RN positions (which is based upon a census of 280 and relief factor of 1.90). ***See Tab # 86 Nursing Staffing Plan***. The Hospital made gains by hiring an additional 39 RNs since September, 2011; with 16 separations, there is a net gain of 23 RNs. In addition, 16 RNs have EOD dates between now and June 2, 2012. Funding for a total of 199.5 RNs was recently identified and hiring may proceed.

Table 1: RNs hired since September 2011

Month	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New Hires	10	7	4	6	3	9	10	39
Separations	4	1	4	2	2	1	6	16
Net Gain for Month	6	6	0	4	1	8	4	23

Table 2: Current Staffing and Funding Levels for Direct Care RNs and Supervisors

	A	B	C	D	E	F	*G*	H	I
	Total # Needed for 50% Mix and 6 NCHPPD	**Total FY 12 Funded Positions**	**Total Filled FTEs (D+E+F)**	**Total On Units***	**Total in Training**	**Total Not Available to the Units**	***Currently Vacant (B-C)***	**FY 12 Funded Vacancies**	**FY 12 Shortage in Funded positions (A-B)**
NM	N/A	14	14	14	0	0	1	0	0
RNs	199.5	199.5	147.2	122	13	12	24	35.5	0
QECs	N/A	3	3	3	0	0	0	0	0
RAs & LPNs	199.5	211	203	188	0	15	0	0	0

* It is estimated that the total number of RNs on the units by the first week in June will be 152 (based upon EOD dates and completion of the six week training although this number does not reflect separations.

2. Immediately hire additional RNs.

SEH Response: See response above. The Hospital hired 39 RNs since September 2011 and with separations there has been a net gain of 23 RNs. There was a delay in hiring additional RNs as there were insufficient funded vacancies; however, that issue was resolved as of early April 2012 and the Hospital now has sufficient number of RN positions and funding to immediately fill all needed RN positions.

3. Monitor the total NCHPPD to ensure that the addition of required numbers of RNs brings the NCHPPD up to the minimum required level (6.0).

</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: The Hospital continues to monitor nursing care hours and RN mix. ***See Tab # 91 Nursing Care Hours Report.*** The CNE worked with the Office of Statistics and Reporting to develop a new database for the management of NCHPPD that reflects census, staffing by position, SAR and overtime, the number of 1:1 staff, falls, medical leaves and restraint and seclusion. Data from the January through March 2012 shows nursing care hours per patient day has fluctuated during the review period with an average of 3.8 in January 2012, 4.1 in February 2012 and 3.8 in March 2012. It appears that the reduction in nursing care hours for March may be due to the doubling of 1:1s in March. The data also reflects the lengthened nursing orientation program as previously described. While this does delay RNs in fully providing services, it ensures they have a better understanding of the Hospital's policies and is expected to improve performance and retention overall. **Analysis and action steps**. There continues to be a shortage of RN staff to meet the 50% mix and targeted nursing care hours, however, the District has now approved the full complement of positions needed to meet the RN mix targets and well as the nursing care hours. Hiring will continue.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
IX.	**DOCUMENTATION**	
	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate assessments of the individual's progress relating to treatment plans and treatment goals.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.	**RESTRAINTS, SECLUSION, AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS**	
	By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	
X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	
X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Recommendations:** 1. See X.B.1. SEH Response: See X.B.1 **Analysis/Action Plans:** There were no incidents of prone restraint, or prone transportation during this reporting period. The Hospital purchased and implemented a new training curriculum, Safety Care to provide staff with additional skills in deescalating situations and identifying need for interventions earlier. Training of the in-house trainers was completed during the last review period, and training of direct care staff is well underway. *See Safety Care Training Data in Section X.A.2 below*. Safety Care training includes training in the development of skills and techniques that can help staff safely prevent and manage behavioral incidents. Topics include understanding challenging behavior, creating a safe and therapeutic environment, understanding staff behavior and emotional reactions reinforcing effectively de-escalation, physical management of IICs, developing a safety plan, management of fights and incident management, among other things. During this review period, nursing staff also completed training in the recovery model which also is expected to impact positively the use of alternatives to restraint or seclusion. The recovery training focused on teaching the core principles of recovery (hope, empowerment, self-direction, holistic, non-linear, strengths based, peer support, respect and responsibility). The training emphasized the importance of giving choices to the individual in care, ensuring the individual in care has the opportunity to learn and use coping mechanisms and specifically addressed the importance of knowing and implementing comfort plans. Training included role-playing based on several scenarios. ***See Tab # 99 Recovery Training Handout and Data*** The Hospital is also working to improve its use of comfort plans. The comfort plan form was revised and tested as a data entry form; the revised form was tested and provided to Avatar for development, which may be completed by the time of the site visit. ***See Tab # 95 Comfort Plan form*** The revisions to the comfort plan include additional selections to the "stress and crisis triggers" section, modifying the "signals of distress" section to remove two options but to add three others and adding additional prompts to the "what would help you" section of the plan. The Hospital also was able to

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>determine that comfort plans were being modified but that reports still showed the print date rather than the date the plan was created; this continued to be an issue throughout the review period but a fix was recently developed and is in testing. In addition, beginning in February 2012, the RN began bringing the comfort plan strategies to the IRP conference as a component of the CINA and Updates. This will facilitate discussion of the comfort plan and strategies can be added to the IRP if the team concludes they should be incorporated.

See section X.B. 1 for data on the use of less restrictive interventions.</td></tr>
<tr><td>X.A.2</td><td>training in the management of the individual crisis cycle and the use of restrictive procedures; and</td><td>Recommendation:

1. Closely monitor outcomes of behavioral emergencies while merging two models for crisis intervention.

SEH Response: Ongoing. According to data from the UI Monthly Report, the number of psychiatric emergencies has fallen from a twelve month high in October 2011 of 47 to a low of 10 in February 2012 (although it increased to 15 in March 2012). Tab # 121 UI Monthly Report. The Hospital has fully converted to Safety Care and no other crisis intervention model is being taught. Nursing staff also are being trained in the recovery model which is also expected to positively impact this requirement.

2. Implement Safety Care training plan.

SEH Response: Training plan implemented. See Data below. Beginning in March 2012, the portion of seclusion and restraint training concerning application of restraints will become part of Safety Care training, and the other parts of seclusion and restraint training (policy) will be available online.

3. On an annual basis, require staff to attend Safety Care update training and demonstrate relevant competencies.

SEH Response: This will be required beginning in Fall 2012.

<u>Facility’s Findings</u>

As the data shows, overall compliance with seclusion and restraint training for existing employees improved from 77% during the prior review period and 86% during this review period; compliance rate for new employees was 100%.

