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

Saint Elizabeths Hospital Compliance Report 8

October 06, 2011

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 conference improved from just 60% during last review period to 84 % during this review period. A similar improvement is

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>noted in the invitation of community case workers, with the mean improving from 77% in the prior review period to 87% during this review period. Social workers have been 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, 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>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C[1]</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>167</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>20</td><td>19</td><td>15</td><td>11</td><td>11</td><td>18</td><td>16</td></tr>
<tr><td>%S</td><td>9</td><td>9</td><td>8</td><td>7</td><td>6</td><td>5</td><td>11</td><td>7</td></tr>
<tr><td>%C Data fields: Family Member invited?</td><td>88</td><td>89</td><td>78</td><td>60</td><td>100</td><td>75</td><td>60</td><td>84</td></tr>
<tr><td>%C Data fields: Community support worker invited</td><td>88</td><td>75</td><td>88</td><td>100</td><td>100</td><td>89</td><td>77</td><td>87</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)
Targeted Sample size is 11, one per unit
See Tab # 7 for 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. 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 at this time.</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.

SEH continues to audit social work attendance at IRP conferences through monthly observations by a core group of coaches/observers. Results are shared with discipline chiefs for follow up. The mean for attendance by social workers at IRP conferences dipped slightly during this review period due to the vacancies, falling from a mean of 88% during the prior</td></tr>
</table>

[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>review period to a mean of 83 % during this review period. (Social worker attendance at IRPs dipped significantly in June, 2011 due to the vacancies and vacation schedules of the remaining staff but was above 90% in both July and August, 2011.) Attendance continues to be monitored through the IRP audits, but it is expected to reach over the 90% level now that the department is at full staffing.

Facility's Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>167</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>20</td><td>19</td><td>15</td><td>11</td><td>11</td><td>18</td><td>16</td></tr>
<tr><td>%S</td><td>9</td><td>9</td><td>8</td><td>7</td><td>6</td><td>5</td><td>11</td><td>7</td></tr>
<tr><td>%C Data fields: Social work Attendance</td><td>77</td><td>85</td><td>89</td><td>67</td><td>91</td><td>91</td><td>88</td><td>83</td></tr>
</table>

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>167</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>20</td><td>19</td><td>15</td><td>11</td><td>11</td><td>18</td><td>16</td></tr>
<tr><td>%S</td><td>9</td><td>9</td><td>8</td><td>7</td><td>6</td><td>5</td><td>11</td><td>7</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>95</td><td>100</td><td>100</td><td>87</td><td>100</td><td>91</td><td>95</td><td>96</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 for 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 remained above 90% for this particular requirement. With a full complement of social workers, their attendance should continue to improve. 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 (new tool indicator # 7). Data from the audits shows excellent performance on this requirement, with the mean 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, indicator # 2, instructions to ensure that if applicable, 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- 8/31/11)

Discipline	# Required	# Attended	# Competent	% Attended	% Competent
Medical	5	5	5	**100**	**100**
Nursing - RN	43	43	42	**100**	**98**
Nursing - RA	2	2	2	**100**	**100**
Administrative	1	1	1	**100**	**100**
Other	1	1	1	**100**	**100**
Total	**52**	**52**	**51**	**100**	**98**

** 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 # 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.

SEH Response: Ongoing. The Hospital addressed this recommendation by amending its clinical chart audit tool, at indicator # 2 to include specific instructions that the present status section of the clinical formulation must include, 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, so there

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

is no data yet available from the clinical chart audit to reflect this. However, it is also monitored through the psychiatric update audits.

Facility's Findings:

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**
%S	12	14	12	14	8	13	**11**	**12**
%C # 21 Does the psychiatric update include an appropriate plan that includes integration of behavioral and psychiatric interventions?	100	94	100	100			**99**	**98**
%C # 1 (NEW TOOL) Does the Update adequately address the significant developments in the individual's clinical status since the last Update?	100	97	100	100	100	97	**100**	**98**
%C # 7 (NEW TOOL) 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	*	**98**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
* Was not available during prior review period.
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

This requirement will be included within the below indicator in the clinical chart audit as well beginning with the next review period.

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%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.	76	63	69	91	75	67	*	**74**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N = Total number of IRP reviews scheduled n = number audited * The mean from the prior period is not available; this question had inter-rater reliability issues during the prior review period and data was determined not to be valid. 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. This was also added to the clinical chart audits, beginning in September 2011.
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 during this review period, from a mean of 81% to 86%. The IRP related timeliness reports are next in the queue for Avatar development and are expected to be completed this Fall, 2011. In the meantime, performance on this requirement is tracked through the clinical chart audits. Audit findings are

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>now reviewed during the clinical administrators meetings and at the clinical leadership meetings. In addition, PID is including this data in their unit based data discussions and will work with staff to identify strategies for improvement. See Tab # 118 Performance Improvement Projects, House Support Project

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 below.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>95</td><td>92</td><td>94</td><td>81</td><td>75</td><td>80</td><td>81</td><td>86</td></tr>
</table>
N = Total number of IRP reviews scheduled
n = number audited
Targeted sample size is 26 reviews per month (2 per unit)
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data shows 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.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See data below. (The District and DOJ agreed data need not be presented for initial psychiatric assessments.)

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								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	7	7	8	6	8	9	**6**	**8**
%S	19	18	22	24	22	20	**19**	**21**
%C. #2. Initial nursing assessments are completed within 8 hrs of admission	57	71	50	67	75	78	**85**	**67**

N = Number of admissions during the month
n = number audited
Tab # 3 CINA AUDIT RESULTS

INITIAL PSYCHOLOGICAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	2	7	7	8	11	4	**5**	**7**
%S	5	18	19	32	31	9	**15**	**18**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	100	100	100	63	100	67	**52**	**87**
%C # 1 (Part B) If Part B completed within 12 days of admission?	33	0	0	75	33	100	**43**	**35**

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								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**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>8</td><td>8</td><td>7</td><td>5</td><td>7</td><td>9</td><td>7</td><td>7</td></tr>
<tr><td>%S</td><td>22</td><td>22</td><td>19</td><td>20</td><td>19</td><td>20</td><td>21</td><td>20</td></tr>
<tr><td>%C # Completed within 5 days of admission</td><td>88</td><td>75</td><td>86</td><td>60</td><td>100</td><td>100</td><td>78</td><td>86</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: Social work has improved in timeliness of initial assessments (from 78% to 86%) even though it had three vacancies for much of the review period. Now that the social work department is fully staffed, it is expected that at least 90% of their initial assessments will be completed timely. The social work supervisors will continue to audit this requirement and address issues with individual social workers as they arise.

The timeliness of the initial assessment completed by nursing fell during this review period, but it is not clear why. Nursing continues to believe the timeliness of the CINA will be impacted positively by modifying the initial assessment form; it is dividing the form into a Part A (to be completed in 8 hours) and Part B (to be completed in 24 hours). Nurses are often unable to complete the form within 8 hours in a number of cases due to the circumstances of admission – at times the individual is uncooperative or sleeping, so the form is not completed and could not be saved as final in Avatar. The CINA in Avatar was modified during the review period into a Part A and Part B, but during testing, additional issues with the assessment were found and additional changes were requested by Nursing in September, 2011 which are in development. In addition, the nurse who completed most of the CINAs retired in August 2011, so the Hospital is now expecting RNs on admission units to complete the CINAs; by having more individuals to complete the forms, timeliness may improve. Nursing will continue to monitor this requirement through the CINA audits.

Psychology substantially improved its completion of Part A of the IPA, going from 52% during the last review period to 87% during this review period, but continues to struggle with timely completion of Part B of the IPAs, in part due to staff shortages. In late August, 2011, the Hospital finally received authority to recruit for the three vacant psychology positions. The positions were announced in August and selections made, pending reference checks. In the meantime, Psychology will continue to monitor this requirement through audits.

The Hospital is continuing also to work on the issue of staff inadvertently saving documents in “draft” when in fact they mean to save the document as final. (Generally, an assessment in draft is not considered timely in the audits.) Reports are available to managers to review those assessments that remain in draft status and data shows that the number of assessments in draft status is decreasing. Further, new functionality was added to Avatar which creates a “My To Do” List and prompts users to look to see what documents are due are in draft. This function will be expanded over the next few months to allow supervisors to access workers “To Do Lists”. Further, audit instructions were revised by some disciplines so that assessments that remain in draft status would be rated as timely ***if*** the assessment specifically reflects that the reason the assessments could not be completed was due to the unavailability/uncooperativeness of the individual in care.
</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</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	consistent with treatment plan meetings.	
V.B.3	individuals are informed of the purposes and major side effects of medication;	
V.B.4	each treatment plan specifically identifies the therapeutic means *by* which the treatment goals for the particular individual shall be 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, 29 of 36 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.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See below.

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%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.	76	63	69	91	75	67	*	**74**

N = All IRP reviews scheduled in the review month
n = number audited
* Data analysis from the prior review period suggested that auditors had different interpretations of the question and thus results were invalid. The question has been revised effective with March clinical chart audits

Tab # 2, CLINICAL CHART AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**
%S	12	14	12	14	8	13	**11**	**12**
%C #10 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	100	97	100	100			**100**	**99**
%C # 11 Does the diagnosis reflect current clinical data or was it changed or updated based upon change in current clinical data?	96	100	97	100			**99**	**98**
%C # 18 Does the pharmacological plan of care reflect the diagnoses, mental status assessment and individual's response to treatment?	100	91	100	100			**99**	**98**
%C # 22 Does the update adequately analyze the risks and benefits of the chosen treatment interventions?	100	100	100	100			**99**	**100**
%C # 7 (new tool) 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		**98**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>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. Also, in April 2011, the Hospital modified the Psychiatric Update 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. As with the clinical chart audit, the Hospital modified its Psychiatric Update audit tool to reduce the number of indicators while still focusing on key aspects of clinical care. Essentially, indicators # 10, 11, 18 and 22 of the Psychiatric Update audit were combined into a new indicator # 7 that assesses the overall plan of care. The Psychiatric Update audits show high levels of compliance on this requirement. These audits will continue.</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 and the post - discharge services audits completed by MHA. 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 to 1 per unit. Tool was modified 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.</td></tr>
</table></td></tr>
</table>

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 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 and 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 review period, the Hospital decided that for the upcoming review period it 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 during this review period, but these will be included in audits beginning in September 2011.
		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. Tool was slightly modified in March 2011 to correct grammar in question 6.
		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.
		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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Co-occurring disorder audit	Target is 10%	Question # 5 relating to discharge criteria was eliminated as the information is collected in other audits.
		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 this 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 all those with a TD diagnosis.
		Co-occurring disorder IRP audit	Ongoing. Target it 20% sample	Last question was eliminated.
		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 question was added beginning with June audits to track communication of results to team.
		Psychology Evaluation	Ongoing for review period. Target is 1 per psychologist who completes them.	No changes to the tool, except question was added beginning with June audits to track communication of results to team.
		IBI/PBS Plan Audit tool	At least a 50% sample	No changes to the tool.
		BI Progress Note Audit	New tool, 20% sample	New tool was created and audits begun to assess if BI-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 additional 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 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.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th colspan="3">PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td colspan="3">
<table>
<tr><td>SW Update audit tool</td><td>Ongoing review period. Target is 1 per social worker.</td><td>Tool was substantially revised. 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.</td></tr>
<tr><td>Emergency Involuntary medication audits</td><td>Audits began in October 2010. Target is 20%.</td><td>No change in tool.</td></tr>
<tr><td>CINA audits</td><td>Ongoing for review period. Target is 20%.</td><td>Old tool was used through August 2011. New tool will be developed once revised CINA is completed.</td></tr>
<tr><td>Nursing Update audits</td><td>Ongoing for period. Target is 2 per unit.</td><td>Old tool was used through August 2011. New tool will be developed once revised CINA is completed.</td></tr>
<tr><td>Seclusion and restraint audit</td><td>Target is 50% of cases.</td><td>Tool was simplified to track only the remaining requirements of the Settlement Agreement.</td></tr>
<tr><td>Discharge record audit tool</td><td>Ongoing. Target is 10%. Sample was modified to exclude pretrial forensic individuals here for competency exams.</td><td>Tool was simplified to track only the remaining requirements of the Settlement Agreement.</td></tr>
<tr><td>Inter-unit transfer audit tool</td><td>Ongoing. Target is 20%.</td><td>No change in tool during this review period.</td></tr>
<tr><td>Group facilitator observation audit tool</td><td>Ongoing. Target is one per group leader per 4 months.</td><td>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.</td></tr>
<tr><td>DMH post discharge audits</td><td>Monthly</td><td>No changes to the tool.</td></tr>
</table>

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</td><td colspan="3"></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>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>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>80</td><td>74</td><td>95</td><td>90</td><td>90</td><td>87</td><td>57</td><td>86</td></tr>
</table>
N = All IRP reviews scheduled in the review month
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 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, which was designed to address deficiencies noted by DOJ in its report and exit conference. 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. The modified Clinical Chart Audit Feedback Form is being used by the clinical chart auditors. 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</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>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>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</td></tr>
<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>76</td><td>63</td><td>69</td><td>91</td><td>75</td><td>67</td><td>*</td><td>74</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>80</td><td>74</td><td>95</td><td>90</td><td>90</td><td>87</td><td>57</td><td>86</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)</td></tr>
</table>

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

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 is now being used by 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. ***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><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>80</td><td>74</td><td>95</td><td>90</td><td>90</td><td>87</td><td>57</td><td>86</td></tr>
</table>

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. In February 2011, the Hospital provided intensive training to each treatment team on developing the parts of the clinical formulation related to discharge – those sections addressing discharge criteria, discharge plans and discharge barriers. With the consultant's assistance, each team took a case and reviewed the specific discharge related issues and redrafted the clinical formulations. Staff were trained on the differences between discharge criteria, discharge plans and discharge barriers. ***See Tab # 1, IRP training data and materials.*** In

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		March 2011 and April 2011, a multi-day training was held with the clinical administrators and social workers to reinforce discharge planning. Consultant trainers helped revise clinical formulations selected by the teams. All of the clinical administrators and social workers attended this training. This was in an effort to align the social work comprehensive initial assessment and the social work update with the clinical formulation. In addition, 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. 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: The Hospital has undertaken a number of steps to improve medical and nursing care, with a focus on earlier identification of changes in physical status as well as 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 medical officer and two nurse practitioners; and a geriatric cluster, with a general medical officer and two nurse practitioners. The medical practitioners will rotate sick call coverage each day, with a goal on ensuring all members of the team have some degree of familiarity with each individual in care, although each will also have a caseload. Nurse practitioners meet with the Chief Nurse Executive quarterly. In addition, nursing has hired three of six quality nurse educators (QECs) who are working to enhance nursing skills on the unit level. The QECs partner with the nurse manager for each unit and provide clinical coaching and support through education, role modeling and supervision. The goal is to create a quality loop beginning with education, then moving to practice, monitoring and compliance. QEC nurses educate staff regarding policy and procedure updates, facilitate staff in achieving competencies through a teach-model-support framework and assist in the design of unit programming. They provide real time monitoring and auditing of clinical processes, collect data for improvement purposes and provide hands on coaching during and proximally to activities such as transfers, changes in physical status, documentation, IRP planning, EARN contacts and emergencies. Each QEC is assigned to two units. To date, three have started and are working with staff on the geriatric and the four admission units. The QEC nurses hired to date have been working directly with unit staff around documentation, change in shift report, nursing role in the IRP, changes in physical status, medical transfers,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		educating staff around clinical skills (e.g. listening for bowel sounds, taking and interpreting vital signs), communicating with physicians and similar activities, depending on the unit needs. Tools to provide QECs with a checklist for structured review of cases were recently developed; one for monitoring the completion of the RN change in physical status formand medical transfers which will look, *inter alia*, at whether indications were missed and a second review tool around STAT medication use and whether opportunities for earlier interventions were missed; these will be implemented in October. ***See Tab # 104 (Change in Physical Condition); Tab # 110 (Emergency Involuntary Medication) and Tab # 111 (STAT Medication)*** To date, QECs report that staff seem more engaged with individuals in care, with fewer codes and improved attitude by staff. Staff also seem eager for training on how to do things correctly to improve the overall quality of care. During this period, the Hospital began to conduct morbidity reviews. In August, two cases were reviewed, one involving an individual in care with colon cancer and a second involving an individual with hyponatremia. The Committee expects to meet monthly beginning in September 2011 to look at morbidity issues. 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, 18 mock code blues have been held, across all shifts and most units. ***See Tab #125 Mock Code Blue Log*** Audits around history and physicals and medical transfers continue. See data below. In addition, the Hospital recently created a form 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 form.*** The form 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 to the individual's plan of care. The form started being used October 1, 2011. Nursing also developed a form for use upon an individual's return from a medical facility. ***See Tab #87 RN Transfer from Medical Facility*** Nurse managers and the new QEC nurses are reviewing the forms and, where needed, are coaching nursing staff on the scope of appropriate follow up interventions and documentation. In addition, nursing implemented use of a new form titled RN Change in Physical Status as part of the implementation of the updated Assessing Change in Physical Status Nursing Procedure. ***See Tab # 105 Assessing Change in Physical Condition Nursing Procedure and related form.*** Under the revised procedure, 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. As with the form for return from a medical facility, nurse managers and the QEC nurses are reviewing the completed forms and providing coaching. Nursing developed a review tool for use by the QECs in assessing RN practice around changes in physical status. ***Tab # 104 Checklist to Review Nursing Medical Transfer form*** 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 procedure, individuals requiring more than once daily insulin will be placed on short acting insulin and prn Lantus using a specific protocol. ***See Tab # 80 Insulin Administration Protocol.*** The Hospital is also seeking to hire a certified

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		diabetic educator to work with staff around diabetes management issues or alternatively, is considering contracting with a qualified nurse to write procedure and train staff. The Hospital is implementing the seizure management policy, and nursing has begun to utilize the recently 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 also can be found in FileNet. The Hospital also modified its procedures around notification of laboratory results. Now, laboratory personnel call the physician for the individual in care whenever any drug levels for therapeutic drugs are outside the normal range. In addition, all physicians are provided daily with a copy of the lab report received from Quest Diagnostics. This process will remain in place as the laboratory interface continues to proceed. 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 the half day training completed quarterly for new hires continues, but is now being provided on house by house basis, and existing staff are invited to attend "refresher" training as well. Mentoring and coaching continues through IRP observations and clinical chart audits and the clinical chart audit feedback form, and training consultants are continuing to work with those units for which issues have been identified. 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. SEH Response: See data below. V.D.6 was removed at the agreement of the parties. In addition, per the recommendation of DOJ to review the audit tools to remove/consolidate indicators, the Hospital modified the clinical chart audit tool. Instructions were modified in new indicator # 2, 3, 4 and # 5 so that now these indicators cover several requirements within the modified Agreement. For example, indicator 4 now includes within its scope an assessment of whether the IRP includes interventions that address treatment and rehabilitation and # 5 now includes an assessment of goals as well as objectives, which eliminated several indicators from the prior tool. However, at the end of the review period, the Hospital decided that, for the upcoming review period, it will include 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). There is no data for these indicators during this review period, but these will be included in audits beginning with September 2011. 4. Provide a summary outline of any significant changes in the number and types of groups offering cognitive remediation and substance use education.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response:

Cognitive Remediation Therapies/Groups Sept 10~ Feb 11		Cognitive Remediation Therapies/Groups Feb 11~ May 11		Cognitive Remediation Therapies/Group May 11~ Aug 11	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
252	1024 (857 enrolled as of Feb 2011)	213	912	243	1042 (936 enrolled)

Co-occurring Disorder Therapies/Groups Sep 10~ Feb 11		Co-occurring Disorder Therapies/Groups Feb 11~Aug 11		Co-occurring Disorder Therapies/Groups Aug 11 ~ present	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
64	394	60	390	60	353

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 built based upon the individual's diagnosis, IPA results, level of functioning, clinical formulation summary, and 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 made in their groups based upon the results of the reassessment.

Beginning in September 2011, the TLC Intensive implemented modified programming around competency for trial to include a weekly mock trial and four competency groups meeting daily each week. Additional changes were made in programming on the transitional side to expand transitional services for those preparing for discharge.

Facility's Findings:

HISTORY AND PHYSICAL AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	37	38	37	25	36	45	**31**	**36**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	0	11	12	6	5	5	**22**	**7**
%S	0	29	32	24	14	11	**69**	**26**
%C. # Timely completion	n/a	100	100	100	100	100	**95**	**100**
%C. # 1 Subsections on basic information completed	n/a	100	100	100	100	100	**100**	**100**
%C. # 2 Part II of H & P includes completed past medical history	n/a	100	100	100	100	100	**100**	**100**
%C. # 3 Immunization section is complete	n/a	100	100	100	100	100	**100**	**100**
%C. # 4 H & P includes complete and appropriate description of review of systems	n/a	100	100	100	100	100	**100**	**100**
%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings	n/a	100	100	100	100	100	**100**	**100**
%C. # 6 Neurological section is completed	n/a	100	100	100	100	100	**100**	**100**
%C. # 7 Cranial nerve section is completed	n/a	100	100	100	100	100	**100**	**100**
%C. # 8 Assessment section is completed and includes synthesis of relevant findings	n/a	100	100	100	100	100	**100**	**100**
%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.	n/a	100	100	100	100	100	**100**	**100**

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

MEDICAL TRANSFER AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	19	26	29	19	18	20	**20**	**22**
n	0	4	6	5	3	3	**2**	**4**
%S	0	15	21	26	17	15	**10**	**16**
%C. # 1 Subsections on basic information completed	n/a	100	100	100	33	67	**60**	**86**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses	n/a	100	100	100	67	67	**80**	**90**
%C. # 3 Reason for medical transfer is clearly indicated on the form	n/a	100	100	80	100	100	**100**	**95**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.	n/a	100	100	100	67	100	**100**	**95**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings	n/a	100	100	100	100	100	**100**	**100**
%C. # 6 All the most recent lab results were provided	n/a	100	100	100	100	100	**100**	**100**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted	n/a	100	100	100	100	100	**100**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 8 The allergy section is completed fully and accurately	n/a	100	100	20	33	67	**100**	**67**
%C. # 9 The form includes a brief description of current behavior and responses to treatment	n/a	100	67	0	33	0	**40**	**43**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer	n/a	75	100	100	100	100	**100**	**95**
%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.	n/a	100	100	100	100	100	**100**	**100**

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

CLINICAL CHART AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%C. # 5 The team revised the focus of hospitalization, objectives as appropriate to reflect the individual's changing needs.	81	65	81	86	75	73	**48**	**77**
%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.	76	63	69	91	75	67	*	**74**

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. 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 to provide additional examples of medically –related objectives and interventions. Audits will continue and additional steps will be identified if needed.