<table>
<tr><th colspan="5">Restraint or Seclusion for Behavioral Reasons: Existing Employees</th><th>3/31/12</th></tr>
<tr><th>Discipline</th><th># Required</th><th># Attended</th><th># Competent</th><th>% Attended</th><th>% Competent*/ % of Attendees Competent**</th></tr>
<tr><td>Chaplain</td><td>6</td><td>6</td><td>6</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Clinical Administrator</td><td>10</td><td>10</td><td>10</td><td>100%</td><td>100%/100%</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Dentistry	11	7	7	64%	64%/100%
Dietary	3	3	3	100%	100%/100%
Medical	13	10	10	77%	77%/100%
Nursing - Nurse Manager	14	13	13	93%	93%/100%
Nursing - RN	98	85	85	87%	87%/100%
Nursing – LPN	30	26	26	87%	87%/100%
Nursing – RA	179	155	155	87%	87%/100%
Psychiatry	60	57	57	95%	95%/100%
Psychology	38	33	33	87%	87%/100%
Rehabilitation	23	21	21	91%	91%/100%
Social Work	16	15	15	94%	94%/100%
Treatment Mall	6	6	6	100%	100%/100%
Clinical (Other)	14	9	9	64%	64%/100%
Security	0	0	0	0%	0%/0%
Total	**533**	**456**	**456**	**86%**	**86%/100%**

** Percentage of those who passed competency exam out of the total number of employees required for training.*

*** Percentage of those who passed competency exam out of the total number of employees who attended training.*

Restraint or Seclusion for Behavioral Reasons: New Employees					3/31/12
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Medical	3	3	3	100%	100%/100%
Dentistry	0	n/a	n/a	n/a	n/a
Nursing - Nurse Manager	5	5	5	100%	100%/100%
Nursing - RN	44	44	44	100%	100%/100%
Nursing - RA	0	n/a	n/a	n/a	n/a
Psychiatry	0	n/a	n/a	n/a	n/a
Psychology	4	4	4	100%	100%/100%
Rehabilitation	0	n/a	n/a	n/a	n/a

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Social Work	1	1	1	100%	100%/100%
Total	**57**	**57**	**57**	**100%**	**100%/100%**

** Percentage of those who passed competency exam out of the total number of employees required for training.*

*** Percentage of those who passed competency exam out of the total number of employees who attended training.*

See Tab # 109 Restraint and Seclusion Training Curricula and Data

Safety care training was implemented beginning in September 2011. As of March 31, 2012, 328 existing staff and 57 new staff completed the training.

SAFETY CARE TRAINING EXISTING EMPLOYEES

Discipline	# Required	# Attended	Total # Competent	% Attended	% Competent /# of Attendees Competent
Chaplain	6	6	6	100%	100%/100%
Clinical Administrator	10	9	9	90%	90%/100%
Dentistry	7	2	2	29%	29%/100%
Dietary	3	3	3	100%	100%/100%
Medical	13	6	6	46%	46%/100%
Nurse Manager & Supervisor	14	8	8	57%	57%/100%
Nursing - RN	98	66	66	67%	67%/100%
Nursing - LPN	30	23	23	77%	77%/100%
Nursing - RA	179	125	125	70%	70%/100%
Psychiatry	42	26	26	62%	62%/100%
Psychology	15	12	12	80%	80%/100%
Rehabilitation	22	14	14	64%	64%/100%
Social Work	15	15	15	100%	100%/100%
Treatment Mall	6	6	6	100%	100%/100%
Clinical (Other)	14	7	7	50%	50%/100%
Security	12	12	12	100%	100%/100%
Total	**486**	**340**	**340**	**70%**	**70%/100%**

Collaborative Problem Solving Training **3/31/12**

	Clinical Staff	Nursing-Day	Nursing-Evening	Nursing- Night
Total # to be trained	78	122	99	79
Total # Trained	54	76	48	57
% Trained	69%	62%	48%	72%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

See Tab # 66 Collaborative Problem-solving Training Information

Recovery Training (includes new and existing staff)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent**
Nurse Mgr & Supervisors	19	17	17	89%	89%
RN	132	128	128	97%	97%
LPN	30	28	28	93%	93%
RA	179	151	151	84%	84%
Total	**360**	**324**	**324**	**90%**	**90%**

See Tab # 99 Recovery Training Information

Analysis/Action Steps: Data shows that compliance with restraint and seclusion training improved for most disciplines except nurse manager and security during this rating period. For Seclusion and restraint training (selected disciplines only):

SECLUSION AND RESTRAINT COMPARISON DATA		
Discipline	**% Compliant Prior review period Seclusion and restraint training**	**% Compliant Current review period Seclusion and restraint training**
Nurse manager	93%	93%
RN	75%	87%
LPN	67%	87%
RA	63%	87%
Psychiatrist	91%	95%
Security	100%	0%

One reason for the decline in performance for security was that they did complete the two day Safety Care training, which was prioritized over retraining on the Hospital's seclusion and restraint policy (note that other aspects of seclusion and restraint training such as applying restraints and use of less restrictive interventions are covered in Safety Care training). As of March 2012, the restraint and seclusion training curricula was modified to remove aspects covered in Safety Care, and the remainder of seclusion and restraint training will be available online. ***See Tab # 109 Seclusion and Restraint and Safety Care Curricula and Data.***

Executive Staff members are being provided with data from Office of Training that reflect the status of employee completion of training. This allows Executive staff to monitor those whose training is not current or about to expire. Further, training is being done also during evening and night shifts and these efforts will continue.

The Hospital continues to implement the training in Collaborative Problem-solving. The majority of staff on all units on all shifts have completed the CPS training although training was suspended in the Fall 2011 due to Safety Care Training.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Collaborative problem solving training will restart in April 2012.
X.A.3	the use of side rails on beds, including a plan:	
X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	
X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification .of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	
X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	
X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Recommendations:** 1. Determine why there has been a decrease in completing and using Comfort Plans. Based on findings, develop a method to ensure that the plans are utilized in the same way as the IRPs, e.g., direct individualized interventions. SEH Response: Throughout most of the rating period, there continued to be issues with the Comfort plan in Avatar that created the perception that Comfort plans were not being modified; updates were occurring (albeit not at the frequency set by policy) but when Comfort plans were printed, the date of the printing populated the report rather than the date the Plan was created or updated. Although Avatar was actively working on the issue, it was only recently resolved, and the revised form is in testing. The Hospital is working to improve its use of comfort plans. The comfort plan form was revised and was tested as a data entry form; the form was recently finalized and is with Avatar for development. The revised form, which is completed with the individual in care, includes sections on “stress and crisis triggers”, “signals of distress”, and “interventions that may help relieve the crisis”. The RN is bringing the comfort plan strategies to the IRP conference as a component of the CINA and Updates. 2. If RA role modifications are made, ensure role clarity and that services are focused on individuals in care. SEH Response: The CNE reviewed the roles and responsibilities of RAs to ensure they were consistent with licensure and to identify opportunities to strengthen the focus on individuals in care and to provide care consistent with recovery principles. Based upon this review, some actions have been taken. RAs were provided additional training in the recovery model which included role playing using several scenarios. Additionally, in an effort to improve RA documentation and to

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

minimize the duplication of documentation between nursing and RAs, an RA documentation form was created. The form provides a structure for the RAs in how and what to document, and in so doing reinforces their roles on the treatment team. ***See Tab # 94 RA Documentation Form.***

3. Monitor to ensure that individuals in Class A status are accompanied from Admissions to units without metal handcuffs and in street clothes rather than hospital gowns.

SEH Response: Completed. Effective November, 2012 the Hospital changed its practice and Class A individuals are no longer accompanied from Admissions with metal restraints or in hospital gowns.

4. Determine and implement strategies to promote safety and security without the use of metal handcuffs when individuals in Class A status visit the medical/dental clinics.