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

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</td></tr>
<tr><td>%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.</td><td>95</td><td>92</td><td>100</td><td>100</td><td>90</td><td>94</td><td>75</td><td>95</td></tr>
</table>
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 improved significantly. 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. 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. This requirement will be monitored through the ongoing clinical chart audits and additional action steps will be identified and implemented if needed.
</td></tr>
<tr><td>V.D.3</td><td>write the objectives in behavioral and measurable terms;</td><td>
Recommendations:

1. Same as above.
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>SEH Response: Same as above.

Facility's Findings:

Please note that this indicator was removed from the audit tool in March, 2011, and was not added back to the audits until Sept, 2011, so no data is available for this review period.

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td></td><td></td><td></td><td></td><td></td><td></td><td>195</td><td></td></tr>
<tr><td>n</td><td></td><td></td><td></td><td></td><td></td><td></td><td>22</td><td></td></tr>
<tr><td>%S</td><td></td><td></td><td></td><td></td><td></td><td></td><td>12</td><td></td></tr>
<tr><td>%C. #7. The IRP includes objectives written in behavioral and measurable terms</td><td></td><td></td><td></td><td></td><td></td><td></td><td>67</td><td></td></tr>
</table>
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: No data is available for this review period on this indicator. The indicator has been added back to the clinical chart audit and will be monitored beginning with the September 2011 clinical chart audits.</td></tr>
<tr><td>V.D.4</td><td>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;</td><td>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, although nursing is still lagging behind other disciplines. One strategy that was implemented was to schedule documentation time for nurses covering groups at the TLCs; this seems to have been more effective for Transitional TLC than Intensive TLC. Additionally, the number of groups provided by nursing staff also was decreased.

4. Continue to monitor this requirement and present aggregated monitoring data including comparative data and</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

analysis of low compliance with plans of correction, as indicated. Supporting documents should be provided.

SEH Response: See data below

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%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.	95	92	100	100	90	94	**75**	**95**

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

	Mar~May 11	Jun~Aug 11	**Mean-Jan~Feb**	**Mean-Mar~Aug**
N			**266**	
n total notes audited	157	163	**41**	**160**
Psychiatry	41	9	**8**	**25**
Psychology	33	38	**7**	**36**
Nursing	5	31	**9**	**18**
Social work	19	20	**8**	**20**
Rehab/chaplain	51	53	**19**	**52**
Clinical administrator	6	6	**n/a**	**6**
TLC	2	6	**n/a**	**4**
%S	61	65	**15**	**63**
%C. #1 Completed timely (all disciplines)	94	93	**90**	**93**
%C #2 Is the number of session scheduled indicated (all disciplines)?	100	100	**100**	**100**
%C #3 Is the number of sessions attended indicated (all disciplines)?	99	100	**100**	**100**
%C #4 Is the number of sessions attended equal to the number of sessions scheduled (all disciplines)?	62	55	**69**	**58**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		%C #5 If applicable, is there a specific reason why numbers (attended versus scheduled) are not identical (all disciplines)	85	95	**74**	**90**
		%C #6 Is the intervention (group name or individual therapy noted and is description of individual's participation level present and informative (all disciplines)	94	97	**96**	**96**

N= 90% of average daily census
n= total therapeutic progress notes audited.
Tab #34 THERAPEUTIC PROGRESS NOTE AUDIT RESULTS

Analysis/Action Plans: As reflected by the clinical chart audits performance improved significantly on this requirement. 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.

The Hospital implemented the therapeutic progress note audit revised at the end of the last rating 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) 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. The audit results suggest however, a high degree of non-attendance at therapeutic interventions.

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: This is now tracked through a management report. Data from house based groups is now included, although there remains some underreporting due to some group leaders failure to return attendance sheets. The report was modified to include some reference to length of stay, as 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 whom 20 hours of treatment is too much regardless of their length of stay. The Avatar module for tracking group scheduling and attendance is cumbersome and continues to pose challenges, and the Hospital is again researching alternative methods of tracking this data.

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

SEH Response: The 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.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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 Unite 1E. The data reflect TLC and unit based groups. However, data based on a 30 day LOS show:

Hours of Mall Groups SCHEDULED (June 2011 & Aug 2011)

	(June 5, 2011 - July 2, 2011)						(July 31, 2011 - Aug 27, 2011)						Mean (June 2011/ Aug 2011)	Mean (%) (June 2011/ Aug 2011)
Hrs	6/5	6/12	6/19	6/26	Mean	Mean (%)	7/31	8/7	8/14	8/21	Mean	Mean (%)		
N	243	245	244	247	**245**	**100%**	235	232	233	234	**234**	**100%**	**239**	**100%**
0 Hrs	11	13	10	13	**12**	**5%**	16	18	16	21	**18**	**8%**	**15**	**6%**
0.1-5 Hrs	13	14	22	20	**17**	**7%**	17	20	21	15	**18**	**8%**	**18**	**7%**
6-10 Hrs	20	21	13	16	**18**	**7%**	9	2	5	4	**5**	**2%**	**11**	**5%**
11-15 Hrs	43	26	19	15	**26**	**11%**	14	12	17	13	**14**	**6%**	**20**	**8%**
16-19 Hrs	25	20	17	12	**19**	**8%**	7	9	11	9	**9**	**4%**	**14**	**6%**
20+ Hrs	131	151	163	171	**154**	**63%**	172	171	163	172	**170**	**73%**	**162**	**68%**

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

Hours of Mall Groups ATTENDED (June 2011 & Aug 2011)

	(June 5, 2011 - July 2, 2011)						(July 31, 2011 - Aug 27, 2011)						Mean (June 2011/ Aug 2011)	Mean(%) (June 2011/ Aug 2011)
Hrs	6/5	6/12	6/19	6/26	Mean	Mean (%)	7/31	8/7	8/14	8/21	Mean	Mean (%)		
N	243	245	244	247	**245**	**100%**	235	232	233	234	**234**	**100%**	**216**	**100%**
0 Hrs	24	17	19	21	**20**	**8%**	20	19	27	53	**30**	**13%**	**22**	**10%**
0.1-5 Hrs	31	35	37	34	**34**	**14%**	33	33	35	92	**48**	**21%**	**36**	**17%**
6-10 Hrs	31	27	31	41	**33**	**13%**	29	18	25	48	**30**	**13%**	**28**	**13%**
11-15 Hrs	40	35	46	69	**48**	**19%**	43	34	40	5	**31**	**13%**	**36**	**17%**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

16-19 Hrs	36	38	46	34	**39**	**16%**	38	48	37	1	**31**	**13%**	**32**	**15%**
20+ Hrs	81	93	65	48	**72**	**29%**	72	80	69	35	**64**	**27%**	**62**	**28%**
N - Individuals with LOS over 30 days and over 60 days for unit 1E														

See Tab # 39 Treatment Hours Report

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

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P***	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%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.	95	92	100	100	90	94	**75**	**95**

N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period reflects only two months of audits.
** Sample size 2 per unit (22)
Tab # 2, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The Hospital continues to review data now available by individual's length of stay. The data shows improvement over the last reporting period in both hours scheduled and hours attended, although the hours are not as expected. For hours scheduled, the mean during this rating period shows that 68% of individuals in care were scheduled for 20 or more hours per week, and that an additional 14% were scheduled for 11 -19 hours per week. This compares with 11% scheduled for 20 hours or more during the prior period. For the attendance data, the mean shows that 28% attended 20 hours or more of treatment each day, and that an additional 15% attended 16 -19 hours of treatment. This compares with 13% attending 20 hours or more of treatment per week for the previous review period. It should be noted that this data does not include the treatment hours of those individuals who participate in a work adjustment training program. (That data is being added and a revised report will be available during the onsite visit.) Despite the progress, 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. Although NetSmart is updating its scheduling module which is expected to be available in the Winter, 2012, the Hospital will be exploring other systems to find one that is more user friendly.

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.*** Of the 25 individuals who fit this

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		category in May 2011, two have been removed from the list, 12 others have shown noticeable improvement in their participation in the TLC programming, and of the remaining 11, all are either showing some recent improvement in their level of engagement, are having their programming retooled, or are in the process of assessment relating to development or modification of behavioral interventions. The clinical chart audit shows significant improvement in formulating objectives and in tying the interventions to objectives. See V.D.4. In February 2011, there was additional training on writing focus statements, objectives and interventions, supplemented by coaching and review of written IRPs and clinical formulations. Further, coaching has been provided to clinical administrators, 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, 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 four groups per week and a weekly mock trial. On the TLC Transitional, there is expanded and revised discharge focused programming. This includes increased participation by peer transition specialists, 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 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 aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
SEH Response: See data below. Please note that the Hospital modified the clinical chart audit tool and combined related indicators during the review period. See Tab # 8 Clinical Chart Audit Tool, instructions and feedback form, which reflects changes made to the tool and instructions.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>81</td><td>65</td><td>81</td><td>86</td><td>75</td><td>73</td><td>48</td><td>77</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><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>167</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>20</td><td>19</td><td>15</td><td>11</td><td>11</td><td>18</td><td>16</td></tr>
<tr><td>%S</td><td>9</td><td>9</td><td>8</td><td>7</td><td>6</td><td>5</td><td>11</td><td>7</td></tr>
<tr><td>%C. # 7 Team bases progress reviews/revisions recommendations on clinical observation and data.</td><td>81</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>79</td><td>96</td></tr>
</table>
N = IRP reviews scheduled
n = number audited
* Mean for the prior review period reflects three months of audits
Tab # 7 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: The data shows much 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><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>N</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>80</td><td>70</td><td>83</td><td>100</td><td>100</td><td>83</td><td>86</td><td>87</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 generally good performance in meeting this requirement, and the trend shows improvement, as staff get 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. 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. Among the expectations is for teams to update the risk factors as part of the present status section of the clinical formulation as well as to develop 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, among others, when an individual has three or more major unusual incidents in a thirty day period. The Director of Psychiatric Services 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 is periodically reviewing 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 the writing of this report, there were 95 individuals in care on a high risk list. Twenty five individuals have been removed from the list during this period. Eleven individuals as of September 15, 2011, met criteria for clinical consultation team review, and of those, 6 have been held. See Tab # 128 Summary of High Risk Data.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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 # 30 Audit Sample Plan, 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 # #s 13 (CIPA Audit Tools) and 16 (Psychiatric Update Tools).*** **Facility's findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS
March through June 2011

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	8	8	8	8	7	11	**7**	**8**
%S	22	21	22	32	19	24	**21**	**23**
%C # 1 Data fields -CIPA completed within 24 hours of admission	100	100	100	100	100	100	**100**	**100**
%C # 4 (old tool) and # 2 (new tool) History of presenting illness	100	100	100	100	100	100	**100**	**100**
%C #6 Medical History obtained	100	100	100	100			**98**	**100**
%C #7 Information about medication obtained	50	88	100	88			**76**	**81**
%C #8 Information about allergies obtained	100	100	100	100			**93**	**100**
%C # 9 Substance abuse assessment completed, or reason provided	100	100	100	100			**98**	**100**
%C # 10 Family history includes	100	88	100	88			**95**	**94**
%C # 11 Social and development history included	100	100	100	88			**100**	**97**
%C # 12 MSE completed					100	100	**100**	**100**
%C #12a MSE section completed (physical appearance)	100	100	100	100			**100**	**100**
%C #12b MSE section completed (eye contact)	100	100	100	100			**100**	**100**
%C #12c MSE section completed (psychomotor activity)	100	100	100	100			**98**	**100**
%C #12d MSE section completed (attitude/behavior)	100	100	100	100			**100**	**100**
%C #12e MSE section completed (speech)	100	100	100	100			**100**	**100**
%C #12f MSE section completed (Mood)	100	100	100	100			**100**	**100**
%C #12g MSE section completed (Affect)	100	100	100	100			**100**	**100**
%C #12h MSE section completed (Perception)	100	75	100	100			**100**	**94**
%C #12i MSE section completed (Thought Processes)	100	100	100	100			**100**	**100**
%C #12j MSE section completed (Thought Content)	71	50	100	88			**83**	**77**
%C #12k MSE section completed (Sensorium)	100	100	100	100			**98**	**100**
%C #12l MSE section completed (Orientation)	100	100	100	100			**95**	**100**
%C #12m MSE section completed (Memory)	100	100	100	100			**98**	**100**
%C # 16 Diagnosis reflects clinical presentation	100	100	100	88			**100**	**97**
%C # 17 Individual's strengths noted	100	100	100	88			**98**	**97**
%C # 18 Appropriate pharmacological plan present	100	100	100	100			**100**	**100**
%C # 19 Risk/benefits associated with medication regimen addressed	100	100	100	100			**97**	**100**
% C # 21 Labs/consultations ordered as clinically indicated	100	100	100	100			**95**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 20 AIMS test administered	88	100	100	88			**83**	**96**

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

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS (revised tool)
July – August, 2011

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	8	8	8	8	7	11	**7**	**8**
%S	22	21	22	32	19	24	**21**	**23**
%C #1 Was the individual's chief complaint reflected in the CIPA?	100	100	100	100	100	100	**98**	**100**
%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, restraint/seclusion history, history of medication compliance) and information about adverse and therapeutic reactions to medications?					100	100	**100**	**100**
%C #4 Was the medical history obtained, including information about current medication, level of compliance and allergies?					100	100		**100**
%C #5 Did the assessment include a description of the patient's family, social and developmental history?					100	100		**100**
%C #6 Is each subsection of the MSE complete and accurate?					100	100	**100**	**100**
%C #7 Were the risk assessment subsections completed and include an appropriate plan to manage risks?					100	100	**100**	**100**
%C #8 Do the diagnoses reflect current clinical data and differential diagnoses?					86	100		**94**
%C #9 Does the plan section of the CIPA reflect the diagnoses, mental status examination results, results of risk assessment and does it include an appropriate rationale for prescription of any high risk medication regimen?					100	100		**100**
%C #10 Was an AIMS test administered?	88	100	100	88	100	100	**83**	**100**
%C # 11 If the assessment was completed by a psychiatric resident or trainee, is there a note from the					100	100		**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

attending psychiatrist that includes documentation that the individual was seen, examined and the case discussed with the resident or trainee?

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

PSYCHIATRIC REASSESSMENT AUDIT RESULTS
March 2011 through June, 2011

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**
%S	12	14	12	14	8	13	**11**	**12**
%C. #Data fields. Psychiatric update completed every 30 days	100	97	100	100	95	74	**99**	**94**
%C #3a MSE section completed (physical appearance)	100	100	100	100			**100**	**100**
%C #3b MSE section completed (eye contact)	100	100	100	100			**100**	**100**
%C #3c MSE section completed (psychomotor activity)	100	100	100	100			**100**	**100**
%C #3d MSE section completed (attitude/behavior)	100	100	100	100			**100**	**100**
%C #3e MSE section completed (speech)	100	100	100	100			**100**	**100**
%C #3f MSE section completed (Mood)	100	100	100	100			**100**	**100**
%C #3g MSE section completed (Perception)	100	100	100	100			**98**	**100**
%C #3h MSE section completed (Thought Processes)	96	100	93	100			**99**	**98**
%C #3i MSE section completed (Thought Content)	100	100	100	100			**99**	**100**
%C #3j MSE section completed (Sensorium)	100	100	100	100			**100**	**100**
%C #3k MSE section completed (Orientation)	100	100	100	100			**99**	**100**
%C #3l MSE section completed (Memory)	100	100	100	100			**99**	**100**
%C #4 Addresses significant developments since last update	100	94	100	100	100	97	**100**	**98**
%C # 5 Explanation for the STAT medication's benefits that outweigh their risks	0	100	100	100			**100**	**86**
%C # 6 Benefits and risks of restraint/seclusion explained	n/a	100	n/a	n/a			**n/a**	**100**
%C # 7 Adverse reactions noted as appropriate	100	94	100	100	100	90	**91**	**97**
%C # 8 Specifics and rationale for two or more anti-psychotics	100	90	100	100			**94**	**97**
%C # 9 Risk assessment sections accurately completed	100	97	100	100			**100**	**99**
%C #10 Psychiatric update reflects response to treatment/progress	100	97	100	100			**100**	**99**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 11 Diagnosis reflects current clinical data	96	100	97	100			**99**	**98**
		%C # 12 Axes completed in dx section	100	97	100	76			**99**	**93**
		%C # 13 Documented justification for R/O or NOS diagnosis	0	50	n/a	100			**86**	**78**
		%C # 14 Medication side effects, benefits and risks are explained	100	97	100	100			**100**	**99**
		%C # 15 Justification for using anti-cholinergics with dx of cognitive disorder	100	33	100	100			**97**	**91**
		%C # 16 Psych Update reflects lab levels obtained at appropriate interval	100	100	100	100			**99**	**100**
		% C # 17 Follow up abnormal lab levels	100	100	100	100			**99**	**100**
		%C # 18 Pharmacological plan of care reflects diagnosis, MS assessment and response to treatment	100	91	100	100			**99**	**98**
		%C # 19 Pharmacological plan addresses monitoring of FGA or SGA for adverse reactions/side effects	96	100	100	100			**100**	**99**
		%C # 20 Rationale for use of benzodiazepines in high risk categories	100	60	50	100			**100**	**86**
		%C # 21 Update includes integration of behavioral and psychiatric interventions	100	94	100	100			**99**	**98**
		%C # 22 Psychiatric update adequately analyzes risks and benefits of chose treatment interventions.	100	100	100	100			**99**	**100**
		%C #23 Note by attending doctor if update completed by trainee	75	100	100	100			**98**	**93**

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

PSYCHIATRIC UPDATE AUDIT RESULTS (revised tool) July – August, 2011								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**
%S	12	14	12	14	8	13	**11**	**12**
%C #1 Does the Update adequately address the significant developments in the individual's clinical status since the last Update?	100	94	100	100	100	97	**100**	**98**
%C # 2 Is each subsection of the MSE complete and accurate?					95	100		**98**
%C #3 Are the appropriate adverse reactions noted in the relevant subsection with respect to treatment with	100	94	100	100	100	90	**91**	**97**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		FGA or SGA anti-psychotics?								
		%C #4 Is polypharmacy (≥2 or more anti-psychotics or ≥4 or more psychotropics) correctly identified and is there an adequate rationale provided?					100	86		**89**
		%C #5 Were the risk assessment subsections completed and include an appropriate plan to manage risks?	100	97	100	100	100	100	**100**	**99**
		%C #6 Do the diagnoses reflect current clinical data and differential diagnoses?					100	100		**100**
		%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		**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?					0	67		**57**

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 and the Psychiatric Updates continue to be completed in a timely manner and show high performance in most indicators. In the CIPA audits, all but two indicators are above the 90% threshold; one of these is the indicator about obtaining medication information, which improved from the prior review period. The only indicator that was below 90% and that did not improve was the indicator concerning thought content, but the data trend suggests improvement toward the end of the review period. Similarly, the audits show improvement in the content of Psychiatric Update. Thirty-one of thirty-three indicators from the old tool were rated at 90% of higher and 6 of 8 indicators for audits completed using the new tool.

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 are being made in the CIPA in Avatar 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). However those changes were not in place during this review period.

See also VI.A.2, VI.A. 4, VI.6.a, VI.A.6.d, and VI.A.7.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.A.2	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;	**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:**

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	8	8	8	8	7	11	**7**	**8**
%S	22	21	22	32	19	24	**21**	**23**
%C # 13 Were the following specific subsections of the risk assessment completed								
a. risk of self injury	100	100	100	100			**100**	**100**
b. risk of completed suicide	100	100	100	100			**98**	**100**
c. risk of physical aggression	100	100	100	100			**98**	**100**
d. risk of sexual aggression	100	100	100	100			**98**	**100**
e. risk of elopement	100	100	100	100			**98**	**100**
%C # 14 Were appropriate precautions noted for each type of risk identified	100	100	88	100			**100**	**97**
%C #7 (NEW TOOL) Risk assessment completed					100	100		**100**

N = Number of admissions in the month
n = number audited- target is 20% sample per month
Tab # 14 CIPA 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">INITIAL PSYCHOLOGY ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>37</td><td>38</td><td>37</td><td>25</td><td>36</td><td>45</td><td>32</td><td>36</td></tr>
<tr><td>n</td><td>2</td><td>7</td><td>7</td><td>8</td><td>11</td><td>4</td><td>5</td><td>7</td></tr>
<tr><td>%S</td><td>5</td><td>18</td><td>19</td><td>32</td><td>31</td><td>9</td><td>15</td><td>18</td></tr>
<tr><td>% C Timeliness of IPA</td><td>100</td><td>100</td><td>100</td><td>63</td><td>100</td><td>67</td><td>50</td><td>87</td></tr>
<tr><td>%C #A7a Assess (screen) violence 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>#A7b Assess (screen) suicide risk</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>67</td><td>100</td><td>97</td></tr>
<tr><td>#A8a Findings violence risk</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>90</td><td>100</td></tr>
<tr><td>#A8b Findings suicide risk</td><td>100</td><td>100</td><td>100</td><td>100</td><td>75</td><td>100</td><td>97</td><td>94</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 with a mean of at least 97% for all sub-indicators. 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 50% to 87%. 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: There are only three, not five vacancies in the Psychology Department; the position number of one of the encumbered positions was previously used to fill a psychologist position and the second cannot be filled for legal reasons. The three vacancies were approved to be filled in late August, 2011 and selections were made for all vacancies. 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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	settings), and personality assessments.	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 the audit tool's instructions relating to Part B of the IPA were modified for the August 2011 audits. Specifically, in many cases, the individual in care is not willing to participate in the assessments conducted in Part B, and thus the psychologist is not able to complete them although multiple attempts are made to do so within the 12 day time frame. The data below for the period of March through July reflects such an occurrence as "not met"; instructions beginning in August 2011 now show those instances as not applicable IF there is a note reflecting attempts were made to complete the Part B assessment during the 12 day period. **Facility's findings:**

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	2	7	7	8	11	4	**5**	**7**
%S	5	18	19	32	31	9	**15**	**18**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	100	100	100	63	100	67	**50**	**87**
%C # 1 (Part B) If Part B completed within 12 days of admission?	33	0	0	75	33	100	**43**	**35**

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

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	2	2	3	4	2	2	**4**	**3**
n	2	1	3	1	2	2	**2**	**2**
%S	100	50	100	25	100	100	**50**	**73**
%C # 1 Completed within 30 days of receipt of referral?	0	100	33				**18**	**33**
%C # 1 a 30 days or less from date of referral to date of acknowledgement in referral				100	100	100		**100**
%C #1 b 60 days or less from date of acknowledgement to date of report				100	100	100		**100**
%C #16 a Form is attached as last page of evaluation	50%	100%	100%				**73**	**80**
%C # 16 There is a progress note in Avatar documenting delivery of report and feedback to the referral to the referral source.	*	*	*	100	100	100		**100**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

* New indicator in June, 2011

Tab #26 PSYCHOLOGICAL, NEUROPYSCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	2	6	2	7	1	2	**10**	**3**
n	1	6	1	3	1	2	**3**	**2**
%S	50	100	50	43	100	100	**27**	**70**
%C # 1a 30 days or less from referral to date of acknowledgment in referral database?	100	67	100	100	100	100	**54**	**86**
%C # 1b 60 days or less from acknowledgment to date of report?				67	100	100		**83**
%C # 13b Date the evaluation is discussed with the recovery team is listed	100	75	n/a	n/a	n/a	n/a	**80**	**80**
%C # 14 Progress note in Avatar documenting delivery of report				n/a	100	100		**100**

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	3	2		2	2	2	**4**	**2**
n	2	2		2	2	2	**2**	**2**
%S	67	100		100	100	100	**40**	**91**
%C #1 Completed within 45 days of referral	50	n/a					**70**	**50**
%C # 1a Picked up within 30 days of referral?	n/a	100		100	100	100		**100**
%C #1b 60 days or less from date of acknowledgement to date of report	n/a	50		100	100	100		**88**
%C # 11 There is a progress note in Avatar documenting delivery of report and feedback to the referral to the referral source.	*	*		n/a	100	100		**100**

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. The audit instructions relative to the IPA Part B were modified in August 2011 to reflect the fact that

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		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 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 a marked improvement in the timeliness of most types of psychological evaluations. For example, data from the IPA Part A show the timeliness improved significantly during this review period over the prior review period (from 52 % to 87%), the timeliness of psychological evaluations improved from 54% to 86% (using revised hospital policy timeframes), timeliness of risk assessments improved from 18% to 33% (and up to 100% using the revised hospital policy timeframes), although timeliness of neuropsychological evaluations fell from 70% to 50% in March using the previous timeframes (completed within 45 days) but improved to 88% between April and August 2011 using the revised timeframes (60 days from assignment to report completion). The Hospital continued its efforts to fill the vacant psychology positions, and, immediately following the approval to recruit for the vacancies in August 2011, announced the positions, and selections were made, pending reference checks. The Director of Psychology will continue to monitor the timeliness of the audits and will make further assignments as needed.
VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments, shall:	
VI.B.2.a	expressly state the purpose(s) for which they are performed;	
VI.B.2.b	be based on current, and accurate data;	
VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**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>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">RISK ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>2</td><td>2</td><td>3</td><td>4</td><td>2</td><td>2</td><td>4</td><td>3</td></tr>
<tr><td>n</td><td>2</td><td>1</td><td>3</td><td>1</td><td>2</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>100</td><td>50</td><td>100</td><td>25</td><td>100</td><td>100</td><td>50</td><td>73</td></tr>
<tr><td>% C # 13 a Summary/discussion that integrates all the data gathered into a clear clinical picture is present</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 #13 b Referral question is answered</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 # 13c Conclusions about the patient’s risk status are stated?</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 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, although performance on indicator # 13 d will need to be closely monitored. Audits will continue and psychology will monitor data and trends. No other actions required.
</td></tr>
<tr><td>VI.B.2.d</td><td>include determinations specifically addressing the purpose(s) of the assessment, and</td><td></td></tr>
<tr><td>VI.B.2.e</td><td>include a summary of the empirical basis for all conclusions, where possible.</td><td></td></tr>
<tr><td>VI.B.3</td><td>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.</td><td></td></tr>
<tr><td>VI.B.4</td><td>By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.</td><td></td></tr>
<tr><td>VI.B.5</td><td>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 for diagnosis and treatment.</td><td>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 the reports and the provision of feedback to the referral source. The various psychological audits are now tracking this as well.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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 RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	2	2	3	4	2	2	**4**	**3**
n	2	1	3	1	2	2	**2**	**2**
%S	100	50	100	25	100	100	**50**	**73**
%C # 16 There is a progress note in Avatar documenting delivery of report and feedback to the referral source.				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

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	2	6	2	7	1	2	**10**	**3**
n	1	6	1	3	1	2	**3**	**2**
%S	50	100	50	43	100	100	**27**	**70**
%C # 13b Date that the evaluation is discussed with the recovery team is listed.	100	75	n/a	n/a	n/a	n/a	**80**	**80**
%C # 14 Progress note in Avatar documenting delivery of report				n/a	100	100		**100**

N= Number of 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: 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 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 100 % compliance in communicating to treatment teams the results of risk assessments, 100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		compliance for results of psychological evaluations, and 100% for results of neuropsychological assessments. 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 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	**Recommendations:** 1. Continue with current corrective action plan.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	SEH Response: Ongoing. The Social Work Department continues to implement the corrective action plan submitted in March 2011 as well as the Strategic Plan provided to DOJ in July 2011. Turning first to staffing, all social worker vacancies were filled effective August 15, 2011. Attendance at the IRPs during this rating period (mean of 83% for IRP attendance for this review period), was adversely affected by the three vacancies but, with the filling of the positions in August 2011, the Hospital expects the attendance to reach 90% during this upcoming review period. Audit tools and instructions were updated, and data for audits also show improved performance in inviting community case workers (improved from 77% to 87%) and family (improved from 60% to 84%) to IRP conferences. Social workers were provided training around discharge issues and in the completion of the initial social work assessment; a similar training on completing the social work update is planned for Fall, 2011. The training included significant hands-on work. Social workers and clinical administrators were jointly trained on completing the discharge plan, discharge criteria and discharge barrier sections of the clinical formulation, using actual cases. Staff were trained on how to integrate the information from the social work initial assessments and updates, so that staff could see how that information could and should be used to drive discharge efforts. Social workers also were coached on how to use the current framework of the Avatar social work forms and still ensure all relevant information would be captured. The Director of Social Work is working with Avatar to revise the forms to link them better to the IRP, and to update the instructions. This work may be completed by the time of the onsite review. Weekly meetings with the MHA and the Community Integration Teams continue. In addition, beginning in September 2011, the TLC Transitional modified its program to improve discharge relating programming, and social work modified its curricula for discharge related groups to increase the focus on more practical skill building that will be needed by individuals in care when they return to the community. The TLC changes include an enhanced use of updated curricula for social work groups in the mall, and transition specialists will have an increased presence in the TLC and in working with individuals in care. In addition, chaplaincy will be working with individuals in care and community faith based organizations to create linkages so that individuals in care if they choose, to do so, will have a “spiritual home” when discharged. Consumer & Family Affairs now work individually with those who are resistant to discharge to facilitate a more supportive, and smooth transition to the community. Finally, individuals not wanting to leave the hospital will be in a process group focused on helping them “warm-up” to the idea of community living through multi-disciplinary approaches, including connections with former individuals in care who successfully reside in the community. Finally, audit results are shared with individual workers, and are also presented at the monthly social worker meetings. 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. Social work and the Avatar team are updating the “light bulbs” for both the SWIA and the Update to improve clarity for workers about what should go in each section. They are also working to redesign the forms in Avatar to better align them with the IRP process and format.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	37	38	37	25	36	45	**32**	**36**
n	8	8	7	5	7	9	**7**	**7**
%S	22	21	19	20	19	20	**21**	**20**
%C # Completed within 5 days of admission	88	75	86	60	100	100	**78**	**86**
%C # 3a SW has reviewed other sources of information such as old records, initial psych assessment etc	50	75	71	60	100	100	**n/a**	**77**
%C # 3b Review of the individual's history is satisfactory and includes benefits, medical developmental, psychiatric, social history, substance abuse history.	88	100	100	100	100	100	**n/a**	**98**
%C # 4a Identifies whether there is a discrepancy or note and if SWIA includes resolution of discrepancy	75	100	100	100	86	100	**20**	**93**
%C #4b If discrepancy is not resolved, the SWIA documents a plan to resolve the discrepancy.	n/a	100	n/a	n/a	n/a	n/a	**n/a**	**100**
%C # 5 Documents the presenting problem in the individual's own words, one's perceived strengths, their own goals for treatment and discharge.	100	86	100	100	100	100		**97**
%C # 6a Describes the individual's strengths and limitations	100	100	86	100	100	100		**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""	50	63	86	80	71	100		**75**
%C #6c Identifies a group for the individual to participate in, if applicable	100	100	100	100	100	100		**100**
%C #6d Overall assessment includes discussion of individual's goals and feelings about community placement	25	75	86	100	86	100		**77**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	246	250	240	246	238	241	**266**	**244**
n	11	12	11	12	8	9	**12**	**11**
%S	4	5	5	5	3	4	**5**	**4**
%C Timely completions	100	100	100	100	100	78	**100**	**97**
%C # 1a Indicates contact with family, significant other and/or guardian	78	90	90	91	88	88		**88**
%C #1b Indicates the family's, significant other's and/or guardian's support towards individual's progress and discharge plan	100	67	90	91	86	71		**85**
%C #2a Documents observable/measurable objectives	64	58	82	83	88	78		**75**
%C # 2b Documents frequency and where progress or lack of progress is	64	42	82	50	75	44		**59**
%C #2c Documents who is responsible for the intervention and what will be addressed or taught	82	75	82	75	88	78		**79**
%C # 2d Documents individual's progress to objectives and interventions	82	67	64	75	75	78		**73**
%C #2e Documents next steps	82	83	73	75	88	100		**83**
%C # 2f Documents if the individual has made progress, the objective and/or intervention has been revised to move the individual toward discharge	50	100	57	25	n/a	75	**67**	**58**
%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	0	50	64	63	60		**44**
%C #3a Documents in the individual's own words their expressed goal	91	91	73	83	88	88		**85**
%C # 3b Documents the individual's perception of progress related to treatment and discharge planning	45	75	89	92	57	86		**74**
%C # 4a The individual's strengths and limitations are described	100	92	100	92	75	67		**89**
%C # 4b Documents the individual's current behaviors and functioning	100	100	100	100	100	100		**100**
%C # 5a Includes anticipated placement for individual (specific or generic)	82	92	82	100	100	89		**90**
%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	92	82	92	100	78		**86**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 5c Includes discharge plan (what steps SHE staff, CSA etc will do to assist with discharge) and provides an update	64	83	82	92	100	78		**83**
		%C # 5d Identifies if the individual has any barriers to discharge to anticipated placement	100	83	82	92	100	100	**79**	92
		%C #5e Discharge plan review is present and updated.	n/a	75	55	42	38	67		52
		%C # 6a There is identifying information regarding the community support worker/csa	100	100	100	100	100	100		100
		%C # 6b Documents the dates the CSA was notified of the IRP	60	55	71	38	50	63		56
		%C # 6c Description of case manager's/CSAs involvement in discharge planning and contact with individual	80	100	71	88	100	75	**81**	**87**
		%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)	82	75	64	92	100	78		**81**
		%C # 6e Documents a recommendation for groups if applicable	25	57	50	60	75	67		**56**

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: Social work substantially revised its audit tools to ensure that it was monitoring the quality of assessments, and measuring to ensure they were focusing on key aspects of social work practice. The new tools measure whether the assessments reflect a fully detailed social history and address discrepancies in the history, appropriately assess individual needs and strengths, provide useful information for discharge planning and include clinical recommendations for treatment objectives and interventions. While these changes mean the Hospital is unable to compare indicators from the prior review period due to the substantial modifications in the tools, it has resulted in higher quality assessments. Of the 19 indicators in the social work initial assessment audit tool, 13 are above 90%. The majority of the others are in the 70-80% range, but those are expected to improve now that social work is at full staffing. With respect to the social work updates, performance has not improved to the same extent as the SWIA, but the updates were more affected by the vacancies, and thus it is not unexpected that improvements have not kept pace with those in the initial assessments. However, with full staffing this issue should be resolved. Other steps described below will also be implemented to improve the quality of the social work updates.

In addition, training was provided to social work staff, who, supported by the consultants, jointly reviewed and completed a social work initial assessment using a specific case. This will be repeated using the social work update.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Social workers also participated in a joint training with clinical administrators around discharge planning, to include development of discharge criteria and identification of discharge barriers. The forms in Avatar are also being revised and instructions will be updated. Social work supervisors are implementing several strategies to continue the positive trend. An assistant supervisory social worker has been identified, 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, and coaching is provided as needed. In addition, the following areas will be targeted for improvement; documentation around objectives and interventions, discharge plan review, notification of CSAs and documentation of groups. The planned corrective actions include a joint training on completion of the social work update, review with staff the examples in the IRP manual, update the Social Work Update form in Avatar to address the inviting of the CSA and discharge plan review, and 1:1 meetings and coaching for those social workers in need of most support.

<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:

1. The hospital should continue to monitor the IRP process utilizing existing audit tools and identify staff in need of coaching.

SEH Response: IRP process monitoring continues although two indicators were removed when the audits tools were removed and streamlined. See Tab # 7 IRP OBSERVATION AUDIT RESULTS. Coaching by internal mentors continues and external consultants have met with several treatment teams around discharge and other issues as needed.

2. The hospital should continue to focus training on identifying factors at point of admission that bear on discharge planning.

SEH Response: Ongoing. Social work and clinical operations held a joint training during this review period where clinical administrators and social workers together reviewed a case and identified discharge criteria, discharge barriers and a discharge plan. Social work also modified its audit tool for the SWIA and now has five indicators that address discharge planning from the time of admission. Audit results are shared with the social workers at monthly meetings and also with individual workers during supervision. Social work updated its instructions for completion of the SWIA and the SW Update, and is working with Avatar team to redesign the forms and update the “light bulb” instructions in Avatar.

The Hospital provides an IRP overview that includes discussion around discharge planning as part of new employee orientation and also began training newly hired individuals on each module of the IRP training on a quarterly basis.

Facility’s findings:

<table>
<tr><th colspan="9">SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>37</td><td>38</td><td>37</td><td>25</td><td>36</td><td>45</td><td>32</td><td>36</td></tr>
<tr><td>n</td><td>8</td><td>8</td><td>7</td><td>5</td><td>7</td><td>9</td><td>7</td><td>7</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%S	22	21	19	20	19	20	**21**	**20**
		%C # 5 Documents the presenting problem in the individual's own words, ones perceived strengths, their own goals for treatment and discharge	100	86	100	100	100	100	*	**97**
		%C # 6a Describes the individual's strengths and limitations	100	100	86	100	100	100	*	**98**
		%C # 6b Has recommendations/interventions that are clinical and specific	50	63	86	80	71	100	*	**75**
		%C # 6c Identifies a group for the individual to participate in, if applicable	100	100	100	100	100	100	*	**100**
		%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	25	75	86	100	86	100	*	**77**
		%C # 7a Includes anticipated placement for individual (specific or generic)	88	88	86	100	100	100	*	**93**
		%C # 7b All areas of discharge criteria are described in detail as to what is needed	88	88	100	100	100	100	**65**	**95**
		%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	88	88	100	100	100	89	*	**93**
		%C # 7d Description of discharge barriers	100	100	100	80	100	100	**87**	**98**
		%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	88	100	100	100	100	100	*	**97**
		%C # 8b Documents the dates the CSA was notified of the IRP	25	33	33	40	40	38		**34**
		%C # 8c Identifies resources needed for discharge, as needed for the individual in care (i.e. benefits, housing etc)	88	88	100	100	100	100		**95**

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	211	244	218	193	222	**167**	**221**
n	22	20	19	15	11	11	**18**	**16**
%S	9	9	8	7	6	5	**11**	**7**

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	90	100	88	92	90	100	**90**	**93**

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**
%S	9	11	8	10	10	7	**13**	**10**
%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)	80	74	95	90	90	87	**57**	**86**
%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.	95	92	100	100	90	94	**75**	**95**

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	21	20	25	17	15	20	**19**	**20**
n	4	5	6	7	2	4	**5**	**5**
%S	19	25	24	41	13	20	**24**	**24**
%C. #17 Were there measurable interventions regarding the individual's particular discharge considerations?	100	100	80	100	100	100	**89**	**96**

<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 # 18 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>89</td><td>100</td></tr>
<tr><td>%C # 19 Timeframes and duration for completion of interventions</td><td>100</td><td>100</td><td>100</td><td>88</td><td>100</td><td>100</td><td>89</td><td>93</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 suggest, the Hospital continues to improve the effectiveness of discharge planning from the time of admission. In March 2011, social workers and clinical administrators were trained on the linkages between social work updates and the discharge piece of the clinical formulations/IRPs. Social workers also, as a discipline, participated in a training specifically addressing completion of the SWIA.

Social work leaders also modified instructions for social workers on how to complete the SWIA and Social Work Updates to provide additional clarity, modified its audit tools and developed instructions to complement each of the revised form instructions, and increased the focus on discharge planning. The changes to the instructions were included in the “light bulbs” in Avatar, and social work is working with Avatar on redesigned forms. Social work also developed examples of discharge criteria and plans to assist workers and teams in addressing discharge issues. See Tab # 1 IRP Training Material Discharge Documentation examples. In addition, social work is planning trainings for Fall, 2011 including a two-day training around social security benefits and the application process, and staff will be trained on use of the LOCUS system, which will allow staff here to determine level of care and streamline the placement. This training will also reinforce for staff the various options available in the community and the requirements for each level of care. Social work staff are also being trained so they may access the ACEDS system to check the benefits status of individuals in care.

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:
1. See VII.A

SEH Response: See VII.A

2. IRP training and coaching should focus on identifying an individual’s strengths and how to incorporate them into specific objectives and attainable goals that will lead to discharge.

SEH Response: The Hospital is providing targeted coaching by the Director of Treatment Services, and the two supervisory social workers through their observations at IRPs for individuals on the “ready-for-discharge” list. Each of these managers are attending about 5 IRPs per month to work with staff on identifying discharge criteria and resolving discharge barriers. Managers are working with staff to identify alternatives that meet the needs of the individual while also building on strengths and articulated desires of the individual in care. Finally, curricula for social work groups around discharge in TLC Transitional were modified in September 2011 to provide more skill building opportunities such as money management
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>and accessing benefits.

3. Implement Corrective Action Plan.

SEH Response: Ongoing. All social work vacancies have been filled. Social work attendance at the IRPs is monitored and is trending upward. Training on identifying discharge barriers and criteria was completed and individual coaching to IRP teams is occurring as needed. TLC curricula for social work related groups in the transitional TLC were modified.

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 extent that they are known; and</td><td>Recommendations:

1. The hospital should continue providing opportunities for the hospital and community to collaborate including the hospital/community seminars. These forums increase the understanding of community resources and the skills necessary for an individual to be successful.

SEH Response: The Hospital and Division of Integrated Care are continuing to collaborate around discharge issues although no joint trainings were held during this period. This was in part due to low attendance by community providers at the trainings. However, the Hospital’s supervisory social workers met with ACT providers and around the scope of ACT services and role of ACT teams as well as advising ACT teams about the Hospital’s IRP process. In addition, every two weeks, a psychiatrist and nurse from the Hospital meet with teams at United Medical’s nursing facility to consult on cases (both SEH discharged individuals and others) and provide clinical support.

2. The hospital should consider implementing a formal and routine process to review the clinical and discharge needs of individuals with multiple admissions or readmissions within 30 days.

SEH Response: This is now integrated into the weekly CIT meetings. Date of last discharge is now tracked in the discharge tracking log, and a CIT team member attends the 7 day IRP for those cases in which an individual in care has been returned to the hospital within 30 days or has returned on multiple occasions. See Tab # 58 Discharge Planning Log

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

SEH Response: Ongoing.

Facility’s findings:

<table>
<tr><th colspan="9">SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>37</td><td>38</td><td>37</td><td>25</td><td>36</td><td>45</td><td>32</td><td>36</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	8	8	7	5	7	9	**7**	**7**
%S	22	21	19	20	19	20	**21**	**20**
%C # 7a Includes anticipated placement for individual (specific or generic)	88	88	86	100	100	100	*	**93**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	88	88	100	100	100	100	**65**	**95**
%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	88	88	100	100	100	89	*	**93**
%C # 7 d Identifies if the individual has any barriers to discharge to anticipated placement (old tool #9)	100	100	100	80	100	100	**87**	**98**

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

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	246	250	240	246	238	241	**266**	**244**
n	11	12	11	12	8	9	**12**	**11**
%S	4	5	5	5	3	4	**5**	**4**
%C # 5a Includes anticipated placement for individual (specific or generic)	82	92	82	100	100	89	*	**90**
%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	92	82	92	100	78	*	**86**
%C # 5c Includes discharge plan (what steps SEH staff, CSA etc will do to assist with discharge) and provides an update	64	83	82	92	100	78	*	**83**
%C # 5d Identifies if the individual has any barriers to discharge to anticipated placement (# 6 from prior tool)	100	83	82	92	100	100	**79**	92
%C #5e Discharge plan review is present and updated.	n/a	75	55	42	38	67	*	52

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**195**	**221**
n	22	24	20	22	20	16	**22**	**21**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S	9	11	8	10	10	7	**12**	**10**
%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)	80	74	95	90	90	87	**57**	**86**

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

Census and 30-Day Readmissions*								
	Feb	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Mean-C**
Individuals in Care – Daily Average	292	276	283	286	276	268	278	**289**
Discharges	53	33	29	38	41	33	33	**37**
# 30-day Readmissions	2	2	2	1	1	0	n/a	**n/a**
% 30-day Readmissions	3.8	6.1	6.9	2.6	2.4	0.0%	n/a	**n/a**

*National Public Rate (NPR) of 30-day readmission: 7.8%, NASMHPD Research Institute, December 2010
Rehospitalization data from August discharges is not yet available.
See Tab # 43 PRISM Report

Analysis/action steps: Average daily census continued to decline; the average daily census in February 2011 was 292 and 278 in August, 2011. 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 July 2011.