SEH Response: The CNE and Medical Director worked with staff at the medical clinics to develop procedures for use of metal restraints for individuals who cannot safely attend clinics without use of restraints. Among the changes made; 1) no metal restraints are permitted to be used within the building. Metal restraints are permitted only to transport Class A persons outside the Hospital building and they are now kept in the Nursing office; their use is tracked. The policy has been updated to clarify this. 2) Leather wristlets may be applied in the medical clinics when clinically necessary but only with a doctor's order. Other changes to the policy must await changes to DC regulations to allow use of ambulatory restraints when necessary in an emergency to escort an assaultive individual from one place (i.e. TLC) to their home unit.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	7	2	6	6	2	2	**3**	**4**
n	4	2	4	3	2	2	**3**	**3**
%S	57	100	67	50	100	100	**83**	**68**
%C # 2 Documentation reflects that individual posed an imminent danger to self or others if not restrained or secluded	100	100	100	100	100	100	**100**	**100**
%C # 3 Documentation reflects r/s used to ensure safety of individuals or others, after less restrictive interventions have been considered and documented	100	100	100	100	100	100	**93**	**100**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Restraint and seclusion usage continues to fall well below the national public rates of *percent of individuals* restrained or secluded of 3.6% for restraint and 2.6% for seclusion.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="7">PERCENT OF INDIVIDUALS RESTRAINED OR SECLUDED</th></tr>
<tr><th></th><th>Sep~11</th><th>Oct~11</th><th>Nov~11</th><th>Dec~11</th><th>Jan~12</th><th>Feb~12</th></tr>
<tr><td>Restraint</td><td>0.3%</td><td>0.0%</td><td>0.3%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td></tr>
<tr><td>Seclusion</td><td>1.5%</td><td>0.6%</td><td>0.6%</td><td>1.3%</td><td>0.6%</td><td>0.7%</td></tr>
</table>
NPR Rate percent of individuals restrained=3.6%
NPR Rate percent of individuals secluded=2.6%
See PRISM Report, Tab # 43

The Hospital’s usage of hours of restraint and seclusion likewise is much lower than the national public rate for hours of restraint (0.42) or seclusion (0.55).

<table>
<tr><th colspan="7">RATE OF RESTRAINT OR SECLUSION HOURS</th></tr>
<tr><th></th><th>Sep~11</th><th>Oct~11</th><th>Nov~11</th><th>Dec~11</th><th>Jan~12</th><th>Feb~12</th></tr>
<tr><td>Restraint</td><td>0.01</td><td>0.00</td><td>0.001</td><td>0.00</td><td>0.00</td><td>0.00</td></tr>
<tr><td>Seclusion</td><td>0.03</td><td>0.003</td><td>0.03</td><td>0.02</td><td>0.016</td><td>0.016</td></tr>
</table>
NPR Hours Rate of restraint=0.55
NPR Hours Rate of seclusion=0.42
See PRISM Report, Tab # 43

Analysis/Action Plans: The Hospital audits show that it is consistently performing above the 90% standard for this requirement.

The Hospital implemented a new curriculum for nonviolent crisis intervention (Safety Care) that is more prevention focused and specifically provides staff with skills and strategies to use of the least restrictive measure appropriate to the situation. The curricula itself is organized in a “least-to-most restrictive” manner, and staff are being trained to use the most positive, least coercive approach that is likely to be safe and effective. To date, 70 percent of staff have completed Safety Care training. See X.A.2 for training data on Safety Care. In addition, nursing staff are undergoing training in principles of recovery and 90% of nursing staff have completed that training. See Tab # 99 Recovery Training Outline and data Finally, in January 2012 nursing revised the comfort plan form and have reemphasized its usage, as for example, nursing staff are now bring comfort plan interventions to the IRPs. It appears that these initiatives are positively impacting the use of alternatives to restraint or seclusion, although it is too early to determine if the new comfort plan form and increased attention to its content has improved staff’s use of the interventions identified in the form.
</td></tr>
<tr><td>X.B.2</td><td>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</td><td>Recommendations:

Maintain compliance.

SEH Response: Compliance maintained.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Facility's Findings:

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>7</td><td>2</td><td>6</td><td>6</td><td>2</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>4</td><td>3</td><td>2</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>57</td><td>100</td><td>67</td><td>50</td><td>100</td><td>100</td><td>83</td><td>68</td></tr>
<tr><td>%C # 4 Restraint/seclusion is not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data from the restraint and seclusion audits show that restraint or seclusion is utilized only to ensure the individual's safety or that of another. Compliance on this indicator was maintained at 100% during this review period. The Hospital continues to provide a number of treatment interventions from the time of admission, including TLC groups and unit based groups. The civil admission unit and the two geriatric units all offer on unit group therapies; the individuals from 1D, 1F and 1G all attend the TLCs. See Tab # 55 TLC and Unit Based Group Schedules. For example, the civil admissions unit (1E) has recreational therapy, substance abuse treatment, music therapy, spirituality group, relaxation group, medical groups, fitness groups, understanding your illness, and groups are scheduled five days a week, for four hours each day. See Tab # 55 TLC and Unit Based Schedules. Groups on the forensic admissions units also include competency groups but most IICs from these units attend the TLCs. PID began to track hours of treatment scheduled for those individuals who are secluded or restrained during a month. However, accurate attendance data is not readily available except for the month of February 2012. This is expected to be rectified by the May visit, when a new Access database to track treatment hours is expected to be operational and should allow auditors to track group attendance as well as scheduled hours.</td></tr>
<tr><td>X.B.3</td><td>are not used as part of a behavioral intervention; and</td><td></td></tr>
<tr><td>X.B.4</td><td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td><td></td></tr>
<tr><td>X.C</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:</td><td></td></tr>
<tr><td>X.C.1</td><td>the specific behaviors requiring the procedure;</td><td></td></tr>
<tr><td>X.C.2</td><td>the maximum duration of the order;</td><td></td></tr>
<tr><td>X.C.3</td><td>behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>not expired;</td><td></td></tr>
<tr><td>X.C.4</td><td>ensure that the individual's physician be promptly consulted regarding the restrictive intervention;</td><td></td></tr>
<tr><td>X.C.5</td><td>ensure that at least every 30 minutes, individuals in seclusion or restraint must be reinformed of the behavioral criteria for their release from the restrictive intervention;</td><td></td></tr>
<tr><td>X.C.6</td><td>ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;</td><td>Recommendation:
Continue monitoring to evaluate the degree to which the current improvement plan is effective.

SEH Response: Ongoing. The Hospital continues to struggle with meeting this requirement.

Facility's Findings:

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>7</td><td>2</td><td>6</td><td>6</td><td>2</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>4</td><td>3</td><td>2</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>57</td><td>100</td><td>67</td><td>50</td><td>100</td><td>100</td><td>83</td><td>68</td></tr>
<tr><td>%C # 6 Treatment team debriefing held within 24 hours or next business day of termination of r/s event</td><td>75</td><td>0</td><td>50</td><td>33</td><td>100</td><td>50</td><td>53</td><td>53</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data shows performance continues to fall below standards. Clinical administrators are regularly reminded that ensuring compliance with this requirement is their responsibility. However, staff noted that the form that Clinical Administrators were using to track the treatment team debriefing only contained one date field, and it was not clear if the Clinical Administrators were reporting the date of the incident, the date of the debriefing or the date the debriefing form was completed. The form was revised effective January 10, 2012 to include separate data fields for the date of the incident and the date the debriefing was held. See Tab # 42 Treatment Team Debriefing Form. The Hospital will monitor whether this change impacts the data.</td></tr>
<tr><td>X.C.7</td><td>comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and</td><td>Recommendations:

Maintain compliance.