In addition, social work and the clinical chart audits show an improving trend around identifying discharge barriers and improving IRPs to address these issues. As noted, training for social workers and clinical administrators around discharge planning was also held with a focus on the linkages between the social work update and the completion of the discharge sections of the clinical formulation. This will continue to be monitored through the identified audits, and additional actions will be taken as needed.

VII.A.4 — the skills necessary to live in a setting in which the individual may be placed.

Recommendations:

1. SEH should continue to refine matching individual's functional skills with the revised TLC curricula.

SEH Response: Ongoing. TLC group assignments are made utilizing the IPA, the clinical formulation, IRPs and progress notes as part of the process in matching the individual to TLC groups. In addition, the TLC reviewed the curricula to ensure they reflect appropriate functional levels. The TLCs were modified in September 2011. TLC Intensive's competency program was revised, to include a weekly mock trial and four competency groups each week for each individual in care. In addition, the Hospital conducted group leader training for those facilitating groups for those with cognitive impairments in September 2011 which is intended to improve the quality of those groups. ***See Tab # 131 Group***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Leader Training Information. Finally, for the weekly IRP/TLC meetings, IRPs are now shown on the screen, which allows TLC and treatment team staff to improve the linkages between the individual's objectives, interventions and functional status. 2. Consider incorporating peer specialists and/or community agency staff into a revised discharge planning curricula. SEH Response: Ongoing. The Hospital provides a full array of supports and activities to support transition to the community. There are a number of discharge related groups at the TLCs including: • Travel Training (RT) • Bridges (Transition specialists) • WRAP (Consumer Action Network) • Discharge Planning (social work) • Principles of Recovery/ Recovery Process (Consumer Affairs) • Art Therapy and Community Re-Entry • Community Living Skills (OT) • Community Awareness/Community Re-Entry (RT Trip) • Community Outings (RT Trip) • Takoma Park (RT Trip, occurs weekly) • Exploring the Community (RT Trips) • Vocational Skills Groups, such as resume writing, job seeking skills (Vocational rehab) • Education/GED groups (educational rehab) • Money Management (TLC) Rehabilitation Services provides regular community based activities, both social (weekly day trips to museums, shopping malls etc, and learning activities such as using the subway or buses) and therapy based. Further thirty individuals (about 10% of the overall census) attend day treatment programs in the community. ***See Tab # 63 List of individuals who attend community day programs.*** The peer transitional specialist program whereby peers work with individuals in the Hospital to ease transition to the community continues. A key piece of this program is an apartment near the Hospital, where transition specialists take individuals for visits and to learn community living skills such as cooking, cleaning and laundry. Outings include utilizing public transportation, grocery shopping, etc. Peer transition specialists also are paired 1:1 with identified individuals to assist in community skill-building and to enhance self-confidence. Volunteer Services also take individuals on community trips at least monthly, where they have an opportunity to interact with community volunteers in normalized settings. Case managers also aid with the transition, visiting individuals in the Hospital, attending treatment plan conferences and taking them to the community to look at housing, obtain benefits or identification, etc. Just recently, chaplaincy developed a group entitled Spiritual Home to assist individuals, if they agree, with establishing roots in a religious community to facilitate a smoother transition to the community and create an established system of religious support upon discharge. Consumer & Family Affairs also began to work individually with those who are resistant to discharge to facilitate a more supportive, and smooth transition to the community. A new group has been developed to

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

reframe the concept of resistive individuals. Individuals not wanting to leave the hospital will be in a process group focusing on helping them "warm-up" to the idea of community living through multi-disciplinary approaches, including connections with former individuals in care who successfully reside in the community.

Finally, Social Work has improved their TLC group curricula to provide more in-depth lessons on distinct components of discharge planning (e.g., money management, understanding your benefits, etc.). The curricula will be available for review during the visit.

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

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

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	37	38	37	25	36	45	**32**	**36**
n	8	8	7	5	7	9	**7**	**7**
%S	22	21	19	20	19	20	**21**	**20**
%C # 6a Describes the individual's strengths and limitations	100	100	86	100	100	100	*	**98**
%C # 6b Has recommendations/interventions that are clinical and specific?	50	63	86	80	71	100	*	**75**
%C # 6c Identifies a group for the individual to participate in, if applicable	100	100	100	100	100	100	*	**100**
%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	25	75	86	100	86	100	*	**77**
%C # 7a Includes anticipated placement for individual (specific or generic)	88	88	86	100	100	100	*	**93**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	88	88	100	100	100	100	**65**	**95**
%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	88	88	100	100	100	89	*	**93**
%C # 7d Description of discharge barriers	100	100	100	80	100	100	**87**	**98**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>* New indicator for this review period
Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>80</td><td>74</td><td>95</td><td>90</td><td>90</td><td>87</td><td>57</td><td>86</td></tr>
</table>
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.</td></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 IRP participation and process.

SEH Response: Ongoing. Attendance is expected to be above 90% now that all vacancies have been filled. Joint training with clinical administrators and social workers around discharge planning and IRPs was completed during this review period. Further, social work supervisors are attending IRPs, observing their staff, and providing feedback about the quality and content of their participation. Audit data from both social work and IRP observations are shared with social work staff at meetings.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

3. Identify staff and/or treatment teams in need of coaching.

SEH Response: Ongoing. Teams are identified from observers and coaching is being provided.

Facility's findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	234	214	244	218	193	222	**167**	**221**
n	22	20	19	15	11	11	**18**	**16**
%S	9	9	8	7	6	5	**11**	**7**
%C Data fields: Family Member invited?	88	89	78	60	100	75	**60**	**84**
%C Data fields: Community support worker invited	88	75	88	100	100	89	**77**	**87**

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

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	8	8	7	5	7	9	**7**	**7**
%S	22	21	19	20	19	20	**21**	**20**
%C # 6a Describes the individual's strengths and limitations	100	100	86	100	100	100	*	**98**
%C # 6b Has recommendations/interventions that are clinical and specific?	50	63	86	80	71	100	*	**75**
%C # 6c Identifies a group for the individual to participate in, if applicable	100	100	100	100	100	100	*	**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

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	246	250	240	246	238	241	**266**	**244**
n	11	12	11	12	8	9	**12**	**11**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S	4	5	5	5	3	4	**5**	**4**
%C # 5a Includes anticipated placement for individual (specific or generic)	82	92	82	100	100	89	*	**90**
%C # 5b Includes discharge criteria for anticipated placement (what individual in care needs to do) and documents update	73	92	82	92	100	78	*	**86**
%C # 5c Includes discharge plan (what steps SHE staff, CSA etc will do to assist with discharge) and provides an update	64	83	82	92	100	78	*	**83**
%C # 5d Identifies if the individual has any barriers to discharge to anticipated placement (# 6 from prior tool)	100	83	82	92	100	100	**79**	92
%C #5e Discharge plan review is present and updated.	n/a	75	55	42	38	67	*	52

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

SEH Response: See VII.C.

Facility's findings:

DISCHARGE MONITORING AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	21	20	25	17	15	20	**19**	**20**
n	4	5	6	7	2	4	**5**	**5**
%S	19	25	24	41	13	20	**24**	**24**
%C. #17 Were there measurable interventions regarding the individual's particular discharge considerations?	100	100	80	100	100	100	**89**	**96**

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: Audit results suggest performance improved in ensuring measurable interventions regarding the individual's discharge considerations, with a mean over 90%. 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 Strategic Action Plan.

2. Continue to monitor readmission rates by legal category.

SEH Response: The Hospital monitors readmission rates through the monthly PRISM report. Data by legal status is available in the PRISM report, data tables.

Facility's findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>21</td><td>20</td><td>25</td><td>17</td><td>15</td><td>20</td><td>19</td><td>20</td></tr>
<tr><td>n</td><td>4</td><td>5</td><td>6</td><td>7</td><td>2</td><td>4</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>19</td><td>25</td><td>24</td><td>41</td><td>13</td><td>20</td><td>24</td><td>24</td></tr>
<tr><td>%C. # 20 Is there evidence of adequate assistance in transitioning prior to discharge?</td><td>100</td><td>100</td><td>100</td><td>86</td><td>100</td><td>100</td><td>74</td><td>96</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. During the review period, chaplaincy developed a group entitled "Spiritual Home", assisting individuals, if they desire, with establishing roots in a religious community to facilitate a smoother transition to the community so that they have an established system of religious support upon discharge. Consumer & Family Affairs began to work individually with those who are resistant to discharge to facilitate a more supportive, and smooth transition to the community. A new group has been developed to reframe the concept of</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>resistive individuals. Individuals not wanting to leave the hospital will be in a process group focused on helping them “warm-up” to the idea of community living through multi-disciplinary approaches, including connections with former individuals in care who successfully reside in the community. Finally, Social Work has improved their curricula to provide more in-depth lessons on distinct components of discharge planning (e.g., money management, understanding your benefits, etc.).

Audits show significant improvement in transitioning individuals to the community, improving from a mean of 74% during the last review period to 96% during this period. This is further supported by the Hospital’s low 30 day rehospitalization rate which is at about 5% for the last 11 months, and was at 0% during for those discharged in July 2011, the most recent month for which data is available 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 for the services, and the discharge 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.

2. Consider adding a note in the clinical record that consumer was provided a copy of discharge plan.

SEH Response: The Hospital considered this recommendation, elected not to implement it but developed an alternative. The Discharge Plan of Care is a form for which Avatar allows for electronic signatures. The feature is activated, and one is located in the treatment rooms on each unit (and in the social workers’ office for the civil admissions unit). The signature pads were relocated to the treatment rooms to facilitate access. There are occasions where individuals in care refuse to sign the electronic signature pad or the pad is not immediately available when the individual in care is ready to leave. Consequently, beginning in September 2011, social workers will now print a copy and note on the top of the discharge plan of care if the individual was provided a copy (or in the case of pretrial individuals who are not returned by the court, if a copy was sent to the Jail); Copies will be scanned into the record through the FileNet system.

Facility findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>21</td><td>20</td><td>25</td><td>17</td><td>15</td><td>20</td><td>19</td><td>20</td></tr>
<tr><td>n</td><td>4</td><td>5</td><td>6</td><td>7</td><td>2</td><td>4</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>19</td><td>25</td><td>24</td><td>41</td><td>13</td><td>20</td><td>24</td><td>24</td></tr>
<tr><td>%C. # 5 Is there documented evidence of active collaboration with a CSA?</td><td>100</td><td>80</td><td>100</td><td>83</td><td>100</td><td>100</td><td>85</td><td>92</td></tr>
<tr><td>%C. # 6 Was the outpatient psychiatrist identified?</td><td>100</td><td>60</td><td>100</td><td>67</td><td>100</td><td>100</td><td>89</td><td>84</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		%C. #7 Was the outpatient/community support worker identified?	100	80	100	100	100	100	**96**	**96**
		%C. # 8 Was the next outpatient (medication or therapy) appointment date indicated?	100	80	100	83	67	75	**76**	**85**
		%C. # 9 Was the exact type of day services or employment indicated?	100	100	100	100	100	100	**92**	**100**
		%C. # 10 Were the type and location of substance abuse/addiction services indicated?	67	67	100	100	100	n/a	**44**	**85**
		%C. # 11 If the individual has an active Axis III diagnosis, were ongoing medical needs identified?	75	100	100	67	100	100	**94**	**89**
		%C. # 12 Was housing secured?	100	80	75	100	100	100	**80**	**92**
		%C. # 13 Was the individual's benefit information completed?	100	100	100	100	100	67	**62**	**96**
		%C. # 14 Were any other specialized services identified?	100	100	n/a	100	100	100	**88**	**100**
		%C. # 15 Was the discharge plan of care signed by the individual or his/her legal representative?	100	67	100	100	100	75	**56**	**89**
		%C. # 16 Was a copy of the discharge plan of care given to the individual or the individual's family or legal representative?	100	67	100	100	100	75	**56**	**89**

N = All discharges in the month
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; were medical needs addressed in the event the individual has an active Axis III diagnosis). 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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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 update 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 Update audit tool there are now three questions that address adverse reactions and high risk medication practices, including evaluating the rationale for 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. Data from these audits will be used to address practice issues with psychiatrists as a group as well as with individual psychiatrists.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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.

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

Finally, the Hospital is continuing its efforts to hire a diabetes educator or consultant who will review protocols and revise them as needed and work with physician and nursing staff around diabetes management issues.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	37	38	37	25	36	45	**32**	**36**
n	8	8	8	8	7	11	**7**	**8**
%S	22	21	22	32	19	24	**21**	**23**
%C # 19 Are the risks associated with the medication regimen addressed?*	100	100	100	100	*	*	**97**	**100**
%C # 9 (NEW TOOL) 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**

N= Number of admissions
n= 20% sample per audit plan
* Discontinued in July, 2011 with new tool
** Indicator added effective July 2011
Tab # 14 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**
%S	12	14	12	14	8	13	**11**	**12**
%C # 5 Explanation for the STAT medication benefits that outweigh the risks?	0	100	100	100	*	*	**100**	**86**
%C # 6 Benefits and risks of restraint or seclusion explained	n/a	100	n/a	n/a	*	*	**n/a**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #7 Are the appropriate adverse reactions noted in the appropriate subsection with respect to FGA or SGA antipsychotics	100	94	100	100	*	*	**91**	**98**
		%C #8 Specification and rationale for two or more antipsychotics	100	90	100	100	*	*	**94**	**97**
		%C # 15 If the medication regimen includes use of anti-cholinergics in an individual with diagnosis of cognitive disorder, is there an adequate justification?	100	33	100	100	*	*	**97**	**91**
		%C # 17 If abnormal labs are indicated, is there evidence of appropriate follow up and response?	100	100	100	100	*	*	**99**	**100**
		%C #19 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	96	100	100	100	*	*	**100**	**99**
		%C # 20 Does the psychopharmacological plan of care adequately address the use of benzodiazepines in high risk populations?	100	60	50	100	*	*	**100**	**86**
		%C # 3 (NEW TOOL) Are the appropriate adverse reactions noted in the relevant subsection with respect to tx with FGAs or SGAs anti-psychotics	100	94	100	100	100	90	**91**	**97**
		%C # 4 (NEW TOOL) Is polypharmacy (≥ 2or more anti-psychotics or ≥ 4 or more psychotropics) correctly identified and is there an adequate rationale	**		**	**	100	86	**	**89**
		%C # 7 (NEW TOOL) 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? (Indicator effective July 2011)	**	**	**	**	100	97	**	**98**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* Indicator eliminated from the tool effective July, 2011
** Indicator added effective July, 2011
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: 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; only two

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		indicators from the prior tool are below 90% and both are trending upward. Data from the revised audit tool shows excellent performance, although the indicator relating to polypharmacy is just below the 90% threshold. The audits will continue to 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 will identify practitioner issues through the audits. The Medical Director will review the documentation expectations during his monthly meetings with psychiatrists. In addition a DUE around use of STAT medication is planned for Fall 2011.
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 AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	37	38	37	25	36	45	**32**	**36**
n	8	8	8	8	7	11	**7**	**8**
%S	22	21	22	32	19	24	**21**	**23**
%C #13a Risk of self injury	100	100	100	100	*	*	**100**	**100**
%C # 13b Risk of completed suicide	100	100	100	100	*	*	**98**	**100**
%C # 13c Risk of physical aggression	100	100	100	100	*	*	**98**	**100**
%C # 13d Risk of sexual aggression	100	100	100	100	*	*	**98**	**100**
%C # 13e Risk of elopement	100	100	100	100	*	*	**98**	**100**
%C # 14 For each type of risk that was identified as mild or above, were appropriate precautions identified?	100	100	88	100	*	*	**100**	**97**
%C # 7 (NEW TOOL) Were the risk assessment subsections completed, and include an appropriate plan to manage risks?	**	**	**	**	100	100	**	**100**

N= Number of admissions
n= number audited. Target is 20%
* Indicator eliminated effective July 2011
** Indicator added effective July 2011
Tab # 14 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N	242	250	250	246	238	241	**267**	**245**
n	28	34	29	34	20	31	**31**	**29**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%S</td><td>12</td><td>14</td><td>12</td><td>14</td><td>8</td><td>13</td><td>11</td><td>12</td></tr>
<tr><td>%C #9 Were the risk assessment subsections of the psychiatric update fully and accurately completed?</td><td>100</td><td>97</td><td>100</td><td>100</td><td>*</td><td>*</td><td>100</td><td>**</td></tr>
<tr><td>%C # 5 (NEW TOOL) Were the risk assessment subsections completed, and include an appropriate plan to manage risks?</td><td>**</td><td>**</td><td>**</td><td>**</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
</table>
N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
* Indicator discontinued effective July 2011
** Indicator added effective July 2011
Tab # 9 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The audit results suggest high 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, finalized and 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. PID tracks the completion of this, 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 this report, there were 95 individuals on one or more lists; 25 individuals are no longer on any lists. Eleven individuals meet the qualifications for a CCT – 6 have had their CCTs, and the remaining 5 are scheduled for CCTs in October 2011.
</td></tr>
<tr><td>VIII.A.1.f</td><td>documentation of, and responses to, side effects of prescribed medications;</td><td></td></tr>
<tr><td>VIII.A.1.g</td><td>documentation of reasons for complex pharmacological treatment;</td><td></td></tr>
<tr><td>VIII.A.1.h</td><td>timely review of the use of "pro re nata"</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.) With respect the MVR, as 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 category A or B and 29% in category C. 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 or revealing errors; 3) burden of paperwork in reporting; 4) lack of understanding on ADR/MV. The six sigma team presented the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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 will be followed up at the October 2011 Pharmacy and Therapeutics Committee meeting.

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	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Total**	**Mean**
Current Review Period	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**July-11**	**Aug-11**		
Previous	5	7	6	7	10	5	**40**	**6.7**
Current	11	6	10	2	5	4	**38**	**7.0**

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;

Probability of ADRs									
Probability	**Previous Period**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Total**	**Mean**
	Current Period	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**July-11**	**Aug-11**		
Doubtful	**Previous**	0	0	0	0	0	0	**0**	**0.0**
	Current	0	0	1	1	0	1	**3**	**0.3**
Possible	**Previous**	4	4	6	5	7	3	**29**	**4.8**
	Current	4	3	7	0	2	2	**18**	**3.0**
Probable	**Previous**	1	3	0	2	3	2	**11**	**1.8**
	Current	7	2	2	1	2	2	**21**	**3.5**
Definite	**Previous**	0	0	0	0	0	0	**0**	**0.0**
	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;

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Severity of ADRs									
Severity Level	Previous Period	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Total	Mean
	Current Period	Mar-11	Apr-11	May-11	Jun-11	July-11	Aug-11		
Mild (0)	Previous	0	2	0	2	4	2	**10**	**1.7**
	Current	3	2	3	0	1	4	**13**	**2.2**
Moderate (1~2)	Previous	5	5	6	5	6	3	**30**	**5.0**
	Current	8	4	7	2	3	5	**29**	**4.8**
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	Mar	Apr	May	June	July	Aug	Total	Mean
Recovered/resolved Completely	7	3	6	0	2	8	**26**	**4.3**
Recovered/resolved with sequelae	3	0	0	0	0	0	**3**	**0.5**
Recovering/resolving	0	0	0	0	0	0	**0**	**0.0**
Not recovered/not resolved*	1	1	3	2	1	1	**9**	**1.5**
Fatal	0	0	0	0	0	**0**	**0**	**0.0**
Unknown	0	2	1	0	1	**0**	**4**	**0.7**

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

Reporter Discipline								
Result	Mar	Apr	May	June	July	Aug	Total	Mean
Nurse	0	0	1	0	0	1	**2**	**0.3**
Pharmacist	0	0	1	1	0	1	**3**	**0.5**
Medical	1	0	0	0	0	3	**4**	**0.7**
Psychiatrist	10	6	8	1	4	4	**33**	**5.5**

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;"

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

ADR#	ID #	Incident Date	Description
ADR #148	# 101849	8/2/2011	Elevated prolactin level

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;
   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 one DUE during this review period and initiated two others. ***Report Tab # 69 Drug Use Evaluations.*** The first DUE involved a review of cases of individuals on clozaril to determine if practice comported with Hospital's medication guidelines. The DUE includes a review of cases involving the ordering of clozaril from the time period of 1/1/10 – 8/29/11 to see if the SEH Clozapine Guidelines were being followed for initiation, monitoring, and/or discontinuation of Clozapine and if not, was there explanatory documentation for each discrepancy. The DUE looked only at the active episode of the individual in care and included the following data points:

- Date Clozapine therapy first initiated
- # patients actively receiving Clozapine as of 8/29/11
- % patients following SEH Clozapine guidelines
- % Patients receiving Clozapine for <6 months, 6-12 months, and > 12 months