SEH Response: Compliance maintained.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>

Facility's Findings:

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<tr><td>n</td><td>4</td><td>2</td><td>4</td><td>3</td><td>2</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>57</td><td>100</td><td>67</td><td>50</td><td>100</td><td>100</td><td>83</td><td>68</td></tr>
<tr><td>%C # 7 Physician conducted face-to- face assessment within one hour of initiation of r/s event</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>93</td><td>100</td></tr>
</table>

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The data shows that the Hospital maintained its high level of performance on this requirement, and has exceeded the 90% threshold for a second six month period.

</td></tr>
<tr><td>X.C.8</td><td>ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.</td><td>

Recommendation:

1. See X.A.2

SEH Response: See X.A.2.

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>7</td><td>2</td><td>6</td><td>6</td><td>2</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>4</td><td>3</td><td>2</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>57</td><td>100</td><td>67</td><td>50</td><td>100</td><td>100</td><td>83</td><td>68</td></tr>
<tr><td>%C # 8 individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.</td><td>50</td><td>50</td><td>100</td><td>100</td><td>50</td><td>100</td><td>60</td><td>76</td></tr>
</table>

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The Hospital's performance on this indicator is improving as more staff have completed Safety Care training. Effective March 2012, Safety Care training includes application of restraints and related competencies, and

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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		the seclusion and restraint training was updated to focus on policy requirements. It is available as an online training. These steps should result in continued improvement in meeting this requirement. ***See Tab # 109 Seclusion and Restraint and Safety Care Curricula and Data***
X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	
X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Recommendation:** 1. See X.A.1 and X.B.1 SEH Response: See X.A.1 and X.B.1. 2. Review and evaluate the utility of existing data sets. Determine if different data sets and/or summaries for trend analysis are needed. Determine what is "signal" and what is "noise". SEH Response: The Hospital implemented a database for tracking this requirement (that IRP be updated for those individuals who are restrained or secluded more than three times in a four week period) as part of its high risk individuals tracking system; it is not tracked through the recommendations tracking database suggested by the most recent DOJ report. Under the system used, for this requirement, a report is run weekly from the UI database which seeks only incidents on restraint or seclusion within time parameters. This is not a complicated or labor intensive process. If any case of use of more than three incidents of restraint or seclusion is identified, the treatment team is notified that a special IRP is needed. This has simplified tracking of this requirement . There have been no incidents of an IIC being placed in restraint or seclusion more than three times in a four week period during this review period (September through February).
X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Recommendations:** 1. Monitor the use of EIM.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: For most of the review period, the Hospital was able to identify those individuals who are given STAT medications on an involuntary basis. This information is shared each month with Pharmacy and Therapeutics Committee. ***See Tab # 76 Pharmacy and Therapeutics Committee Monthly Report*** In an effort to facilitate the data collection however, the Hospital modified the drop down menu for medication administration to ensure a more reliable tracking of whether the administration was voluntary or involuntary. Previous choices included "Nurse administered" and "Nurse administered Involuntarily". These choices were modified to "Nurse administered voluntarily" and "Nurse administered involuntarily" and nursing staff were trained by their managers on how to use the new selections. At the same time, the Hospital also modified the choices for ordering medication to separate out "STAT" and "NOW" so that we can collect data through a report that tracks medications ordered to be given as STAT (which permits a nurse to administer the medication involuntarily if the IIC refuses the medication) and that are actually administered on an involuntary basis. These changes were effective January 2012 and a report is available.

Data shows the following:

	Sep~11	Oct~11	Nov~11	Dec~11	Jan~12	Feb~12
# Unique EIM events	4	3	2	1	1	5
# Unique IIC given EIM	3	3	2	1	1	3

2. Develop a simple mechanism to evaluate IRP changes following tiered levels of review.

SEH Response: Currently the Hospital's PBS team (through a readily available management report) monitors Avatar monthly for use of STAT medication, whether administered voluntarily or involuntarily. In those cases where it appears three or more STAT medications were administered in a 30 day period, the PBS team leader refers the case to the unit psychologist, for evaluation of the need for behavioral interventions. In the event the IIC meets the requirement set out by the PBS policy (3 or more EIMs in four week period) the individual is placed on a high risk list, and PID tracks to ensure the issue is addressed in the IRP through the high risk tracking system.

Facility's Findings:

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N # of EIM events during the month	4	3	2	1	1	5	**5**	**3**
# of Unique Patients Given EIM	3	3	2	1	1	3	**4**	**2**
# Total EIM ordered/administered	9	7	4	2	2	8	**10**	**5**
n	0	3	1	1	1	5	**2**	**2**
%S	0	100	50	100	100	100	**33**	**69**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C 1 a if the record reflects that EIMs were prescribed only when the individual experiences a mental health crisis or deterioration in which the immediate provision of mental health treatment was necessary to prevent serious injury to the individual or others and only to the extent necessary to stabilize the individual and		100	100	100	100	100	**100**	**100**
%C 1b the medication is a standard treatment for the individual's diagnosis, symptoms or conditions		100	100	100	100	100	**100**	**100**

N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 140 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

Analysis/Action Plans: The audits show high levels of compliance. The Hospital will continue monitoring this through audits.

X.F.2 a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and

Recommendations:

1. See F.X.1

SEH Response: See X.F.1.

Facility's Findings:

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N # of EIM events during the month	4	3	2	1	1	5	**5**	**3**
# of Unique Patients Given EIM	3	3	2	1	1	3	**4**	**2**
# Total EIM ordered/administered	9	7	4	2	2	8	**10**	**5**
n	0	3	1	1	1	5	**2**	**2**
%S	0	100	50	100	100	100	**33**	**69**
%C 2 a If there is documentation in the record that a physician conducted a face to face assessment AND		33	100	100	0	60	**90**	**55**
%C 2 b that assessment was within 1 one of the EIM administration		67	100	100	0	40	**100**	**55**

N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 140 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: The audits indicate declining performance. The Medical Director has discussed his findings with the involved physicians. The Hospital will continue monitoring this through audits.</td></tr>
<tr><td>X.F.3</td><td>the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.</td><td>Recommendation:

See X.F.1 and X.E.

SEH Response: See X.F.1 and X.E.

Facility's Findings:

<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N # of EIM events during the month
# of Unique Patients Given EIM
Total EIM ordered/administered</td><td>4
3
9</td><td>3
3
7</td><td>2
2
4</td><td>1
1
2</td><td>1
1
2</td><td>5
3
8</td><td>5
4
10</td><td>3
2
5</td></tr>
<tr><td>n</td><td>0</td><td>3</td><td>1</td><td>1</td><td>1</td><td>5</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>0</td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>33</td><td>69</td></tr>
<tr><td>%C 3 a The review indicates that the treatment team timely reviewed three or more emergency involuntary administration in 4 week period and</td><td></td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
<tr><td>%C b modified the IRP or medication regimen in a timely manner or documented reasons why modification was not clinical appropriate</td><td></td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
<tr><td>%C c implemented the revised plan, if applicable</td><td></td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
</table>
N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 140 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

Analysis and action plan: No cases fell within this requirement during this review period.</td></tr>
<tr><td>X.G</td><td>By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding</td><td>Recommendations:

See X.A.2.