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		• Types of each discrepancy within each time frame (i.e. how many monitoring discrepancies in the 6-12 month time frame) • % of discrepancies with explanatory documentation. The DUE was completed in late September and results will be presented at October's P and T Committee meeting. Results of the DUE show that 31 individuals in care, or approximately 11% of the census, received clozapine during the review period. One IIC's order for clozapine was discontinued due to an ADR and another had clozapine therapy interrupted for 7 weeks, but re-initiation guidelines were not followed. Of the 31, only 7 (23%) cases followed the medication guidelines. Types of discrepancies included not following appropriate CBC/ANC lab level monitoring intervals, lack of documentation regarding previous unsuccessful adequate trials of at least two chemical classes of anti-psychotic agents and/or adverse reaction that prohibits use and concurrent anti-psychotic usage. Forty eight percent of individuals were receiving clozapine for less than 6 months, 13% for six to twelve months, and 39% more than 12 months. Results are to be presented to the P and T Committee in October 2011, and the recommendations include re-educating psychiatrists and pharmacy staff on the medication guidelines. A second DUE was approved by the P & T Committee in September, 2011. This will review the use of NOW/STAT medication and will involve a real time review shortly after the NOW/STAT medication is ordered. Data to be collected prospectively includes the individual's demographics to include name, unit, age, hospital #, sex, diagnoses, and date of hospital admission and standing orders at the time of the NOW/STAT order. Questions to be analyzed include: ○ Could NOW/STAT order have been avoided/prevented? ○ Is there documentation regarding the order(s)? ○ Voluntary or Involuntary? ○ Is the order the same drug as a current standing order? ▪ If not, is it in the same drug class as a current standing order? ○ Was the order effective? ○ Was a Code 13 involved? ○ Time of order from hospital admission It is expected that the review will cover a 45-60 day period. A third DUE is also in development. This DUE involves review of cases where individuals in care are prescribed both long acting and daily doses of the same medication. The DUE will review those cases to determine if there is a documented rationale for this prescribing practice. 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:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-10**	**Feb-10**	**Total**	**Mean**
Current Review Period	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**July-11**	**Aug-11**		
Previous	18	6	8	21	2	20	**75**	**12.5**
Current	8	20	14	19	15	13	**89**	**15.0**

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									
	Mar	Apr	May	June	July	Aug	**Total**	**Mean-P**	**Mean-C**
Administering	1	0	0	3	1	0	**5**	**3.8**	**0.8**
Dispensing	1	4	0	3	1	0	**9**	**1.5**	**1.5**
Monitoring	0	0	0	0	0	0	**0**	**0.0**	**0.0**
Prescribing	6	15	14	11	11	13	**70**	**5.2**	**11.7**
Procurement	0	0	0	0	0	0	**0**	**0.7**	**0.0**
Transcribing/Documenting	0	1	1	1	1	0	**4**	**0.7**	**0.7**
Other/NA	0	0	0	1	2	0	**3**	**0.8**	**0.5**

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

See Tab # 76 MVR SUMMARY REPORTS

Classification by Outcome Category								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
Potential - A	0	2	0	2	6	0	**0.7**	**1.7**
Potential - B	7	17	13	14	6	13	**4.8**	**11.7**
Potential Subtotal	*7*	*19*	*13*	*16*	*12*	*13*		
Actual - C	1	1	1	0	4	0	**6.5**	**1.2**
Actual - D	0	0	0	3	0	0	**0.5**	**0.5**
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**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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	1	1	1	3	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

	Mar	Apr	May	June	July	Aug	**Total**	**Mean-P**	**Mean-C**
Administering	1	0	0	3	1	0	5	**3.7**	**0.8**
Dispensing	1	4	0	3	1	0	9	**1.5**	**1.5**
Monitoring	0	0	0	0	0	0	0	**0.0**	**0.0**
Prescribing	6	15	14	11	11	13	70	**5.2**	**11.7**
Procurement	0	0	0	0	0	0	0	**0.7**	**0.0**
Transcribing/Documenting	0	1	0	1	1	0	3	**0.7**	**0.5**
Other/NA	0	0	0	1	2	0	2	**0.8**	**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.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		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. 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 0.54% in March, 2011, to 0.36% in August, 2011. The percentage of nurses with no missing documentation was 57 % in August 2011. (Thirty six percent missed documentation in 1-10 doses, and only 7% had between 10 and 50 doses with missed documentation.) Information is tracked by unit and by nurse. ***See Tab # 85 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 (April 19, 2011, April 21, 2011, and May 10, 2011. ***See Tab # 130 Mortality reports.*** All Hospital mortality reports were recently finalized and submitted to DMH for review. DMH completed its review of one of the deaths, and two more are scheduled for October, 2011. 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 Policy and Sentinel Event Policy were revised. ***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.
VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 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	

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:</td><td></td></tr>
<tr><td>VIII.B.1.a</td><td>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]</td><td>
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, 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.

Facility's findings:

<table>
<tr><th colspan="9">INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>37</td><td>38</td><td>37</td><td>25</td><td>36</td><td>45</td><td>32</td><td>36</td></tr>
<tr><td>n</td><td>2</td><td>7</td><td>7</td><td>8</td><td>8</td><td>4</td><td>5</td><td>6</td></tr>
<tr><td>%S</td><td>5</td><td>18</td><td>19</td><td>32</td><td>22</td><td>9</td><td>15</td><td>18</td></tr>
<tr><td>%C #B- 2 (Part B) Behavioral intervention screening</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 # B- 3 (Part B) Behavioral observations</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>
<tr><td>%C # B- 5b (Part B) Behavioral plan appropriateness</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>90</td><td>100</td></tr>
<tr><td colspan="9">N = Monthly admissions</td></tr>
</table>
</td></tr>
</table>

[2] Psychology uses a combination of peer review and supervisory audits. PBS plans, neuropsychology reports, progress notes and IIRPBIs 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.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>n = number audited-target is 20% sample (Audit sample plan)
Tab # 18 IPA AUDIT RESULTS

<table>
<tr><th colspan="9">BEHAVIORAL INTERVENTION PROGRESS NOTE AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td></td><td></td><td>14</td><td>18</td><td>19</td><td>20</td><td></td><td>18</td></tr>
<tr><td>n</td><td></td><td></td><td>4</td><td>3</td><td>3</td><td>5</td><td></td><td>4</td></tr>
<tr><td>%S</td><td></td><td></td><td>29</td><td>17</td><td>16</td><td>25</td><td></td><td>21</td></tr>
<tr><td>%C # 1 Progress notes list the reporting period</td><td></td><td></td><td>100</td><td>33</td><td>100</td><td>100</td><td></td><td>87</td></tr>
<tr><td>%C # 2 Progress notes report on the occurrence of target behaviors</td><td></td><td></td><td>100</td><td>100</td><td>100</td><td>100</td><td></td><td>100</td></tr>
<tr><td>%C # 3 Progress notes comment on changes in the occurrence of the target behaviors</td><td></td><td></td><td>100</td><td>100</td><td>100</td><td>100</td><td></td><td>100</td></tr>
<tr><td>%C # 4 Progress notes provide analysis of the staff's preventions/interventions as guided by the IBI/PBS plan or behavior guidelines</td><td></td><td></td><td>100</td><td>67</td><td>100</td><td>100</td><td></td><td>93</td></tr>
<tr><td>%C # 5 Progress notes provide assessment of effectiveness of the IBI, Guideline or Plan</td><td></td><td></td><td>100</td><td>33</td><td>100</td><td>100</td><td></td><td>87</td></tr>
<tr><td>%C # 6 Progress notes provide recommendations/plan for modifications to the IBI, Guideline or Plan</td><td></td><td></td><td>100</td><td>67</td><td>100</td><td>100</td><td></td><td>93</td></tr>
<tr><td>%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</td><td></td><td></td><td>100</td><td>33</td><td>100</td><td>100</td><td></td><td>87</td></tr>
<tr><td>%C #8 Number of missing progress notes over the review period.</td><td></td><td></td><td>75</td><td>33</td><td>100</td><td>100</td><td></td><td>80</td></tr>
</table>
N=Number of individuals in care with BI
n=number audited
Tab # 20 BI PROGRESS NOTE AUDIT TOOL AND RESULTS

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 many indicators over 90% and all are at least at the 80% mark. These audits will continue.</td></tr>
<tr><td>VIII.B.1.b</td><td>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</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>for earning reinforcement;</td><td></td></tr>
<tr><td>VIII.B.1.c</td><td>ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not ,the use of aversive contingencies;</td><td></td></tr>
<tr><td>VIII.B.1.d</td><td>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;</td><td></td></tr>
<tr><td>VIII.B.1.e</td><td>ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and</td><td>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:

<table>
<tr><th colspan="9">BEHAVIORAL INTERVENTIONS AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>3</td><td>2</td><td>5</td><td>4</td><td>1</td><td>3</td><td>4</td><td>3</td></tr>
<tr><td>n</td><td>2</td><td>2</td><td>5</td><td>4</td><td>1</td><td>2</td><td>2</td><td>3</td></tr>
<tr><td>%S</td><td>67</td><td>100</td><td>100</td><td>100</td><td>100</td><td>67</td><td>43</td><td>89</td></tr>
<tr><td>%C. #1. The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms</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>#2. Appropriate data collection methods are used</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>#3. A structural assessment is completed</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>100</td><td>n/a</td></tr>
<tr><td>#4. A functional assessment is completed</td><td>n/a</td><td>n/a</td><td>n/a</td><td>100</td><td>n/a</td><td>n/a</td><td>100</td><td>100</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		#5. The target maladaptive behavior is described in terms of its predisposing, precipitating, and perpetuating factors	100	100	100	100	100	100	**100**	**100**
		#6. A baseline estimate of the behavior is presented in terms of objective measures (e.g., rate, frequency, duration, severity, intensity).	100	100	40	75	100	100	**70**	**75**
		#7. At least one hypothesis is generated from the assessment data	100	100	100	100	100	100	**90**	**100**
		#8. Behavioral interventions are directly related to the hypothesis	100	100	100	100	100	100	**100**	**100**
		#9. Appropriate interventions are developed if the target maladaptive behavior is to be made irrelevant	50	100	100	100	100	100	**90**	**100**
		#10. Appropriate interventions are developed if the target maladaptive behavior is to be made inefficient	50	100	60	100	100	100	**78**	**100**
		#11. Appropriate interventions are developed if the target maladaptive behavior is to be made ineffective	100	100	40	100	100	100	**100**	**100**
		#12. Behavioral interventions do not use aversive contingencies	100	100	100	100	100	100	**90**	**100**
		#13. The behavioral intervention plan is revised as clinically indicated by outcome data	100	n/a	n/a	100	100	100	**100**	**100**
		#14. Should the individual engage in the target maladaptive behavior, the staff know how to respond to it in an effective manner	50	100	60	100	100	100	**70**	**81**
		N = Individuals referred for behavioral interventions n = number audited ***Tab # 84 BEHAVIORAL INTERVENTIONS AUDIT RESULTS.*** **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 that of the prior review period on all but two indicators, and both of these are trending in a positive direction. Based upon the data, no additional actions will be taken, but audits will continue and corrective actions will be taken as indicated.								
VIII.B.1.f	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.	**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. 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 a selection certificate was issued. Selections have been made, pending reference and background checks.								

<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>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 this 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="3">CURRICULUM BASED
GROUP FACILITATOR MONITORING AUDIT RESULTS</th></tr>
<tr><th></th><th>Percent Compliance*</th><th>Average Score</th></tr>
<tr><td>N =142 (# of group leaders all type of groups)</td><td></td><td></td></tr>
<tr><td>n= 54(number observed curricula based groups)</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>4.3</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>4.3</td></tr>
<tr><td>%C #3. Leader identifies group agenda and maintains focus on agenda for the full session.</td><td>87</td><td>4.1</td></tr>
<tr><td>%C #4. Leader’s presentation style is engaging and effective.</td><td>91</td><td>4.3</td></tr>
<tr><td>%C #5. Directions, objectives and other information is provided in a clear manner.</td><td>91</td><td>4.2</td></tr>
<tr><td>%C #6. Leader utilizes positive instructional techniques.</td><td>89</td><td>4.1</td></tr>
<tr><td>%C #7. Leader uses reality orientation, sensory stimulation, and other therapeutic techniques appropriately.</td><td>93</td><td>4.2</td></tr>
<tr><td>%C #8. Leader presents information in a manner appropriate to the functional level of group members.</td><td>94</td><td>4.4</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		%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	4.2
		%C # 10 All group leaders appeared to be at the appropriate cognitive and/or functional level for the group.	89	
		%C # 11 Individuals' Treatment Goals/objectives are linked with group objectives	78	

***** 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**
N =142 (Number of group leaders, all type groups)		
n= 26 (number observed)		
%C. # 1 Sets group agenda and discussed group rules	87	3.9
%C #2. Encouraged member self-disclosure that was relevant to the current group agenda without forcing it	92	4.3
%C #3. Encouraged here and now versus story-telling disclosure.	90	4.1
%C #4. Interrupted ill-timed or excessive member disclosure and reframed injurious feedback	89	3.7
%C #5. Encouraged positive feedback.	91	4.1
%C #6. Helped members apply in-group feedback to out of group situations.	89	3.9
%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	3.9
%C #8. Maintained an active engagement with the group and its work.	96	4.6
%C #9. Recognized and responded to the meaning of group members' comments.	96	4.3
%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	4.2

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 11 All group members appeared to be at the appropriate cognitive or functional level for group	76	
%C # 12 Individuals/ treatment goals and objectives are linked with the group objectives	74	

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

See Tab # 106 GROUP FACILITATOR MONITORING RESULTS

Analysis/Action plan:

During this 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 three times 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. 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. Two 12 hour trainings on leading groups are also being held, one in September and a second in October. Data from the audits show overall performance is somewhat better for curriculum based groups, and across all groups, an average of 80% of leaders are performing at an acceptable or above level.

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 four competency groups each week, and TLC, psychology and PBS team staff revisited treatment strategies for each unengaged individual. In TLC transitional, there was an expansion and revision of discharge focused programming. ***Tab # 50 Status Report; Treatment of Unengaged Individuals.*** All transition specialists are now spending all of their time in the Transitional TLC. A new group has been developed by Consumer and Family Affairs to reframe the concept of resistive individuals. Individuals not wanting to leave the hospital will be in a process group focused on helping them "warm-up" to the idea of community living through multi-disciplinary approaches, including connections with former individuals in care who successfully reside in the community. Chaplaincy has developed a group entitled "Spiritual Home" which is designed to assist interested individuals in establishing roots in a religious community; this is expected to facilitate a smoother transition to the community because the individual in care will have an established system of religious support upon discharge. Social Work has improved their curricula to provide more in-depth lessons on distinct components of discharge planning (e.g., money management, understanding your benefits, etc.). ***Tab # 55 TLC and Unit Based Group Schedules***

VIII.B.3	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.	**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.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		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. Twenty five individuals were originally identified and not engaged in treatment. Of those, two are now sufficiently engaged to be able to be removed from the list, and another 12 are more engaged in treatment. ***See Tab # 50 Status Report: Treatment of Unengaged Individuals*** **Facility's findings:** See VIII.B.2 **Analysis/Action Plans:** Continue with audits as well as the group leader training.
VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	
VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	
VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	
VIII.B.4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	
VIII.B.4.d	programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;	
VIII.B.4.e	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;	**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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>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><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>234</td><td>214</td><td>244</td><td>218</td><td>193</td><td>222</td><td>195</td><td>221</td></tr>
<tr><td>n</td><td>22</td><td>24</td><td>20</td><td>22</td><td>20</td><td>16</td><td>22</td><td>21</td></tr>
<tr><td>%S</td><td>9</td><td>11</td><td>8</td><td>10</td><td>10</td><td>7</td><td>13</td><td>10</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>76</td><td>63</td><td>69</td><td>91</td><td>75</td><td>67</td><td>*</td><td>74</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 is needed 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. In addition, outside consultants have worked with selected teams on writing of objectives and interventions. See Tab # 1 for IRP Training Materials and Data. This continues to be a focus for internal mentors in working with teams.</td></tr>
<tr><td>VIII.B.4.f</td><td>clinically relevant information remains readily accessible; and</td><td></td></tr>
<tr><td>VIII.B.4.g</td><td>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.</td><td></td></tr>
<tr><td>C.</td><td>Pharmacy Services</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	**Analysis/Action Plan:** The Hospital has undertaken a number of initiatives to address this new requirement. 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 medical officer and two nurse practitioners; and a geriatric cluster, with a general medical officer and two nurse practitioners. The medical practitioners will 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. Nurse practitioners meet with the Chief Nurse Executive quarterly. In addition, nursing hired three of six quality nurse educators (QECs) who are working to enhance nursing skills on the unit level. The QECs partner with the nurse manager for each unit and provide clinical coaching and support through education, role modeling and supervision. The goal is to create a quality loop of education, practice, monitoring and compliance. QEC nurses educate staff regarding policy and procedure updates, facilitate staff in achieving competencies through a teach-model-support framework and assist in the design of unit programming. They provide real time monitoring and auditing of clinical processes, collect data for improvement purposes and provide hands on coaching during and proximally to activities such as transfers, changes in physical status, documentation, IRP nursing interventions,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		EARN contacts and emergencies. Each QEC is assigned to two units. To date, three have started and are working with staff on the geriatric and the four admission units. The QEC nurses have been working directly with unit staff around documentation, change in shift report, nursing role in the IRP, changes in physical status, medical transfers, educating staff around clinical skills (e.g. listening for bowel sounds, taking and interpreting vital signs), communicating with physicians and similar activities, depending on the unit needs. Tools for QECs were recently developed, one for monitoring the completion of the RN change in physical status form and medical transfers which will look, inter alia, at whether indications were missed; other review tools were completed to monitor STAT and emergency involuntary medication use and whether opportunities for earlier interventions were missed; these will be implemented in October. To date, QECs report that staff seem more engaged with individuals in care, with fewer codes and improved attitude by staff. Staff also seem eager for training on how to do things correctly to improve the overall quality of care. During this period, the Hospital began 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. The Committee expects to meet monthly beginning in September 2011 to look at morbidity issues. 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, 18 mock code blues have been held, across all shifts and most units. ***See Tab # 125 Mock Code Blue Log*** Audits around history and physicals and medical transfers continue. See data below. In addition, the Hospital recently created a form 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 form.*** The form 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 to the individual's plan of care. The form started being used October, 1, 2011 although it is not yet in Avatar. Nursing also developed a form for use upon an individual's return from a medical facility. ***See Tab # 87 RN Transfer Return Form.*** The new QEC nurses and Nurse Managers for those units which do not yet have a QEC are reviewing the forms and coaching nursing staff on the scope of appropriate follow up interventions and documentation using a checklist. ***See Tab # 104 Nursing Checklist: Change in Physical Status and/or Medical Transfers.*** The review includes a review of both the outgoing and return documentation around the medical transfer as well as reassessments for 72 hours after the individual's return. Nursing also implemented use of a new form titled RN Assessment of Change in Physical Status as part of the implementation of the updated Assessing Change in Physical Status Nursing Procedure. ***See Tab # 105 Nursing Procedure Assessing Change in Physical Condition and related form.*** Under the revised procedure, nursing staff assess individuals in care on an ongoing basis to identify potential 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 to be 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. As with the form for return from a medical facility, nurse managers and the QEC nurses are reviewing the completed forms using a structured checklist to assess the quality of documentation and clinical practice. The checklist includes questions around the timeliness of the assessment, the appropriateness of the clinical assessment as well as the quality of the documentation. Information will be collected, and QECs or Nurse Managers will provide education and

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		coaching promptly after the completion of the checklist. ***See Tab # 104 Nursing Checklist: Change in Physical Status and/or Medical Transfers.*** Use of the checklist to review completion of the medical transfer and/or RN change in physical condition forms began October 1, 2011. 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 more than once daily insulin will be placed on short acting insulin and prn Lantus using a specific protocol. It is also seeking to hire a certified diabetic educator to work with staff around diabetes management issues or alternatively, is considering contracting with a qualified nurse to write procedures and train staff. Nurse managers are also observing at least one medication or insulin administration per RN per quarter, and 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.*** All individuals who did not meet the competency standards have been retrained. Those who continue not to meet the standard (1 individual) has been relieved of medication administration duties until he can pass the competency. The Hospital is implementing the new seizure management policy, and nursing has begun to utilize the recently updated seizure observation form. ***See Tab # 49 Seizure Management Policy and Observation 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. However, the prior version of the seizure observation form also can be found in FileNet. The Hospital implemented a new system to notify physicians of abnormal laboratory results pending completion of the automated interface. Now, laboratory personnel must call the physician whenever levels are outside the normal range for therapeutic drugs. In addition, each physician is provided with a copy of the daily laboratory results so that they can check results for individuals in care they serve. During the review period, nursing made substantial revisions to its CINA and Nursing Update forms and in September, 2011, requested changes to Avatar forms; it is expected that these changes will improve identification of and treatment for psychiatric and medical issues. Both forms are in development with Avatar. Nursing, in the meantime, requested that the light bulb instructions for the Nursing Update form now in Avatar be updated in an effort to improve linking information in the Update to the IRP while the new Nursing Update form is being developed. Nursing elected to defer development of new audit tools until the new forms can be implemented. Copies of the proposed form changes can be found in Tab ##s 22 (CINA) and 24 (Nursing Update). The Hospital formalized a template for morning rounds which is to be rolled out to all units in October, 2011. The template prompts discussion of key facts for the individual in care, including diagnoses, medication, laboratory orders and results, and “to dos”.
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	**Recommendations:** 1. Resolve AVATAR barriers that prevent RNs from entering relevant nursing interventions into the IIRP. Train the designated RN to prioritize and individualize interventions.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	SEH Response: It should be noted that beginning in September, RNs on each of the admissions unit will have responsibility for completing the CINAs. Nursing staff have been given security to enter interventions into the IIRP, and recently the CNE and the Director of Medical Affairs finalized a business process to improve coordination of the IIRP development. Under the process, RNs will now enter the nursing interventions into the IIRP directly. Nursing will work with the admitting doctor to ensure that the IIRP is initiated promptly, and nurse managers or QEC nurses will follow up each morning to ensure that the interventions were added. 2. Expedite implementation of new policies and forms including assignment sheets. Monitor implementation and make operational adjustments as indicated. SEH Response: The following revised policies have been implemented during this review period: Nursing Documentation Procedure, Nursing Transfer Procedure, Nursing Procedure on Assessment of Change in Physical Condition, Nursing Procedure on Dysphagia, Nursing Procedure on Seclusion and Restraint, and Nursing Procedure on Medication Administration and Reconciliation. Nurse manager provided staff with the new policies and highlighted the changes with their staff. QEC nurses are also acting as coaches with nurse managers to ensure staff are implementing the practice changes. Several checklists were developed and implemented in October 2011 to monitor practice on key areas, including use of STAT medication and emergency involuntary medication, RN assessment of changes in physical condition, First Dose Medication checklist and RN medical transfer documentation. 3. Align EARN with recovery principles and link activities with established basic nursing functions, e.g. consistent assignment to work with specific individuals, integration with IRP, integration with routine documentation requirements. SEH Response: EARN is aligned with recovery principles; EARN is a delivery mechanism that is based upon engagement principles that foster proactive interactions with individuals in care. EARN Is now implemented on all units and the TLCS. However, EARN implementation is affected by staffing, and as staffing increases, with fewer floating assignments, EARN implementation can be expanded and should become increasingly more effective. Once fully implemented, EARN is expected to improve the staff's ability to identify stressors, improve staff relationships with individuals in care, and improve documentation that will foster treatment and improved outcomes. The EARN database has been completed but currently EARN tracks the number of contacts only. 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. Consider devoting one meeting per month to reviewing aggregate data so that real trends (versus practitioner specific issues or normal variation) can be identified and acted upon. SEH Response: The CNE is working with an outside consultant to restructure nurse manager meetings. The current plan is to have one Executive meeting each month, which will include review of policy and procedures, house monthly reports (each house reviewed once per quarter), data, environment of care and similar issues. Other meetings will focus on management and clinical competencies issues, among others.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