SEH Response: See X.A.2.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	implementation of all such policies and the use of less restrictive interventions.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XI.	**PROTECTION FROM HARM**	
	By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect.· SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals' living at the facility.	Training on reporting abuse and neglect continues to be included in the new employee orientation, and the annual renewal is offered multiple times during the year and is available on the intranet. The percentage compliant remained above 90%. See data below. ***Tab # 114 Reporting Abuse and Neglect Training data and curriculum outline.***

Reporting Suspected Individual Abuse, Neglect & Exploitation (09/01/10 ~ 03/31/11)
Continuing employees

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	6	6	100	100%/100%
Clinical Administrator	10	10	10	100	100%/100%
Dentistry	11	11	11	100	100%/100%
Dietary	3	3	3	100	100%/100%
Medical	13	10	10	77%	77%/100%
Nursing - Nurse Manager	14	13	13	93%	93%/100%
Nursing - RN	98	89	89	91%	91%/100%
Nursing - LPN	30	29	29	97%	97%/100%
Nursing - RA	179	170	170	95%	95%/100%
Psychiatry	60	57	57	95%	95%/100%
Psychology	38	36	36	95%	95%/100%
Rehabilitation	23	20	20	87%	87%/100%
Social Work	15	15	15	100%	100%/100%
Treatment Mall	6	1	1	17%	17%/100%
Clinical (Other)	6	5	5	83%	83%/100%
Non-Clinical/Administrative	182	165	165	91%	91%/100%
Total	**694**	**640**	**640**	**92%**	**92%/100%**

** Percentage of those who passed competency exam out of the total number of employees required for training.*

*** Percentage of those who passed competency exam out of the total number of employees who attended training.*

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Reporting Suspected Individual Abuse, Neglect & Exploitation New Employees				09/01/10 ~ 03/15/11	
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Dentistry	0	n/a	n/a	n/a	n/a
Medical	3	3	3	100%	100%/100%
Nursing - Nurse Manager	5	5	5	100%	100%/100%
Nursing - RN	44	44	44	100%	100%/100%
Psychiatry	0	n/a	n/a	n/a	n/a
Psychology	4	4	4	100%	100%/100%
Rehabilitation	0	n/a	n/a	n/a	n/a
Social Work	1	1	1	100%	100%/100%
Non-clinical	12	10	10	83	83%/100%
Total	**69**	**67**	**67**	**97%**	**97%/100%**

** Percentage of those who passed competency exam out of the total number of employees required for training.*

The Hospital continues to require criminal background checks for unlicensed staff prior to hiring. Such checks for licensed staff are not completed by SEH as they are done as part of the licensing process.

During this review period, the Hospital continued its implementation of its High Risk Indicator Tracking and Review policy. ***See Tab # 129 High Risk Tracking and Review Policy.*** The initial version of the Policy included 8 categories of behavioral and 8 categories of medical high risks, and specified criteria for placement on a list and criteria for removal from a list. In March 2011, the Hospital identified individuals who met the criteria and began tracking them. The Performance Improvement Committee reviewed the policy and recommended changes in February, 2012. The changes included adding a high risk category for fire starters and modifying some of the time frames for getting off a high a risk list as well as some language "clean up" on technical aspects of the policy.

As of March 22, 2012, 97 IICs were identified as meeting one or more high risks. Of the 97, 34 had one or more behavioral risks identified, 5 had one or more medical risks identified, and 58 were on both behavioral and medical risk lists. The Risk Manager continues to monitor those with three or more major UIs in a 30 day period. ***See Tab # 46 Risk Indicator UI Tracking Reports.*** As of March 2012, of the 97 individuals on one or more high risk lists 88 (or 91%) had the risk addressed in the IRPs. During the course of the review period, 27 individuals in care were removed from any high risk list. ***Tab # 128 Summary of High Risk Indicator Lists.***

During the prior review period, in an effort to get a better understanding of the incidents of violence, the Hospital conducted an analysis of incidents of all aggressive acts (to include physical assault, aggressive behavior, self-injurious behavior and destruction of property) occurring between October 1, 2010 through May 31st, 2011. The data analysis

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

included a review of clinical characteristics of individuals who had 1 or more aggressive acts during this period, as well as a review of incidents by type, location, and by time of day. The analysis also included a review of the clinical characteristics of the individuals who are aggressors. Following this data review, PID reviewed the cases of the 13 individuals in care with 8 or more incidents using an audit tool. The reviewed showed a significant percentage of these 13 individuals with diagnoses of mental retardation or borderline intellectual functioning and included recommendations that included improving staff's capacity to address individuals with these needs. Results were presented to the Executive staff and subsequently to clinical staff at a clinical leadership meeting. Another study reviewing cases of assaults against staff was recently completed and is discussed in more detail in Chapter XII and XIII.

Over the Fall, 2011 the Hospital implemented Safety Care training for all clinical staff, and in December 2011 began training nursing staff on the recovery model. Beginning in November 2011 the Hospital began to see a decline in physical assaults.

	Sep~11	Oct~11	Nov~11	Dec~11	Jan~12	Feb~12
Physical Assaults	52	64	45	27	28	22
Psych Emerg	41	47	24	16	12	10
Injury	34	46	30	30	25	20

The Hospital is continuing to monitor this data closely, and assault data began to be presented monthly to the Risk Management and Safety Committee. ***See Tab 124 Risk Management Committee Minutes*** Its Performance Improvement Department also completed a quality review of cases involving assaults on staff during the period of November 2011 through January 2012.

After the most recent DOJ visit, the Hospital reconsidered its policy of using the security suite on 1D as overflow beds. Effective November 2011, the suite is no longer used, even if it means court ordered admissions of forensic individuals must wait a day or two before being admitted.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.	**INCIDENT MANAGEMENT**	
	By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	
XII.A	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Recommendation:** 1. Continue current processes for incident management, investigation report development and approval and efforts to complete investigations within the policy timeframe. SEH Response: Ongoing. The Director PID continues to approve investigations, and recommendations of the Risk Manager that implicate policy matters are reviewed regularly by Executive staff and either approved, modified or disapproved. Timeliness of investigations improved again during this rating period; there were a total of 37 investigations (all types) completed, with an average time to completion of 30 days. For abuse and neglect investigations, the average time for completion was 43 days (improved form 50.6 days during the last review period), which is within the 45 day time frame of the Hospital policy. The Hospital is also considering hiring an additional investigator if a position can be identified. The Hospital continues to monitor the application of the Incident Management policies in several ways. First, the Risk Manager reviews each UI to identify areas of noncompliance with the incident management policies. He also reviews collateral hospital reports such as the 24 Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents noted in the reports have corresponding UIs. Second, the Risk Manager investigation reports are reviewed by a supervisor to ensure the investigations and reports meet Hospital standards. Finally, all managers review monthly the Unusual Incident Monthly Report **(*See Tab # 121*)** and unit specific data is shared with each treatment team through the House support PID project and the PRISM report. ***See Tab # 43 PRISM Report; Tab # 126 Unit Partnership Documents*.** Timeliness in reporting incidents of possible neglect or abuse fell, from 83% during the last reporting period to 68% during this reporting period. ***See Tab # 121 UI Monthly Reporting***. 2. Continue monitoring of outcomes of these efforts. SEH Response: Ongoing.
XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	
XII.A.2	immediate reporting by staff to supervisory	**Recommendation:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	1. Continue current practice. SEH Response: Current practice continues. The Hospital also has a senior executive staff member on call 24 hours a day, and the solution center staff contact the covering administrator in the event of an emergency. Additionally, the Risk Manager is available 24 hours a day 7 days a week. **Facility's findings:**