5. See VIII.D.11

SEH Response: See VIII.D.11

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P***	**Mean-C**
N	234	214	244	218	193	222	**167**	**221**
n	22	20	19	15	11	11	**18**	**16**
%S	9	9	8	7	6	5	**11**	**7**
%C # Data fields Presence of RN in IRP meetings	95	95	95	87	100	91	**87**	**94**

N=All IRPs scheduled
n=number audited in the month
* The mean from the indicated period is based upon three months of audits
Tab # 7 IRP OBSERVATION AUDIT RESULTS

INITIAL NURSING ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	37	38	37	25	36	45	**32**	**36**
n	7	7	8	6	8	9	**6**	**8**
%S	19	18	22	24	22	20	**19**	**21**
Completed within 8 hours	57	71	50	67	75	78	**85**	**67**
%C #9 If assessment identified risk in any risk screens, was nature of risk described sufficiently to develop adequate nursing interventions to address risk	86	100	88	83	75	100	**81**	**89**
%C #13 If prior medical history was noted was there appropriate description of the event so that interventions could be identified if needed?	83	100	100	100	75	89	**85**	**91**
%C # 16 Did the assessment include a physical assessment of all systems	86	100	100	100	75	100	**97**	**93**
%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?	67	100	88	100	83	86	**81**	**87**
%C #25 Did the record overall support the findings in the mental status examination sections?	100	100	100	100	88	100	**97**	**98**
%C # 26 Were the MSE section findings consistent with the risk assessment findings?	100	100	100	100	88	100	**100**	**98**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #28 Was the recovery assessment section completed?	71	71	75	100	50	67	**87**	**71**
		%C #30 Do the assessments in each domain of the functional rehabilitation screens accurately reflect the record?	83	86	100	100	63	89	**68**	**86**
		%C #33 Were nursing interventions developed?	86	100	100	100	88	89	**76**	**93**
		%C #34 Was a nursing intervention developed for each area of risk identified in the assessment?	43	86	100	100	75	44	**69**	**73**
		%C #35 Were the nursing interventions specific and individualized and tailored to the individual's needs?	43	57	50	83	50	56	**58**	**56**
		%C #36 Were the interventions appropriate to the functional level of the individual?	57	71	63	100	63	56	**88**	**67**

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

NURSING UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	239	254	249	251	232	233	**270**	**243**
n	17	22	21	21	22	22	**14**	**21**
%S	7	9	8	8	9	9	**5**	**9**
%C #2 Has the advance instruction/comfort plan form been reviewed and updated	100	100	95	95	100	100	**90**	**98**
%C # 5 Are strengths clearly described	94	100	100	95	100	100	**92**	**98**
%C # 6 Is the current mental status carefully described	100	95	52	48	59	59	**96**	**68**
%C # 7 Is improvement re current mental status summarized per instructions	94	77	48	48	59	59	**96**	**63**
%C # 8 Is current safety risk indicated	88	81	100	95	95	86	**94**	**91**
%C # 9 Is change in safety risk since last update noted	88	95	100	95	91	86	**79**	**93**
%C # 10 Summary of current health and wellness challenges which require monitoring or treatment adequately noted	94	95	95	95	100	100	**96**	**97**
%C # 11 Pertinent risk assessment tool ratings (falls, skin integrity, dysphagia) included	93	95	90	95	73	55	**86**	**83**
%C # 12 Includes cognitive and perceptual/neurological symptoms if indicated	87	90	75	81	41	36	**90**	**67**
%C # 13 Includes summary of vital signs and weight	53	82	71	67	73	82	**74**	**72**
%C # 14 Includes pertinent changes in lab values	67	60	74	55	45	41	**79**	**56**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 15 Includes capacity for ADLS and if the individual is able to manage ADLs independently	82	86	90	86	100	91	**86**	**89**
% C # 16 Includes progress/lack of progress and conclusion	94	95	100	100	100	100	**85**	**98**
%C # 26 Summarizes the progress toward recovery goals	73	75	91	92	94	100	**60**	**88**
%C # 29 Describes relationships in the milieu	73	76	80	95	91	82	**65**	**83**
%C # 30 Describes circumstances if individual has been involved in conflicts or arguments	44	60	50	38	86	77	**71**	**60**
%C # 32 Describes hobbies or leisure skills	47	36	42	48	59	50	**59**	**47**
%C # 34 Notes discharge issues	76	64	80	81	95	86	**76**	**81**
%C # 35 Notes progress or lack of progress and conclusions	88	95	90	90	100	100	**77**	**94**
%C # 36 Describes if individual knows what nursing is doing for him and why	82	81	75	95	95	91	**83**	**87**
%C # 37 RN summarizes progress and makes recommendations to IRP	93	71	79	86	86	73	**79**	**81**
%C # 38 RN identifies issues not covered in focus areas or data that reflect currently inactive problems but may become issues later	81	68	72	86	86	73	**71**	**78**

N= End of month Census less new monthly admissions
n= number of updates audited
See Tab# 3 NURSING UPDATE AUDIT RESULTS

Analysis/Action Plan: Data shows that the attendance of the registered nurse at the IRP is improved over the last reporting period and that it now exceeds the 90% threshold. ***See Tab # 7 IRP Observation Monitoring Results.*** Data from the CINA and Nursing Updates show performance around the quality of the initial nursing assessment and the nursing update is improved over last review period, but is still not meeting the expected level for many indicators. ***See Tab # 3 CINA and Nursing Update audit Results***

The CINA audit showed that a majority of indicators are trending upward, including indicators around risk assessment and interventions to address risk, medical history screening, physical assessment screening, choking screening, and functional rehabilitation screening. Key indicators with a negative trend include the timeliness of the CINA, completion of sections around diabetes, completion of the recovery assessment section and the development of nursing interventions. The timeliness issue is expected to be resolved when the CINA is divided into two parts. Nurse managers and QECs will work with individual RNs as issues are identified.

With respect to the Nursing Update audit results, several things should be noted. Of the 40 indicators (excluding timeliness), 4 are new ones or revised, and of the remaining 24 trended in a positive direction, but 12 trended in a negative direction. There are clear areas of where performance improved can be identified - - these include indicators

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

around forensic/legal, substance abuse and the individual's understanding of the interventions being provided by nursing. However, other critical areas show a negative trend, including those involving clinical data and the psychiatric and psychological focus areas. Some of this may be a result of changes to the audit process - -beginning in March, 2011, the auditing process was changed so that there was one designated individual who conducted the audits, in order to address previously identified inter-rater reliability issues. This ensured a more consistent interpretation of the audit instructions, and the Hospital believes presents a more accurate portrayal of progress. Nursing leadership is using the data to identify areas of strength and areas in which improvement is needed. The data results are shared with nurse managers and they, with the QECs, are working with individual staff to improve the quality of the Update.

In addition, the audit results revealed issues with the Update form itself and nursing is working to finalize the CINA and Nursing Update forms. The CINA is being divided into two forms; after testing of the revised, two-part form, nursing in early September 2011, requested additional changes from the Avatar team to make it more user friendly and more responsive to the Hospital's needs. Similarly, the Hospital is substantially reworking the Nursing Update form. The revised form will ensure better linkage to the IRP objectives and interventions. This too was submitted to Avatar in early September, 2011. The changes requested are reflected in Tab # 26 and 28. ***See Tab #22 Revised CINA and Tab # 24 Nursing Update forms*** The Hospital continues to use the CINA now in Avatar while awaiting the changes. The current nursing update Avatar form will continue to be used while the new form is developed, but the instructions have been updated to provide additional guidance to staff in completing the form. Revised CINA and nursing update audit tools will be completed and ready for implementation when the new forms are finalized.

The Hospital also is implementing a number of other strategies to improve nursing practice and skills; much of this review period was on filling vacancies and strengthening the core competencies of nurse managers.

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 is tied to unit census and acuity. ***See Tab # 86 Nursing Staffing Plan***. The District made significant gains by hiring an additional 41 nursing staff since April, 2011; 9 additional RNs and 1 Nurse Manager have offers and EOD dates over the next three pay periods. Twenty two nurse vacancies from the end of FY 11 are funded in FY12, but there remains a shortage of 28 RN positions needed in FY12 for which no funding has been identified. Funds will need to be identified if the Hospital is to meet the 50% RN mix.

Table 1: RNs hired since April 2011

Month	April	May	June	July	August	September	Total
New Hires	1	5	8	13	19	10	56
Separations	1	3	2	2	3	4	15
Net Gain for Month	0	2	6	11	16	6	41

* Nine RNs and 1 Nurse Manager have offers and will be starting over the next three pay periods. They are NOT counted in the 41.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

	A Total # Needed for 50% Mix and 6 NCHPPD	B Total FY 11 Funded Positions	C Total Filled FTEs (D+E+F)	D Total On Units	E Total in Training	F Total on Long term Admin Leave/Workers Comp/Not Employed in Nursing	*G* *Currently Vacant (B-C)*	H FY 12 Additional Funded Positions	I FY 12 Shortage in Funded positions (A-B)
NM	N/A	14.5	13.5	13.5	0	0	1	0	0
RNs	184.5	156.5	134.5	84	35	15.5	22	0	28
QECs	N/A	6	3	2	1	0	3	0	0
RAs	248.5	230.5	230.5	205	0	25.5	0	0	18

* NCHPPD and RN mix values above are calculated for the general patient population. Individuals on special 24-hour 1-to-1 staff-to-patient assignments are excluded from the calculation. They receive dedicated care from recovery assistants and RNs. The Hospital can range from 8-15 individuals in care on 1-to-1 assignments every day. The calculations above assume an average of 30 shifts dedicated to individuals in care on 1-to-1 assignments, which translates to 11 individuals on 1-to-1's over a 24 hour period.

There also has been effort to strengthen the management competencies of nurse managers. Nurse managers, working with an outside consultant, identified cores leadership and management competencies and have completed competency based training in these. The competencies include customer focus, managing and measuring work, motivating others, problem-solving, process and time management, total quality management, managing diversity, ethics and values, and organizational agility. Nurse managers completed four modules; Module 1 focused on leadership competencies around ethics, values, managing diversity and motivating others. Module 2 focused on customer focus, problem-solving, and organizational agility, and Module 3 focused on managing and measuring work, process management and TQM, and Module 4 on the role of nursing in the recovery model of mental health services. ***See Tab # 102 Nurse Manager competencies and related training.*** This will provide the leadership foundation for continued work with staff around improving clinical skills. 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, QEC implementation, and recovery training that will be provided to all staff over the next several months.

Also during this review period, nursing implemented the new procedures finalized in the Spring, 2011. Key procedures that have been implemented include procedures around change in physical status, seizure management policy, diabetes management policy, medical transfers and related documentation. RNs are expected to complete nursing update notes each week, and nursing is attending IRPs over 90% of the time. ***See Tab # 7, IRP Observation Monitoring Audit Results.*** QEC nurses on four units (1A and 1B and 1D and 1E) are working with staff around documentation, change of shift report, and are providing remedial training on vital signs, physical examination and medication administration. (An additional QEC began work on September 26, 2011 and is assigned to support 1F and 1G). QECs and nurse managers are reviewing

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		changes in physical status forms, nursing notes around medical transfers and seizure observation forms not only to ensure they are completed, but to provide feedback on the quality of the documentation and nursing service. Checklist forms for use by QECs and nurse managers to provide a structural review of STAT medication use, RN assessment of changes in physical status and medical transfers (to include review of cases to determine in opportunities to avoid emergent circumstances) were recently finalized and were implemented in late September 2011. These efforts are expected to improve the quality of care, and provide opportunities for educating staff, improving practice, monitoring practice and ensuring Hospital standards are being met. In addition, 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, 96% of RNS passed competency for diabetes management and insulin administration. ***See Tab # 103 Insulin and Medication Administration observation data*** Two RNs did not pass competency, both were provided remediation training, which one completed successfully. The second has been taken from insulin administration duties and is receiving mentoring on the day shift. One LPN did not pass competency. He is receiving retraining. With respect to medication administration observations, 98.6% of RNs successfully completed competency (one failed and is being retrained), and 2 LPNs failed competency. Both are no longer administering medication until retraining is completed and competency obtained. 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 0.36%, with 57% of nurses with no missed documentation. ***See Tab # 85 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. With respect to behavioral interventions, the PBS team is providing weekly coaching to TLC nursing staff relating to those individuals whose participation in the TLC programming is marginal, reinforcing PBS training nursing staff have had. In addition, the PBS team continues to train nursing staff throughout the Hospital on positive collaborative problem solving. ***See Tab # 66 Collaborative Problem Solving Training*** To date, 77% of non nursing clinical staff, 80% of nursing day shift, 68% of nursing evening shift, and 79 % of night nursing shift have completed the training. Seven internal trainers completed Safety Care training, and all direct care staff is expected to complete this training by next Spring.
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:** 1. Resolve AVATAR issues. SEH Response: In an effort to resolve the various issues with AVATAR, the Avatar team conducted a series of town hall meetings and a consumer satisfaction survey to obtain detailed information from direct care staff about the challenges they face in using Avatar. In addition, Avatar staff sat with direct care staff and observed them using the system, timing how long certain activities were taking and how frequent issues arose. Key areas identified included speed of the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		application, performance of the vital signs screens, performance of eMAR and lack of a comprehensive patient record review. The District identified $407,000 in funds for Avatar enhancements during FY 2011. As a result of these efforts, key issues around Avatar were resolved. The Hospital implemented a chart review feature in August 2011, which lists episode specific information including demographics, unit assignment, vital signs details, diagnoses, clinical assessment reports, discharge plans and summary, date of entry and assessment status. In addition, by the end of July 2011, Avatar resolved the "bugs" that were affecting eMAR and Vital signs screens. For several days in June 2011, speed was such an issue that the Hospital, based upon a recommendation of the Pharmacy and Therapeutics Committee, suspended use of Avatar for medication administration and instead reverted to a paper system. A patch was issued, installed and tested during high medication pass times; retrieval time of eMAR screens was reduced from 10+ minutes to less than 30 seconds. Similarly, the issues with the Vital Signs screens were resolved in July 2011, after it was discovered that the system was recording multiple rows of data into the tables which was affecting system performance and speed. ***See Tab # 71 Avatar Summary Document.*** Nursing now is able to enter nursing interventions into the IRP in Avatar. The survey revealed that staff would benefit from additional training in Avatar. The Hospital contracted with NetSmart to provide refresher and "tip" training in September 2011. As of the writing of this report, 165 staff have participated in the training. 2. Implement audit tools in order to identify improvements necessary to meet the requirements of this provision. SEH Response: Development of new audit tools for the CINA and Nursing Update was deferred pending the revision of the CINA and Nursing Update forms, which were submitted to Avatar for revision in September 2011. Checklists for review of documentation around STAT medication use, RN assessment of changes in physical condition, nursing documentation concerning medical transfers and nursing documentation of medical transfers were developed and will be used by the QECs and nurse managers beginning October 2011. 3. See VIII.D.11 SEH Response: See VIII.D.11. **Analysis and action steps:** See generally response to VIII.D.2. The Hospital implemented several new nursing procedures this review period to address this requirement. The Nursing Procedure for Assessment of Change in Physical Condition was implemented and the RN Change in Physical Status note is now being completed by nurses and scanned into FileNet. ***See Tab # 105 Nursing Procedure, Assessment of Change in Physical Condition*** A checklist was recently developed to audit these forms, and reviews by QECs and nurse managers will begin in October 2011. ***See Tab # 104 Checklist for RN Change in Physical Status Note*** The medical transfer note by nursing is also implemented and likewise is being scanned in FileNet pending development of the form in Avatar. ***See Tab # 87 Nursing Procedure, RN Medical Transfer form.*** The QECs and nurse managers are reviewing this documentation as well as documentation in the days following an individual's return from the Hospital and providing feedback to staff concerning the content and quality of the notes. ***See Tab # 104 Checklist for RN Change in Physical Status Note*** QECs are also providing coaching on monitoring medically necessary

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		measurements. ***See Tab # 67 QECs Nursing Plan.***
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Recommendations:** 1. Identify and implement opportunities to streamline the eMAR requirements. SEH Response: A review of Avatar around medication administration suggested that the issues were not related to the eMAR requirements themselves, but were a result of technical difficulties that caused significant delays in loading the screens. These issues were resolved in June 2011. See VIII.D.3 at recommendation # 1. 2. Resolve issues associated with AVATAR. SEH Response: See VIII.D.3 at recommendation # 1 3. Complete the medication administration policy. SEH Response: A draft of the policy is complete and the policy will be finalized by the site visit. **Analysis/Action plan:** See responses to recommendations. The Hospital continues to monitor the rate of missed documentation for routinely scheduled medications. ***Tab # 85 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. Information is also tracked by unit. This will continue. The Hospital policy on medication administration was updated to include specific language around first dose medication monitoring and the nursing procedure is also being updated; the policy is in draft form and will be finalized by the site visit. In addition, 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, 96% of RNS passed competency for diabetes management and insulin administration. ***See Tab # 103 Insulin and Medication Administration observation data*** Two RNs did not pass competency, both were provided remediation training, which one completed successfully. The second has been taken from insulin administration duties and is receiving mentoring on the day shift. One LPN did not pass competency. He is receiving retraining. With respect to medication administration observations, 98.6% of RNs successfully completed competency (one failed and is being retrained), and 2 LPNs failed competency. Both are no longer administering medication until retraining is completed and competency obtained.
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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 appropriate follow-up occurs to prevent recurrence of such errors	**Recommendations:** Maintain compliance. SEH Response: Compliance maintained. Fourteen medication variances of all types were reported by nursing during the reporting period, a significant decrease from the prior review period during which nursing reported 42 variances.

MEDICATION VARIANCES BY REPORTER

	Mar~11	Apr~11	May~11	Jun~11	July~11	Aug~11	Mean-P	Mean-C
Physician	0	0	0	1	1	0	0.7	0.5
Nursing	2	5	1	2	3	1	7.0	2.3
Pharmacy	6	15	13	15	11	12	4.7	12.0
Not identified	0	0	0	1	0	0	0.2	0.2

See Tab # 76 MVR data

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 0.36% in August, 2011.

In an effort to improve the reporting of MVs, the Hospital in early Summer 2011 launched a Six Sigma review of ADRs and MVR. The project began with a review of data and was followed by audit of records to assess the degree of underreporting. The audit, which looked only at specific data sets, such as rationale for medication changes documented in Avatar, was conducted by a psychiatrist and the Chief Pharmacist, and used a list of data sets to detect any suspected ADRs or MVRs during a one month period. Audit results suggest a significant number of ADRs and MVs go unreported. ***See Tab # 47 Six Sigma ADR/MVR audit findings.*** Data sets from which cases were reviewed 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 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.)

With respect 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%. Most of the unreported MVR appear to be in the potential category - - 71% in category A or B and 29% in category C.

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 or revealing

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		errors; 3) burden of paperwork in reporting; 4) lack of understanding on ADR/MV. The six sigma team presented the findings to the Pharmacy and Therapeutics Committee in September 2011 and made preliminary recommendations to improve reporting. The Committee requested additional information concerning some of the recommendations such as how could a short form report be implemented, whether certain alerts could be built into Avatar to remind staff to complete the form, and/or whether Pharmacy could obtain daily reports around the initial ordering of certain medications to track ADRs. See VIII.D.4 for additional information and data.
VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;	
VIII.D.8	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;	**Recommendations:** 1. See VIII.D.2, D.3, D.4, and D.9. SEH Response: See VIII.D.2, D.3 and D.9. 2. Develop clearer expectations for RA documentation with a close eye on minimizing potential for duplication of/conflict with the RN note content. SEH Response: The Hospital is piloting a training program on 1B using the QECs to train RA staff around documentation. Under the pilot, the QEC is working with unit RA staff to provide guidance of what a note should include, emphasizing that RAs should focus on what they observe in the individual's behavior and symptoms and what is important to communicate to the team. The training includes improving the understanding of the RA on how the RN and treatment teams will use the information. If successful, the training will be rolled out to other units through QECs and nurse managers. **Analysis and Action plan:** See discussion about re role of QECs and implementation of the checklist reviews for RN Assessment for change of physical status, RN medical transfer form, and STAT medication.
9	Ensure that each individual's treatment plan identifies:	
VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**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: Clinical administrators and nurse managers from each treatment team met with the ADON and the Acting Director of Clinical Operations to develop strategies for ensuring that IRPs include nursing interventions and that the clinical formulations reflect the updates from nursing staff on the individual in care's progress or lack thereof as well as key changes in physical status. While this was not monitored during this review period, an indicator to address this was added to the clinical chart audit effective with September 2011 audits. **2.** Monitor policy implementation, identify trends, take action to address trends, and monitor effectiveness of actions taken.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Ongoing.

Facility's Findings:
The question below was deleted from the audit beginning in March, 2011 but will be added back effective with September 2011 audits.