Report Delay of Abuse and Neglect Incidents

Report Gap (Days)	Previous Review Period (Mar 11~Aug 11)						Current Review Period (Sep 11~Feb 12)						Previous Total	Current Total
	2011-3	2011-4	2011-5	2011-6	2011-7	2011-8	2011-9	2011-10	2011-11	2011-12	2012-1	2012-2		
<=1 day (on time)	**3**	**4**	**3**	**4**	**5**	**5**	**5**	**3**	**3**	**3**	**0**	**1**	**24**	**15**
>1 & <=5 days	**0**	**0**	**2**	**0**	**0**	**2**	**0**	**1**	**1**	**0**	**0**	**1**	**4**	**3**
>5 & <=10 days	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**
>10 days	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**2**
Total abuse/neglect UIs	**3**	**4**	**6**	**4**	**5**	**7**	**6**	**5**	**4**	**4**	**1**	**2**	**29**	**22**
Timely reporting (<=1 day)	***100%***	***100%***	***50%***	***100%***	***100%***	***71%***	***83%***	***60%***	***75%***	***75%***	***0%***	***50%***	***83%***	***68%***
Reports Delayed (>1 day)	***0*** ***0%***	***0*** ***0%***	***3*** ***50%***	***0*** ***0%***	***0*** ***0%***	***2*** ***29%***	***1*** ***17%***	***2*** ***40%***	***1*** ***25%***	***1*** ***25%***	***1*** ***100%***	***1*** ***50%***	***5*** ***17%***	***7*** ***32%***

See Tab # 121 UI Monthly Report.

Analysis/Action Steps: Overall the number of abuse/neglect reports submitted timely fell, from 83% in the prior period to 68% during this period. It should be noted that at this time, the Hospital still measures timeliness from the date of the incident, not from the date of discovery, so that the 68% statistic somewhat overstates the percentage of abuse or neglect incidents involving a delay.

The Risk Manager continues to emphasize the importance of adherence to the hospital policy that staff shall be free of retaliation when reporting an allegation of A/N/E. This is included in the training on reporting abuse and neglect. There is no evidence that any retaliation occurred during this review period although one employee contacted the Risk Manager about a comment made to her by a former union officer concerning her statements that were made as part of an investigation which was released during the disciplinary appeals process. The employee who complained was offered and accepted a reassignment, and the offending employee was reminded about the no retaliation policy.

As evidenced by the data described above, the Risk Manager's actions to ensure that staff are compliant with their duty to report UIs of all types has been effective. The Risk Manager continues to review collateral hospital reports such as the 24

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents of any type noted in the reports have corresponding UIs if required by the policy.
XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Recommendation:** When a staff member named in an allegation of A/N/E is not removed under the exception in Policy 302.4-09, the investigation should include documentation of this circumstance. SEH Response: In February 2011, the Hospital began including in its reports a notation as to whether staff were removed pending the investigation. Since July 2011, this has been expanded, and in the section of the report called initial administrative action, the Risk Manager began indicating the reason the individual was not removed pending the investigations outcome. The Hospital completed 37 investigations (all types) during the period of September 1, 2011 to February 29, 2012. Of the 37 investigations, 22 were substantiated and 15 were unsubstantiated. The average length of time to complete the investigations (all types) was 30 days, and was 43 days for abuse and neglect investigations. ***See Chura Advanced Document Request, Tab # 6.***
XII.A.4	adequate training for all staff on recognizing and reporting incidents;	
XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	
XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	
XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	
XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline "harassment, threats, or licensure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	
XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	
XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	
XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	
XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as s result of investigations.	**Recommendations:** 1. Continue tracking recommendations for programmatic and staff-specific corrective actions identified in investigations. SEH Response: Tracking continues. ***See Tab 119 Recommendations Tracking Summary and Detailed Report.*** Since tracking began, there have been a total of 193 recommendations. Of these, 132 have been closed, and 61 remain open. Among the 61 open recommendations are those related to HR actions, training and systemic or policy issues.
XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Recommendations:** Continue current practice in maintaining the database and take appropriate actions when implementation appears to have stalled. SEH Response: Database is maintained and implementation is monitored monthly. ***See Tab 119 Recommendations Tracking Report.***

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>XII.D</td><td>By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.</td><td></td></tr>
<tr><td>XII.E</td><td>By 24 months from the Effective Date hereof~ SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:</td><td>Recommendation:
Continue current practice of collecting, displaying and promulgating incident data. Develop incident reduction initiatives based on particular findings and identify them as having their origin in the review of incident data.

SEH Response: Ongoing. Incident data is included in monthly PRISM reports and the annual Trend Analysis, both of which are available on the intranet. In addition, as part of the unit partnership, unit specific incident data is shared with each treatment team. See Tab # # 43 PRISM Report; Tab # 41 Trend Analysis and Tab # 126 Unit Partnership Documents. Recommendations that emanate from the incident data are tracked through the recommendation data base. An example of using incident review data to drive performance improvement includes the recent analysis of the effect of use of interventions during psychiatric emergencies. This was noticed as part of the review of UIs and an initial analysis was completed which suggests that use of interventions in addition to verbal counseling were effective in de-escalating aggression. See Tab # 117 c Violence Reduction Materials. While PID considered doing a more detailed case review of these cases, hospital leadership requested PI review the incidents of violence against staff instead, which was completed. See Tab # 127 Violence Against Staff Study. Other examples include the presentation of fall and assault data monthly to Risk Management Safety Committee which began in December 2011. See Tab # 124 Risk Management and Safety Committee Minutes.