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N							**195**	
n							**22**	
%S							**12**	
%C. #17. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement							**91**	

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								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	234	214	244	218	193	222	**167**	**221**
n	22	20	19	15	11	11	**18**	**16**
%S	9	9	8	7	6	5	**11**	**7**
%C RN attendance at IRP	95	95	95	87	100	91	**87**	**94**
%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	95	100	100	87	100	91	**95**	**96**

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: In an effort to streamline the audit tools, the Hospital eliminated the indicator relating to this requirement from the clinical chart audit tool and thus no data for the review period is available. However, it has returned the indicator to the clinical chart audit tool beginning with the September 2011 audits. Data from the IRP observations suggests improved performance on this indicator. In addition, the Acting Director of Clinical Operations and the ADON met with the clinical administrator and nurse manager from each treatment team in an effort to improve

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>nursing interventions in the IRP. The goal of the meetings was to ensure nurse managers understood how the IRPs were developed and the role of the nursing update in informing the team. Instructions to the nursing update to highlight the linkages to the IRP were also updated in Avatar while the revised nursing update form is being developed and tested.</td></tr>
<tr><td>VIII.D.9.b</td><td>the related symptoms and target variables to be monitored by nursing and other unit staff; and</td><td>Recommendations:
1. See VIII.D.2, D.3, D.4, D.8 and D.9.a.

SEH Response: See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 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 # 8, Clinical Chart Audit Tool and Instructions

Facility’s Findings:

The question below was deleted from the audit beginning in March, 2011 but will be added back effective with September 2011 audits.

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td></td><td></td><td></td><td></td><td></td><td></td><td>195</td><td></td></tr>
<tr><td>n</td><td></td><td></td><td></td><td></td><td></td><td></td><td>22</td><td></td></tr>
<tr><td>%S</td><td></td><td></td><td></td><td></td><td></td><td></td><td>12</td><td></td></tr>
<tr><td>%C. #18. The IRP identifies the related symptoms and target variables to be monitored by nursing and other staff</td><td></td><td></td><td></td><td></td><td></td><td></td><td>78</td><td></td></tr>
</table>
N = All IRPs due in the review month
n = number audited
Tab # 2 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The Hospital will re-include this indicator in the clinical chart audits to identify areas and or units in which additional training or coaching may be needed during the upcoming review period.</td></tr>
<tr><td>VIII.D.9.c</td><td>the frequency by which staff need to monitor such symptoms:</td><td>Recommendation:

See VIII.D.2, D.3, D.4, D.8, D.9.a, and D.9.b

SEH Response: See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a.</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:

The question below was deleted from the audit beginning in March, 2011 but will be added back effective with September 2011 audits.

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td></td><td></td><td></td><td></td><td></td><td></td><td>195</td><td></td></tr>
<tr><td>n</td><td></td><td></td><td></td><td></td><td></td><td></td><td>22</td><td></td></tr>
<tr><td>%S</td><td></td><td></td><td></td><td></td><td></td><td></td><td>12</td><td></td></tr>
<tr><td>%C. #19. The IRP identifies the frequency by which staff need to monitor such symptoms</td><td></td><td></td><td></td><td></td><td></td><td></td><td>80</td><td></td></tr>
</table>
N = All IRPs due in the review month
n = number audited
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>
<tr><td>VIII.D.11</td><td>Ensure sufficient nursing staff to provide nursing care and services</td><td>Recommendations:
1. Immediately hire additional RNs. At this time, an RN skill mix of at least 50% will be needed to meet the provisions in this agreement. Although this figure can be reconsidered in 2 – 3 years when new processes have taken hold, in light of the SEH service population, the RN Skill Mix should not go below 40%.

SEH Response: The CNE developed a staffing plan that ensures a 50% RN mix and is tied to unit census and acuity. See Tab # 86 Nursing Staffing Plan. The District made significant gains by hiring an additional 41 nursing staff since April, 2011; 9 additional RNs and 1 Nurse Manager have offers and EOD dates over the next three pay periods. Twenty two</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

nurse vacancies from the end of FY 11 are funded in FY12, but there remains a shortage of 28 RN positions needed in FY12 for which no funding has been identified.

Table 1: RNs hired since April 2011

Month	April	May	June	July	August	September	Total
New Hires	1	5	8	13	19	10	56
Separations	1	3	2	2	3	4	15
Net Gain for Month	0	2	6	11	16	6	41

* Nine RNs and 1 Nurse Manager have offers and will be starting over the next three pay periods. They are NOT counted in the 41.

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 11 Funded Positions**	**Total Filled FTEs (D+E+F)**	**Total On Units**	**Total in Training**	**Total on Long term Admin Leave/Workers Comp/Not Employed in Nursing**	***Currently Vacant (B-C)***	**FY 12 Additional Funded Positions**	**FY 12 Shortage in Funded positions (A-B)**
NM	N/A	14.5	13.5	13.5	0	0	1	0	0
RNs	184.5	156.5	134.5	84	35	15.5	22	0	28
QECs	N/A	6	3	2	1	0	3	0	0
RAs	248.5	230.5	230.5	205	0	25.5	0	0	18

* NCHPPD and RN mix values above are calculated for the general patient population. Individuals on special 24-hour 1-to-1 staff-to-patient assignments are excluded from the calculation. They receive dedicated care from recovery assistants and RNs. The Hospital can range from 8-15 individuals in care on 1-to-1 assignments every day. The calculations above assume an average of 30 shifts dedicated to individuals in care on 1-to-1 assignments, which translates to 11 individuals on 1-to-1's over a 24 hour period.

2. 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).

SEH Response: The Hospital continues to monitor nursing care hours and RN mix. ***See Tab # 91 Nursing Care Hours Report.*** Data from the review period shows nursing care hours per patient day has fluctuated during the review period from 5.4 hours in March, May and July to a low of 4.9 hours in August 2011. This is despite the net gains in RN staffing,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		and may reflect that many of the new nurses were in training for much of August, 2011, the census was higher in August and the higher than average number of 1:1s during that month. **Analysis and action steps**. There continues to be a shortage of RN staff to meet the 50% mix and targeted nursing care hours. Hiring continues but once all vacancies are filled, additional funds will need to be identified to allow the hiring of additional RNs.

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. Finalize revisions to the restraint and seclusion policy. SEH Response: Completed. While many of the changes are merely editorial or reordering of subsections of the policy, the following substantive changes were included: clarified that seclusion room must be locked when not in use, that the seclusion room may not be used as a comfort room, and the adding of more information about the required training 2. Evaluate and resolve factors contributing to prone restraint use. SEH Response: There were no instances of prone restraint during this review period. Staff are all being retrained in crisis intervention using the "Safety care" curriculum. Training began in September 2011 and is expected to be completed by next Spring 2012. **Analysis/Action Plans:** There were no incidents of prone restraint, or prone transportation. The Hospital is continuing restraint and seclusion training. In addition, it purchased 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 has been completed, and staff training is underway. The Safety Care curriculum is designed to teach skills and techniques that can help staff safely prevent and manage behavioral incidents. Goals include prevention of behavioral crises, reversal of escalation and intensity of crises when they occur, teaching and strengthening of behaviors that are incompatible with crisis behaviors, and ending crises as quickly as possible. Topics include understanding challenging behavior, creating a safe and therapeutic environment, staff behavior and emotional reactions, how to reinforce effectively, de-escalation physical management, developing a safety plan, management of fights and incident management, among other things. There were some incidents of "open seclusion" – when the door to the seclusion room was left open with an individual in care in the room. This was identified by PID and discussed at a Risk Management Committee meeting, The Hospital policy was clarified to make clear that the seclusion room can only be used for the purpose of seclusion and not as a comfort room, and this is to be included in the new seclusion and restraint training. See section X.B. 1 for data on the use of less restrictive interventions.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Recommendation:** Proceed quickly to implement the new training module. If this cannot be implemented quickly, train nursing staff using NVCI. SEH Response: The Hospital purchased a new non-violent crisis intervention module, and internal trainers were trained in late August, 2011. Training of staff began in September 2011. See response to X.A.1 for additional information. Implementation of Safety Care is initially focused on nursing care staff and will gradually be expanded to include all clinical staff. The Hospital anticipated training its trainers earlier in the review period and thus suspended training on the NCVI for existing employees, but had difficulty in identifying a vendor (there were no bidders on the request for proposal issued in June, 2011). Consequently some individuals became noncompliant with this training requirement. These individuals have been prioritized in scheduling the Safety care training. ***See Tab # 109 Training data, Seclusion and restraint, NVCI training and Tab # 66, Collaborative Problem-solving Training Information.*** As the data shows, overall compliance with seclusion and restraint training for existing employees declined from 92% during last review period to 77% during this review period; compliance rate for new employees was 88%.

Restraint or Seclusion for Behavioral Reasons: Existing Employees — 9/30/2011

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	7	7	7	100%	100%/100%
Clinical Administrator	11	11	11	100%	100%/100%
Dentistry	5	3	3	60%	60%/100%
Dietary	3	3	3	100%	100%/100%
Medical	9	6	6	67%	67%/100%
Nursing - Nurse Manager	15	14	14	93%	93%/100%
Nursing - RN	71	53	53	75%	75%/100%
Nursing - LPN	33	22	22	67%	67%/100%
Nursing - RA	182	114	114	63%	63%/100%
Psychiatry	46	42	42	91%	91%/100%
Psychology	12	10	10	83%	83%/100%
Rehabilitation	18	17	17	94%	94%/100%
Social Work	13	13	13	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Treatment Mall	5	5	5	100%	100%/100%
Clinical (Other)	11	10	10	91%	91%/100%
Security (including Contractors)	37	37	37	100%	100%/100%
Total	**478**	**367**	**367**	**77%**	**77%/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					9/30/2011
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Medical	3	3	3	100%	100%/100%
Dentistry	3	3	3	100%	100%/100%
Nursing - Nurse Manager	3	3	3	100%	100%/100%
Nursing - RN	48	39	39	81%	81%/100%
Nursing - RA	0	n/a	n/a	n/a	n/a
Psychiatry	8	8	8	100%	100%/100%
Psychology	9	9	9	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Social Work	3	3	3	100%	100%/100%
Total	**78**	**69**	**69**	**88%**	**88%/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.*

There was also some improvement in the compliance with non-violent crisis intervention (NVCI) training, from an overall compliance rating of 59% during last review period to 70 % for existing employees and 90% for new employees during this review period.

NVCI: Existing Employees					9/30/2011
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	7	7	7	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Clinical Administrator	11	9	9	82%	82%/100%
Dentistry	5	4	4	80%	80%/100%
Dietary	3	2	2	67%	67%/100%
Medical	9	6	6	67%	67%/100%
Nursing - Nurse Manager	15	14	14	93%	93%/100%
Nursing - RN	71	45	45	63%	63%/100%
Nursing - LPN	33	25	25	76%	76%/100%
Nursing - RA	182	136	136	75%	75%/100%
Psychiatry	46	38	38	83%	83%/100%
Psychology	12	8	8	67%	67%/100%
Rehabilitation	18	15	15	83%	83%/100%
Social Work	13	12	12	92%	92%/100%
Treatment Mall	5	5	5	100%	100%/100%
Clinical (Other)	11	8	8	73%	73%/100%
Security (including Contractors)	37	2	2	5%	5%/100%
Total	**478**	**336**	**336**	**70%**	**70%/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.*

Non-Violent Crisis Intervention (CPI Certification) New Employees 09/01/10 ~ 03/15/11

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Dentistry	3	3	3	100%	100%/100%
Medical	3	3	3	100%	100%/100%
Nursing - Nurse Manager	3	2	2	67%	67%/100%
Nursing - RN	49	41	41	85%	85%/100%
Psychiatry	8	8	8	100%	100%/100%
Social Work	3	3	3	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Psychology	9	9	9	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Total	78	**70**	**70**	**90%**	**90%/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 # 127 Restraint and Seclusion and NVCI Training Data and Curricula Outlines

Safety care training was implemented beginning in September 2011. As of September 30, 2011, 127 staff had completed the training.

SAFETY CARE TRAINING 9/30/11

Discipline	# Required	# Attended	# Competent w/o Provisions	# Competent with Provisions	Total # Competent	% Attended	% Competent /# of Attendees Competent
Chaplain	7	1	1	0	1	14%	14%/100%
Clinical Administrator	11	1	1	0	1	9%	9%/100%
Dentistry	5	0	0	0	0	0%	n/a
Dietary	3	0	0	0	0	0%	n/a
Medical	9	1	1	0	1	11%	11%/100%
Nurse Manager	15	8	7	1	8	53%	53%/100%
Nursing - RN	71	38	36	2	38	54%	54%/100%
Nursing - LPN	33	13	12	1	13	39%	42%/100%
Nursing - RA	182	58	51	6	57	32%	32%/100%
Psychiatry	46	1	1	0	1	2%	2%/100%
Psychology	12	1	1	0	1	8%	8%/100%
Rehabilitation	18	2	2	0	2	11%	11%/100%
Social Work	13	1	1	0	1	8%	8%/100%
Treatment Mall	5	0	0	0	0	0%	n/a
Clinical	11	0	0	0	0	0%	n/a

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

(Other)							
Security (including Contractors)	37	2	1	1	2	5%	5%/100%
Total	**478**	**127**	**115**	**11**	**126**	**27%**	**27%/100%**

Collaborative Problem Solving Training				**9/1/2011**
	Clinical Staff	Nursing-Day	Nursing-Evening	Nursing- Night
Total # to be trained	77	110	95	72
Total # Trained	59	88	65	57
% Trained	77%	80%	68%	79%

See Tab # 66 Collaborative Problem-solving Training Information

Analysis/Action Steps: Data shows that compliance with restraint and seclusion training declined 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	88%	93%
RN	97%	75%
LPN	100%	67%
RA	94%	63%
Psychiatrist	97%	91%
Security	100%	100%

One reason for the decline in performance was the delay in the expected award of the Safety Care contract. Staff may have delayed their training in anticipation of the Safety care training, but the failure of any vendor to respond to the solicitation announced in June 2011 unexpectedly delayed the Safety care roll out.

For NVCI training (and not including safety care data) there was improvement in each discipline:

NVCI TRAINING COMPARISON		
Discipline	**% Compliant Prior review period NCVI training**	**% Compliant Current review period NCVI training**
Nurse manager	47%	93%

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>RN</td><td>60%</td><td>63%</td></tr>
<tr><td>LPN</td><td>63%</td><td>76%</td></tr>
<tr><td>RA</td><td>61%</td><td>75%</td></tr>
<tr><td>Psychiatrist</td><td>85%</td><td>83%</td></tr>
</table>

See Tab # 109 Seclusion and restraint, NVCI training 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 has expanded the training in Collaborative Problem-solving. The majority of staff on all units on all shifts have completed the CPS training. Collaborative Problem solving training involves training staff on alternative ways to resolve conflicts, with a focus on staff/individual in care conflicts. See Tab # 66 Collaborative Problem Solving Training data.
</td></tr>
<tr><td>X.A.3</td><td>the use of side rails on beds, including a plan:</td><td></td></tr>
<tr><td>X.A.3.a</td><td>to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and</td><td></td></tr>
<tr><td>X.A.3.b</td><td>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.</td><td></td></tr>
<tr><td>X.B</td><td>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:</td><td></td></tr>
<tr><td>X.B.1</td><td>are used after a hierarchy of less restrictive measures has been considered and documented;</td><td>Recommendations:

1. Reinforce the use of comfort plans and ensure integration into the IRPs.

SEH Response: Nurse managers, QECs and houses based treatment staff are using the comfort plans but not to the extent expected. PID recently completed a review of the records of 13 individuals in care with 8 or more incidents of any type of aggressive act between October 1, 2010 and May 31, 2011. See Tab # 127 PID: Study of Aggression. The review included a set of five indicators around presence and use of the comfort plans with these individuals in care. Data shows variable results; 92% of individuals had a comfort plan in Avatar or FileNet; 100% of those were personalized. The review showed</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

that in only 31% of cases however, were comfort items offered or used and that 31% of individuals in care asked for comfort items but in 100% of cases, they were provided when requested. While the sample reviewed is small, the review suggests that staff are not yet routinely offering comfort items unless they are requested by the individual in care. The study includes some recommendations concerning identifying barriers to use of comfort plans.

The Hospital has elected not to require that the content of the comfort plans also be specified in the IRP.

2. Adjust the RA role title and clarify job functions before the pilot is completed.

SEH Response: The Hospital is still working on developing the modified RA role. The parameters have been developed, such that RAs will have recovery focused responsibilities that include support, early intervention and prevention. The manner of implementation is still under consideration. Additional information should be available during the on site visit.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	6	2	1	3	5	0	**6**	**3**
n	4	2	1	2	5	0	**3**	**2**
%S	67	100	100	67	100	n/a	**50**	**66**
%C # 2 Documentation reflects that individual posed an imminent danger to self or others if not restrained or secluded	100	100	100	100	100	n/a	**82**	**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	n/a	**94**	**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.

PERCENT OF INDIVIDUALS RESTRAINED OR SECLUDED						
	Mar~11	Apr~11	May~11	June~11	July~11	Aug~11
Restraint	0.0%	0.0%	0.0%	0.6%	0.7%	0.0%
Seclusion	1.0%	0.3%	0.3%	0.3%	1.0%	0.0%

NPR Rate percent of individuals restrained=3.6%
NPR Rate percent of individuals secluded=2.6%
See PRISM Report, Tab # 43

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
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><td></td><td>Mar~11</td><td>Apr~11</td><td>May~11</td><td>June~11</td><td>July~11</td><td>Aug~11</td></tr>
<tr><td>Restraint</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.01</td><td>0.01</td><td>0.0%</td></tr>
<tr><td>Seclusion</td><td>0.05</td><td>0.01</td><td>0.00</td><td>0.01</td><td>0.03</td><td>0.0%</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 performing above the 90% mark for this requirement. The Hospital purchased a new curriculum for nonviolent crisis intervention that is more prevention focused and specifically trains staff in developing and using skills and strategies that are 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. Internal trainers were trained in late August, 2011 and staff training began in September 2011. See X.A.2 for training data on Safety Care.

The Hospital also continued its training of treatment teams on Collaborative Problem Solving. The training, which was developed and completed by the Hospital's PBS team, provides team members with new skills to address both the individual in care's concerns as well as the staff's concerns. Data shows that about three quarters of all direct care staff, across all shifts have completed the training. See Tab # 66 Collaborative Problem Solving Training Materials and Rosters. Specifically, 77% of direct care non nursing clinical staff have completed CPS training, 80% of day shift nursing staff, 68% of evening shift nursing staff, and 79% of night shift nursing staff have completed CPS training.
</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:

1. Determine and resolve barriers to unit-based groups as well as TLC attendance.

SEH Response: The Hospital believes that attendance is improving but issues in recording attendance remain. Avatar is developing a new module for scheduling groups and recording group attendance; it is in testing, and depending on the results, the Hospital may elect to purchase the new module. NETSMART, the vendor will be doing a demonstration of the new module for the Hospital within the next 45 days and thereafter the Hospital will decide whether to purchase the new module. A new feature was added which allows the Hospital to track groups missed for other treatment activities such as clinic appointments or trips to the community for discharge activities. Attendance at unit based groups is now entered into Avatar.

The Hospital continues to monitor the TLCs and unit-based groups to evaluate the appropriateness of individuals' group
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

placements and capacity of group leaders. In September 2011, the readiness ruler assessment was repeated on all individuals in care who attend substance abuse therapies to evaluate their stage of change and functional levels. Treatment Services also reviewed the 25 individuals in care who were unengaged. Two of the 25 were improved sufficiently to be removed from the list and 12 others are improved. Changes will be made to others' treatment regimens to improve engagement.

Further, the TLC curricula and programming have been strengthened. For example, on the Intensive side, a new competency program for forensic pretrial patients was developed and implemented at the end of September 2011, to include a weekly mock trial and 4 groups per week. Programming on the TLC Transitional also was updated to include a focus on identifying community connections for those individuals reluctant to leave the Hospital.

The Hospital continues to struggle with attendance at unit based groups. In some cases, groups were being cancelled due to staffing shortages. To address this, the Hospital has increased the number of unit based groups provided by rehabilitation services staff, especially on the civil admissions and geriatric units as those individuals are either too acutely ill or cognitively challenged to fully participate in the TLC.

2. Review the number of active treatment hours provided to individuals involved in seclusion or restraint use.

SEH Response: PID staff reviewed treatment hours data for individuals restrained or secluded in June 2011 as a pilot. The data showed that one individual was scheduled for 15 hours of treatment (groups and 1:1 meetings) during the relevant period, and attended 1 hour. The second individual was scheduled for 9 hours initially which expanded to 14 hours and attended between 10-14 hours. The episodes for both individuals were within their first 60 days from admission – the second individual was within 30 days of admission. The plan is to add a review of treatment hours scheduled and attended to the restraint and seclusion audits beginning in September 2011.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Mar	Apr	May	June	July	Aug	**Mean-P**	**Mean-C**
N	6	2	1	3	5	0	**6**	**3**
n	4	2	1	2	5	0	**3**	**2**
%S	67	100	100	67	100	n/a	**50**	**66**
%C # 4 There is no evidence that restraint/seclusion was used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.	100	100	100	100	100	n/a	**88**	**100**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		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 improved from 88% to 100% during this review period. The Hospital provides a number of treatment interventions from the time of admission, including TLC groups and unit based groups. The admissions units all offer group therapies, in addition to completing assessments. ***See Tab # 55 TLC and Unit Based group schedules.*** For example, the civil admissions unit (1E) has recreational therapy, substance abuse treatment, music therapy, self-esteem group, spirituality group, expression group, relaxation group, living well, medical groups, fitness groups, trauma informed care group, understanding your illness, discharge planning, reality orientation; 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 and recreational groups. PID will begin to track hours of treatment scheduled and attended for those individuals who are secluded or restrained during a month, and also compare the dates of the episodes to date of admission.
X.B.3	are not used as part of a behavioral intervention; and	
X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	
X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	
X.C.1	the specific behaviors requiring the procedure;	
X.C.2	the maximum duration of the order;	
X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	
X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	
X.C.5	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;	
X.C.6	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;	**Recommendation:** Continue monitoring to evaluate the degree to which the current improvement plan is effective. SEH Response: Ongoing **Facility's Findings:**

<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">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>6</td><td>2</td><td>1</td><td>3</td><td>5</td><td>0</td><td>6</td><td>3</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>1</td><td>2</td><td>5</td><td>0</td><td>3</td><td>2</td></tr>
<tr><td>%S</td><td>67</td><td>100</td><td>100</td><td>67</td><td>100</td><td>n/a</td><td>50</td><td>66</td></tr>
<tr><td>%C # 12 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>0</td><td>100</td><td>40</td><td>n/a</td><td>88</td><td>57</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 a decline in performance on this requirement. This may be due to the fact that the manager who was tracking that the debriefing occurred left the Hospital in May 2011. A new manager has been identified to track this going forward. Clinical administrators are reminded that ensuring compliance with this requirement is their responsibility.
</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:

Continue monitoring.