The February Unusual Incident report (most recent one available as of the writing of this report) reflects a yearly total of all UIs the period of March 2011 through February 2012 at 2449. The data below includes a comparison between the February tally and the 12 month mean for selected incident types and shows that in most cases February data is better than means for the prior twelve months.
.
<table>
<tr><th></th><th>12 MONTH TOTAL</th><th>% TOTAL INCIDENTS</th><th>12 MONTH MEAN 9/10-8/11</th><th>12 MONTH MEAN 3/11-2/12</th><th># INCIDENTS FEBRUARY 2012</th></tr>
<tr><td>Physical Assault</td><td>512</td><td>21%</td><td>44</td><td>43</td><td>22</td></tr>
<tr><td>Contraband</td><td>182</td><td>7%</td><td>12</td><td>15</td><td>13</td></tr>
<tr><td>Falls</td><td>220</td><td>9%</td><td>21</td><td>18</td><td>14</td></tr>
<tr><td>Physical Injury</td><td>363</td><td>15%</td><td>31</td><td>30</td><td>20</td></tr>
<tr><td>Aggressive Behavior</td><td>273</td><td>11%</td><td>18</td><td>23</td><td>24</td></tr>
<tr><td>Psychiatric Emergency</td><td>256</td><td>10%</td><td>23</td><td>21</td><td>10</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		<table><tr><td>Property Destruction</td><td>41</td><td>2%</td><td>3</td><td>3</td><td>4</td></tr><tr><td>Abuse/neglect/ exploitation</td><td>51</td><td>2%</td><td>7</td><td>4</td><td>2</td></tr></table> The total number of reported unusual incidents in February 2012 is 155, of which 145 were those where at least one individual in care was involved; 100 or 65% were major UIs; and 25 (16%) were high, 81 (52%) were medium, and 49 (32%) were low in severity. The 145 patient-involved UI included a total of 99 unique individuals in care, which is about 33% of the total inpatients served by the Hospital for at least one day in February 2012. The number/percentage of individuals in care repeatedly involved in UIs decreased in February. Thirteen (13) individuals were involved in >= 4 UIs which is the third lowest number reported in 12 months. In February, the number of reported physical assaults was 22, the lowest number in the last 12 months. Over half of the total UIs (52%) took place during day shift (between 7:00am and 3:00pm) in the 12 month period. The peak times were between 8:00am and 9:00am and 8:00pm and 9:00pm. On average, the top five units where most of the major Unusual Incidents took place in 12 months are the admissions and geriatric units. Reported UIs went up significantly in March 2012 (the first month of the new reporting period), largely due to nursing substantially improving its reporting of medication and/or vital signs refusals.
XII.E.1.	Track trends by at least the following categories:	
XII.E.1.a	type of incident;	
XII.E.1.b	staff involved and staff present;	
XII.E.1.c	individuals involved and witnesses identified;	
XII.E.1.d	location of incident;	
XII.E.1.e	date and time of incident;	
XII.E.1.f	cause(s) of incident; and	
XII.E.1.g	actions taken.	
XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing. the individual's current treatment regimen.	**Recommendation:** Revise the High-Risk Indicator Tracking and Review policy as planned by the hospital and to also address the issues raised above. SEH Response: The Hospital's Performance Improvement Committee reviewed the High Risk Policy Tracking and Review Policy and considered the recommendations by the DOJ consultant. It modified the Policy to clarify the process when a treatment team psychiatrist does not complete the timely note required by the Policy and to distinguish between sexual assault and sexual behavior. It also added fire setting as a high risk category and modified some of the time frames for removal from a high risk list. ***See Tab # 129 High Risk Tracking Policy.*** However, the Hospital is not implementing the changes recommended that criteria for high risk behaviors separately include recent history of falls or suicide attempts. These criteria are specifically included in a Comprehensive Fall Assessment and in the suicide assessment found in the IPA, and clinical staff believe that is the appropriate mechanism to capture the data.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Recommendation:** Consider reformatting the High Risks lists to make them easier to read when posted on a wall, as is the hospital's expectation. Consider removing the risk factors that are not relevant for the particular unit. This will also permit the use of a larger font and larger check boxes. SEH Response: The Hospital modified the list to the extent possible to make it easier to read, but decided not to remove risk factors that may not apply in a given week to a unit since that may change week to week and staff prefer to see the entire list of risks on the high risk list.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.	**QUALITY IMPROVEMENT**	
	By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	
XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	
XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Recommendations:** 1. Continue to comprehensively study factors that impact the safety of individuals in care in an effort to identify root causes. Track outcomes of corrective measures implemented. SEH Response: Ongoing. The PRISM report is completed monthly and tracks identified indicators. ***See Tab # 43 PRISM report*** The Annual Trend Analysis also was completed during this review period. ***Tab # 41 Trend Analysis*** The Hospital also produces several other monthly trend reports, including the UI report and the Pharmacy report. ***See Tab # 76 Pharmacy and Therapeutics Committee Report and Tab # 121 UI Monthly Report*** In addition, the Hospital held 14 clinical consultation committee (CCT) meetings and 7 SERC committee meetings during the rating period. Recommendations from various Hospital committees and investigations continue to be tracked. During last review period, in an effort to get a better understanding of the incidents of violence, the Hospital conducted an analysis of incidents of all aggressive acts (to include physical assault, aggressive behavior, self-injurious behavior and destruction of property) occurring between October 1, 2010 through May 31st, 2011. The data analysis included a review of clinical characteristics of individuals who had 1 or more aggressive acts during this period, as well as a review of incidents by type, location, and by time of day. The study also included a review of the clinical characteristics of the individuals who are aggressors. Following this review PID reviewed the medical records of the 13 individuals in care with 8 or more incidents using an audit tool. Data from the studies was shared with Executive staff, PIC and clinical leaders. The study resulted in 7 recommendations covering a variety of topics, including training and IRP content. Of the 7 recommendations, 6 are ongoing or were completed during this rating period. These include: routinely reviewing diagnoses as part of the IRP process (ongoing and monitored through IRP observations), modifying IRP objectives and interventions when there is a lack of progress (ongoing and monitored through clinical chart audits), determining barriers for staff implementation of comfort plans and IBIs (ongoing, changes were made to the form and Avatar fixes are in testing), addressing trauma through IRP objectives and interventions (ongoing and monitored through clinical chart audits), review and update of High Risk Tracking and Review Policy (completed) and reviewing the findings for the eight IICs with the treatment teams (completed). The PBS refresher training curricula is being slightly modified to include for additional information on how to work with individuals with an MR or cognitive diagnosis; that training was deferred while nursing staff completed recovery and Safety Care training. The PBS team will be adding information about effective

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		interventions for those with cognitive issues as part of its refresher training. During this review period, the Hospital continued its focus on understanding the incidence of violence at the Hospital. In the Fall 2011, PI staff began to notice that since the adoption of Safety Care by the Hospital, Unusual Incident Report (UI) narratives improved. Many UI reports included a more robust account of the interventions that were used during an aggressive incident and/or during and after an assault. Subsequently, PID staff reviewed approximately 200 UI reports which showed that in psychiatric emergencies where interventions were employed, fewer resulted in a subsequent assault. In contrast, the review of UI reports describing actual assaults revealed that based upon the UI narratives, very few interventions were used prior to the assault occurring. (Several interventions, however, were used post assault, predominately change of location and IM medication administration). ***See Tab # 117 Violence Reduction Materials.*** Thereafter, PID considered a more detailed study of these incidents to evaluate if the quality and quantity of interventions were improving as Safety Care was implemented and if they were positively impacting outcomes. However, based upon input from the CNE and results of a Sentinel Event Review Committee (SERC) meeting held to review two incidents involving significant staff injuries, the scope of the proposed study was modified to focus instead on an emerging trend - - while the overall number of assaults was decreasing, assaults against staff seemed to be increasing, and the severity of the assaults likewise was increasing. PID thus revised its study question to look at assaults against staff between November 1, 2011 and January 31, 2012 that resulted in an injury. PID staff looked at 16 cases using a tool to determine if there were missed opportunities to address issues before the assault. The review included a review of IRPs, psychiatric care and nursing care. The study, although limited in time and scope, revealed a number of trends about involved IICs, IRPs, medication management and staffing. For example, involved IICs tended to be younger than the general Hospital population (35 years old versus 55 years old), lengths of stay were shorter, and a higher percentage of involved IICs carried a mood disorder diagnosis than does the Hospital's general population. The majority involved IICs were not on a high risk list prior to the assault against staff but the clinical formulations prior to the incidents did indentify risk of violence. Half of the cases presented some type of issue related to medications prior to the incident. Half also received STAT medication within the 30 days prior to the incident. Other findings and recommendations can be found in the report. ***Tab # 127 Assaults on Staff.*** The Hospital is continuing to implement its PID/House partnership project; both unit-based and PID staff have enthusiastically embraced this project. Each house is assigned two liaisons, to include a staff member from PID and one from OSR. PID and OSR staff have been meeting monthly, at the same time each month, with house staff to review the units' PRISM and UI data, provide policy updates, relay information about Hospital projects, learn from unit staff the challenges they are facing and respond to their requests for support. Also added to the data review during this review period was data around reporting of ADR and MVR. The UI data continues to be broken down to the unit level, trends are noted and specifies type of UIs are compared with the incidence with the Hospital generally PID provides specifics of the incidents as requested by the units, including the specific individuals in care involved and time of incident. Each team is provided with minutes that summarize the meetings and issues are tracked for presentation to PIC etc. During the meetings, staff from the units raised the issue of how to get this information to evening and night staff; PID decided to create a bulletin board in staff areas so it could post such information on each unit. Among the issues identified by unit staff were staffing levels, communication, contraband, violence, food, data, UI reporting and policies. ***See Tab # 126 Unit Partnership documents.*** PID also is taking data from the IRP observation and discharge audits directly to discipline heads

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		for their information and action steps as needed. Other performance related projects are continuing. The Director of Psychiatric Services reviews the care of those individuals who reach the threshold of three major UIs in a month, and the recommendations are entered into a progress note in Avatar and also captured by PID in a tracking spreadsheet. Twenty nine of thirty four of the cases that required review by the Director of Psychiatric Services have completed reviews. In December, 2011, PID began presenting fall and assault data to the Risk Management Committee each month. ***See Tab # 124 Risk Management and Safety Committee Minutes.*** PID and the Office of Statistics and Reporting also support the various audits required under the Agreement; PID staff conduct the transfer, discharge, restraint/seclusion audits, observe IRP conferences, do data related data analysis and special studies. The Office of Consumer Affairs continues to work on improving satisfaction with the food services at the Hospital. ***See Tab # 132 Six Sigma Food Project.*** Over the last six months, the project has continued and actions taken included: 1) revision of the survey tools and methodology of the surveys; 2) increased the amount of food by adding 100 calories to breakfast and adding a fruit snack between the end of breakfast and the mid morning snack; 3) implemented a sandwich chosen by the individual for lunch every other Wednesday; 4) created specific breakfast times to allow choice for the individual; 5) added display of menus at the TLCs and publicized many of the initiatives among others. Finally, it should be noted that the Director of the Performance Improvement Department resigned effective March 24, 2012 to pursue an opportunity in the private sector. The Hospital is taking the opportunity to make some changes to PID's organizational structure to more closely resemble the structure post-DOJ case. However, the overall staffing of the Department will not be reduced.
XIII.B.1	disseminating corrective action plans to all persons responsible for their implementation;	**Recommendations:** Follow the recommendations cited above in the Recommendations database. SEH Response: Ongoing. Database is maintained and updated regularly. Added to the database during this review period were recommendations emanating from investigation reports, the Aggression study completed in the Fall 2011, and recommendations from Risk Management Committee around falls and assaults. Of the 7 recommendations from the Aggression review completed in the Fall 2011, 6 are ongoing or were completed during this rating period and one is in the planning stage. Those completed include routinely reviewing diagnoses as part of the IRP process (ongoing and monitored through IRP observations), modifying IRP objectives and interventions when there is a lack of progress (ongoing and monitored through clinical chart audits), determining barriers for staff implementation of comfort plans and IBIs (ongoing, but changes made to form and Avatar fixes are in testing), addressing trauma through IRP objectives and interventions (ongoing and monitored through clinical chart audits), review and update of High Risk Tracking and Review Policy (completed) and reviewing the findings for the eight IICs with the treatment teams (completed). The Training Department is working to create additional opportunities for training staff on how to work with individuals with an MR or cognitive diagnosis; that training was deferred while nursing staff completed recovery training. Recommendations from the recent Assault on Staff review are awaiting presentation to Executive staff as of the writing of this report.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>XIII.B.2</td><td>monitoring and documenting the outcomes achieved; and</td><td>

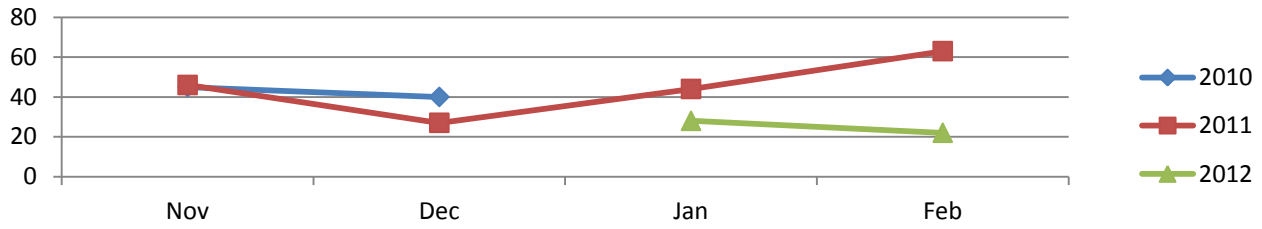
Recommendations:

Continue implementation of initiatives aimed at reducing violence and improving the quality of care provided.

SEH Response: See XIII.B above. While the issues have not been fully resolved, data shows a significant decrease in the number of physical assaults, which have been at less than half the October 2011 over the last three months. Further, in comparing assault data from the same month a year before also shows a significant decline in assaults from the same time last year.

Data shows:

<table>
<tr><th colspan="8">PHYSICAL ASSAULT COMPARISON DATA FROM PRIOR YEAR</th></tr>
<tr><td>Nov 10</td><td>46</td><td>Dec 10</td><td>40</td><td>Jan 11</td><td>44</td><td>Feb 11</td><td>63</td></tr>
<tr><td>Nov 11</td><td>45</td><td>Dec 11</td><td>27</td><td>Jan 12</td><td>28</td><td>Feb 12</td><td>22</td></tr>
</table>



Aggressive Act
*These totals include property destruction, self-injurious behavior, physical and sexual assault and non-physical contact aggressive behavior.

Sept	Oct	Nov	Dec	Jan	Feb
101	114	74	52	51	51

</td></tr>
<tr><td>XIII.B.3</td><td>modifying corrective action plans, as necessary</td><td>

Recommendation:

Continue current practice.

SEH Response: Ongoing. PID maintains a database that tracks recommendations emanating from various hospital committees, special studies, and investigations. PID manages the database, and tracks the status of approved recommendations. ***See Tab # 118 PID Project List, Tab # 119 Summary of Recommendation Tracking Database.***

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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Recommendation:** Continue current practices. SEH Response: Ongoing.
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation	**Recommendation:** Consult with house staff asking whether another format for presenting PID data might be more helpful to them, e.g. presentation of the house's incident history over time in graph form with a trend line, so that staff can assess their progress in reducing incidents, particularly those related to violence and injuries. SEH Response: Complete. Trend lines are used for unit data presentations.
XIII.C.2	monitoring and documenting the outcomes achieved; and	**Recommendations:** Continue maintaining a focus on decreasing aggression and monitoring progress or lack thereof. SEH Response: Ongoing. See XIII.B. B.1 and B.2.
XIII.C.3	modifying corrective action plans, as necessary.	**Recommendations:** Continue current review process for recommendations aimed at reducing violence and improving the quality of care and the quality of life of individuals in care. SEH Response: Ongoing. See XIII.B.
XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Recommendation:** Continue identification and implementation of Performance Improvement Initiatives and evaluate outcome. SEH Response: Ongoing. See XIII.B, B.1 and B.2.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIV.	**ENVIRONMENTAL CONDITIONS**	
	By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	
XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	
XIV.B	By 36 months from the Effective Date hereof, SHE shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	
XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	
XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory .individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.	
XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	
XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair	.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	