SEH Response: Monitoring continues.

Facility's Findings:

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>6</td><td>2</td><td>1</td><td>3</td><td>5</td><td>0</td><td>6</td><td>3</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>1</td><td>2</td><td>5</td><td>0</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>67</td><td>100</td><td>100</td><td>67</td><td>100</td><td>n/a</td><td>50</td><td>66</td></tr>
<tr><td>%C # 14 Physician conducted face-to- face assessment within one hour of initiation of r/s event</td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>n/a</td><td>86</td><td>93</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 improved its performance on this requirement, and is now exceeding the 90% threshold. The Medical Director and the Director of Psychiatry training have reminded physicians to ensure the progress note makes it clear if a face-to-face assessment was completed.
</td></tr>
<tr><td>X.C.8</td><td>ensure that any individual placed in seclusion</td><td>Recommendation:</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>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>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>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>6</td><td>2</td><td>1</td><td>3</td><td>5</td><td>0</td><td>6</td><td>3</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>1</td><td>2</td><td>5</td><td>0</td><td>3</td><td>2</td></tr>
<tr><td>%S</td><td>67</td><td>100</td><td>100</td><td>67</td><td>100</td><td>n/a</td><td>50</td><td>66</td></tr>
<tr><td>%C # 15 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>100</td><td>50</td><td>0</td><td>50</td><td>40</td><td>n/a</td><td>64</td><td>57</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 declined slightly, and generally, compliance with the restraint and seclusion training requirement has not been met. See X.A.2. One reason is that some training was deferred in late Spring or early summer in anticipation of Safety care contract award, but when no vendors bid in the June 2011 announcement, some individuals' training lagged. Seclusion and restraint training has restarted. However, since the new Safety care training includes application of restraints and related competencies, the seclusion and restraint training will be updated and once that is completed, will be available as on online training, which should improve compliance with this requirement.</td></tr>
<tr><td>X.D</td><td>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.</td><td></td></tr>
<tr><td>X.E</td><td>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.</td><td>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.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: The Hospital implemented a database for tracking this requirement as part of its high risk individuals tracking system. This has simplified tracking of this requirement.
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 EMIP. SEH Response: For most of the review period, the Hospital is able to identify those individuals who are given STAT medications on an emergency involuntary basis. This information is shared each month with Pharmacy and Therapeutics Committee. However an issue developed with the report in Avatar and the Hospital could not run the report for a period of time. This was due to a data corruption issue, which has been resolved. In part, because of this as well as an issue identified during a P and T Committee meeting, Hospital has decided to modify the drop down menu to ensure a more reliable tracking of whether the administration was voluntary or involuntary. The change will eliminate any confusion for nursing staff in describing the administration as voluntary or involuntary. Additional changes in the drop down menus to eliminate confusion STAT or NOW will be made in October 2011. With the above caveat, the emergency involuntary medication administration has ranged from a high of 13 events in March 2011 to a low of 1 in August 2011. Please note that June data is questionable due to the temporary discontinuation of the use of eMAR for 5 days while the Avatar team worked to resolve issues with the eMAR module. 2. Determine barriers to addressing violence in IRPs. SEH Response: This is much improved. PID is tracking whether the clinical formulations and/or IRPs address violence for those individuals on the high risk list for violence. As of the writing of this report, there are 95 individuals on one or more high risk lists. Of those, 92 of 95 have addressed in the IRP the issue prompt, the placement on a high risk list. In addition, PID completed an audit of the records of 13 individuals in care that had 8 or more aggressive acts of any type between October 1, 2010 and May 31, 2011. Audits results show that in 92% of the cases, the IRP addressed the risk after it was identified, that in 100% of the cases the IRP included objectives related to the aggressive acts, that in 92% of cases, it had specific interventions to address the aggressive acts and 85% of the cases had some type of behavioral intervention. However, the audits showed that in only 69% of the cases were the IRP objectives modified to reflect continuing aggressive acts and in only 54% were the IRP interventions modified to reflect continuing aggressive acts. This data was shared with clinical leadership and recommendations from the report will be presented to Executive staff, PIC and VRI committee.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		3. Develop a simple mechanism to evaluate IRP changes following tiered levels of review. SEH Response: Currently the Hospital's PBS team monitors Avatar weekly for use of STAT medication and in those cases where it appears three or more STAT medications were administered in a 30 day period, refers the case to the unit psychologist, for evaluation of the need for behavioral interventions. This is also reviewed through the clinical chart audits. Further, once an individual is placed on a high risk list, PID tracks to ensure the issue is addressed in the IRP. **Facility's Findings:**
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

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N # of EIM events during the month	13	9	3	0	4	1	**9**	**5**
# of Unique Patients Given EIM	8	9	3	0	3	1	**6**	**4**
# Total EIM ordered/administered	26	18	7	0	7	2	**15**	**10**
n	2	2	2	0	3	1	**2**	**2**
%S	15	22	67	0	75	100	**23**	**33**
%C #1 EIMs 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.								
%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	**90**	**100**
%C 1b the medication is a standard treatment for the individual's diagnosis, symptoms or conditions	100	100	100		100	100	**90**	**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.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
SEH Response: See X.F.1.

Facility's Findings:

<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N # of EIM events during the month
# of Unique Patients Given EIM
Total EIM ordered/administered</td><td>13
8
26</td><td>9
9
18</td><td>3
3
7</td><td>0
0
0</td><td>4
3
7</td><td>1
1
2</td><td>9
6
15</td><td>5
4
10</td></tr>
<tr><td>n</td><td>2</td><td>2</td><td>2</td><td>0</td><td>3</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>15</td><td>22</td><td>67</td><td>0</td><td>75</td><td>100</td><td>23</td><td>33</td></tr>
<tr><td>%C #2. A physician conducted a face-to-face assessment of the individual within one hour of the administration of the EIM</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>%C 2 a If there is documentation in the record that a physician conducted a face to face assessment AND</td><td>100</td><td>100</td><td>50</td><td></td><td>100</td><td>100</td><td>90</td><td>90</td></tr>
<tr><td>%C 2 b that assessment was within 1 one of the EIM administration</td><td>100</td><td>100</td><td>100</td><td></td><td>100</td><td>100</td><td>90</td><td>100</td></tr>
</table>
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.
</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:

Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes.

SEH Response: This is tracked through the emergency involuntary medication audits and the High Risk Indicator Tracking and Review Policy. Tab # 129 High Risk Indicator Tracking and Review Policy. In addition, the Hospital's PBS team monitors Avatar weekly for identification of involving the use of STAT medication. In cases where it appears three or more STAT medications were administered in a 30 day-period, PBS refers the case to the unit psychologist, for evaluation of the need for behavioral interventions. This is also reviewed through the clinical chart audits.

Facility's Findings:
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

	Mar	Apr	May	June	July	Aug	Mean-P	Mean-C
N # of EIM events during the month	13	9	3	0	4	1	**9**	**5**
# of Unique Patients Given EIM	8	9	3	0	3	1	**6**	**4**
# Total EIM ordered/administered	26	18	7	0	7	2	**15**	**10**
n	2	2	2	0	3	1	**2**	**2**
%S	15	22	67	0	75	100	**23**	**33**
%C #3. The individual's core treatment team conducts a review (within three business days) whenever three administrations of Emergency psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate							**100**	
%C a The review indicates that the treatment team timely reviewed three or more emergency involuntary administration in 4 week period and	n/a	n/a	n/a	n/a	n/a	n/a	**100**	**n/a**
%C b modified the IRP or medication regimen in a timely manner or documented reasons why modification was not clinical appropriate	n/a	n/a	n/a	n/a	n/a	n/a	**100**	**n/a**
%C c implemented the revised plan, if applicable	n/a	n/a	n/a	n/a	n/a	n/a	**100**	**n/a**

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

Analysis and action plan: The audits show high levels of compliance. The Hospital will continue monitoring this through audits.

X.G	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 implementation of all such policies and the	**Recommendations:** Maintain current levels of practice. SEH Response: See X.A.2. See discussion at X.C.8.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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	7	7	7	100	100%/100%
Clinical Administrator	11	11	11	100	100%/100%
Dentistry	5	5	5	100	100%/100%
Dietary	3	3	3	100	100%/100%
Medical	9	7	7	78	78%/100%
Nursing - Nurse Manager	15	15	15	100	100%/100%
Nursing - RN	71	63	63	89	89%/100%
Nursing - LPN	33	31	31	94	94%/100%
Nursing - RA	182	172	172	95	95%/100%
Psychiatry	46	40	40	87	87%/100%
Psychology	12	6	6	50	50%/100%
Rehabilitation	18	15	15	83	83%/100%
Social Work	13	13	13	100	100%/100%
Treatment Mall	5	2	2	40	40%/100%
Clinical (Other)	11	11	11	100	100%/100%
Non-Clinical/Administrative	185	166	166	90	90%/100%
Total	**626**	**567**	**567**	**91**	**91%/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	3	3	3	100%	100%/100%
Medical	3	3	3	100%	100%/100%
Nursing - Nurse Manager	3	3	3	100%	100%/100%
Nursing - RN	48	42	42	88%	88%/100%
Psychiatry	8	8	8	100%	100%/100%
Psychology	9	9	9	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Social Work	3	3	3	100%	100%/100%
Total	**78**	**72**	**72**	**92%**	**92%/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 Policy identifies 8 categories of behavioral and 8 categories of medical high risks, and specifies 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. As of September 28, 2011, 95 IICs were on one or more risks. Of 95, 72 had one or more behavioral risks identified, 7 had one or more medical risks identified, and 16 were on both behavioral and medical risk lists. This is in addition to the list of individuals with three or more major UIs in a 30 day period, which continues to be monitored by the Risk Manager. ***See Tab # 46 Risk Indicator UI Tracking Reports.*** As of September 2011, there were 95 individuals on one or more high risk lists and 97% had the risk addressed in the IRPs. During the course of the review period, 25 individuals in care were removed from any high risk list. ***Tab # 128 Summary of High Risk Indicator Lists.***

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. Data showed that there were, on average, two aggression incidents per day; 71% of the aggressive acts were physical assaults, 21% other types of aggressive behaviors and 8% self-injurious behavior. Of the aggressive acts, 49% were peer to peer only, 42% were individual to staff only, and 4% were to both staff and peers. Eleven percent of aggressive acts were to property, (about 7 per month, two of which per month on average resulted in actual destruction

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		of property). In severity, 27% were high severity, 42% medium severity and 32% low severity. About half of the aggressive incidents occurred on three units (all admission units). Aggression incidents tend to occur between 8-9 a.m., 12-1 p.m., 4-5 p.m. and 8-9 p.m. (In August 2011, while the number of physical assault increased substantially, the severity of the incidents decreased significantly; 57% of the assaults in August were low severity, compared with 38% in the prior month.) The analysis also included a review of the clinical characteristics of the individuals who are aggressors. Just under 90% of those characterized as aggressors had a psychotic disorder diagnosis, but looking at the subset of those with 8 or more incidents of aggressive acts, over 90% of those had a psychotic disorder diagnosis. Further, the individuals with 8 or more incidents were significantly more likely to carry an Axis II diagnosis (70% compared with just over 40% for all individuals in care), and were more often diagnosed with mental retardation (39% compared with 10% for all individuals in care). ***See Tab # 127 Aggression Analysis.*** None of the 13 individuals in care with 8 or more incidents of aggressive acts during this period carried a documented history of noncompliance with treatment diagnosis. Following this data review, PID reviewed the cases of the 13 individuals in care with 8 or more incidents using an audit tool. The study included a review of Avatar and FileNet records and was designed to elicit data around discipline assessments of aggressive acts, trauma and other risk indicators, treatment information (IRPs and behavioral interventions), comfort plans, medication and meaningful day activity. The analysis of this study is attached at Tab # 127. Data from the studies is being shared with Executive staff, PIC and clinical leaders.

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 investigation report approval processes and recent timely completion of investigations. SEH Response: Ongoing. The Director, PID continues to approve investigations, and those recommendations of the Risk Manager that implicate policy matters are reviewed regularly by Executive staff and either approved, modified or disapproved. Timeliness of investigations has improved significantly; during this rating period, there were a total of 42 investigations (all types) completed, with an average time to completion of just less than 36 days. For abuse and neglect investigations, the average time for completion was 50.6 days 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 has improved significantly, from 48% during the last reporting period to 83% during this reporting period. ***See Tab # 121 UI Monthly Reporting***.
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 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;	**Recommendation:** 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.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Facility's findings:

Report Delay of Abuse and Neglect Incidents

Report Gap (Days)	Previous Review Period (Sep-10~Feb-11)						Current Review Period (Mar-11~Aug-11)						Previous Total	Current Total
	2010-9	2010-10	2010-11	2010-12	2011-1	2011-2	2011-3	2011-4	2011-5	2011-6	2011-7	2011-8		
<=1 day (on time)	**2**	**7**	**4**	**2**	**5**	**4**	**3**	**4**	**3**	**4**	**5**	**5**	**24**	**24**
>1 & <=5 days	**0**	**0**	**2**	**1**	**3**	**3**	**0**	**0**	**2**	**0**	**0**	**2**	**9**	**4**
>5 & <=10 days	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
>10 days	**1**	**0**	**13**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**16**	**1**
Total abuse/neglect UIs	**3**	**8**	**19**	**4**	**9**	**7**	**3**	**4**	**6**	**4**	**5**	**7**	**50**	**29**
Timely reporting (<=1 day)	***67%***	***88%***	***21%***	***50%***	***56%***	***57%***	***100%***	***100%***	***50%***	***100%***	***100%***	***71%***	***48%***	***83%***
Reports Delayed (>1 day)	***1 33%***	***1 13%***	***15 79%***	***2 50%***	***4 44%***	***3 43%***	***0 0%***	***0 0%***	***3 50%***	***0 0%***	***0 0%***	***2 29%***	***26 52%***	***5 17%***

See Tab # 121 UI Monthly Report.

Analysis/Action Steps: Overall the number of abuse/neglect reports submitted timely improved significantly, from 48% in the prior period to 83% during this period. The percentage of delayed abuse/neglect reports (>1 day after incident occurred) dropped from 52% in the previous period to just 17% during this rating 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 17% statistic likely overstates the percentage of abuse or neglect incidents involving a delay.

During last review period, the Risk Manager posted a broadcast on the Hospital's intranet site that reiterates the hospital policy that staff shall be free of retaliation when reporting an allegation of A/N/E. This continues to be included in the training on reporting abuse and neglect, and there is no evidence that any retaliation has occurred.

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 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 of any type noted in the reports have corresponding UIs if required by the policy.

See also XII.A.1.

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	**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.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	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 41 investigations (all types) between March 1, 2011 and August 31, 2011, up from 39 during the prior review period. Of the 41 investigations, 19 were substantiated and 22 were unsubstantiated. The average length of time to complete the investigations (all types) was 36 days, and was 50.6 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.	
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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 135 recommendations. Of these, 67 have been closed, and 68 remain open. Among the 68 open recommendations are those related to HR actions, training and systemic issues; 26 of the open have been implemented but need ongoing monitoring, 22 were initiated but not yet implemented, and 15 have been given to the responsible party for implementation. The remaining recommendations are in other stages of the process.
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 maintaining the Recommendations Database and monitor implementation on at least a sample basis. SEH Response: Database is maintained and implementation is monitored monthly. ***See Tab 119 Recommendations Tracking Report***
XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	
XII.E	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:	
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:** Consider adding to the criteria for falls and choking a recent history of these events in addition to risk assessments indicating high risk. Add a recent suicide attempt as a risk factor indicating high risk for suicide as well. SEH Response: The Hospital elected not to implement this recommendation because both are factors that are within the fall and choking screenings/assessments completed by nursing respectively. ***See Tab #93 Nursing Procedures around Dysphagia, and Tab # 83 Nursing Procedures around Falls Assessment.*** Further, recent suicide attempt is captured within the risk assessments completed by psychiatry and psychology, and thus are considered within the criteria already set out in the policy.
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:** 1. Revise format, production, and distribution schedule of the High Risk lists as necessary to meet the needs of the IRP teams. For example, a bolded list of individuals on high risk lists or revisions in the size of the grid might be more useful to unit staff than the present format which is difficult to read when posted on the wall. SEH Response: The Hospital modified its distribution of high risk lists in two key ways. First, instead of all units receiving a copy of all of the high risk lists, each unit now only receives its own list (TLCS continue to receive all lists). In addition, the list for posting has been reformatted to create more clarity and for easier reading. **2.** Reconcile the timeframes and review requirements in the High Risk Tracking and Review Policy and the directions in

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		the weekly notification of individuals who have reached the 3 or more incidents threshold. SEH Response: Completed.

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 and identify and track implementation of corrective measures. SEH Response: Ongoing. 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. Data showed that there were on average, two aggression incidents per day, 71% physical assaults, 21% other types of aggressive behaviors and 8% self-injurious behavior. Of the aggressive acts, 49% were peer to peer only, 42% were individual to staff only, and 4% were to both staff and peers. Eleven percent of aggressive acts were to property, (about 7 per month, two of which per month on average resulted in actual destruction of property). In severity, 27% were high severity, 42% medium severity and 32% low severity. In August, 2011, while the number of physical assault increased substantially, the severity of the incidents decreased significantly; 57% of the assaults in August were low severity, compared with 38% in the prior month. About half of the aggressive incidents occurred on three units (all admission units). Aggression incidents tend to occur between 8-9 a.m., 12-1 p.m., 4-5 p.m. and 8-9 p.m. The study also included a review of the clinical characteristics of the individuals who are aggressors. The individuals with 8 or more incidents carried an psychotic disorder diagnosis in over 90% of the cases, were significantly more likely to carry an Axis II diagnosis (70% compared with just over 40% for the general patient population), and were more often diagnosed with MR (39% compared with 10% for the general patient population). ***See Tab #127 Aggression Analysis.*** Following this review PID reviewed the medical records of the 13 individuals in care with 8 or more incidents using an audit tool. The study included a review of Avatar and FileNet records and, although not a random or statistically significant sample, it was designed to elicit data around discipline assessments of aggressive acts, trauma and other risk indicators, treatment information (IRPs and behavioral interventions), comfort plans, medication and meaningful day activity. The report of this study is attached at ***Tab # 127***. Data from the studies is being shared with Executive staff, PIC

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		and clinical leaders. The Hospital is also continuing to implement its PID/House partnership project; both unit based and PID staff have enthusiastically embraced this project. PID and OSR staff have been meeting monthly with house staff to review the units PRISM data, unit based UI data, provide policy updates, relay information about Hospital projects and to learn from unit based staff the challenges they are facing and respond to their requests for support. The UI data is broken down to the unit level, and specifies type of UI, compares the incidence with the Hospital generally, identifies the specific individuals in care involved, as well as time of incident, by unit and compared overall to the Hospital. Each house is assigned two liaisons, to include a staff member from PID and one from OSR. The meetings are set with each unit for the same time each month, and most last about an hour. Minutes are provided to each team 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 is expanding data presentation to include data from IRP observation audits and discharge audits. Although originally planned for this review period, the STAT medication study was deferred so that PID could complete the violence analysis and study. PID is exploring partnering with nursing QECs on an evaluation of STAT medication. Other performance related projects are continuing. The Hospital continues to monitor key indicators each month and produces the PRISM report. ***See Tab # 43 PRISM report.*** 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. Unit specific assault data over time was prepared by PID and used as part of a clinical leadership meeting to discuss themes and possible interventions to address the violence. ***See Tab # 118 Performance Improvement Projects*** PID, partnering with the Office of Consumer Affairs, is doing additional analysis around food related issues, including surveys of individuals in care and observations of food service. ***See Tab # 132 Summary Consumer Food Satisfaction Study.*** PID also noted through monitoring of the 24 hour nursing report that some units were using the seclusion room for "open seclusion" on occasion. Because the policy does not contemplate such a use for the seclusion room, PID staff reviewed each case from an approximately 2-3 month period of "open seclusion", and the issue was presented to the Risk Management Committee. Recommendations from the committee to modify the policy to clarify that a seclusion room is not to be used as a comfort room and that the seclusion room should remained locked were implemented. PID and the Office of Statistics and Reporting also support the various audits under the Agreement. PID staff conduct the transfer, discharge, restraint/seclusion audits, observe IRP conferences, do data related data analysis and special studies. Finally, the Office of Consumer Affairs completed its annual consumer satisfaction survey and surveys of individuals as they were being discharged, which includes eight domains (outcome, dignity, rights, participation in treatment, environment, medication and treatment, support and cultural awareness. There were 141 responses. Overall, consumer satisfaction has either stayed the same or slightly decreased except in the "rights" domain. However, with respect to

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		results, the levels of satisfaction of individuals completing the annual survey either stayed the same or improved over last year; the levels of satisfaction for those at the time of discharge however, overall declined. Performance is below the national rate in all domains. ***See Tab # 133 for Executive Summary of Consumer Satisfaction Survey.***
XIII.B.1	disseminating corrective action plans to all persons responsible for their implementation;	**Recommendations:** Continue current practice of tracking recommendations and updating the database to include the current status of implementation as determined by monitoring on at least a sample basis. SEH Response: Ongoing. Database is maintained and updated regularly.
XIII.B.2	monitoring and documenting the outcomes achieved; and	**Recommendations:** Continue implementation of initiatives aimed at reducing violence and improving the quality of care provided. SEH Response: See XIII.B above.
XIII.B.3	modifying corrective action plans, as necessary	**Recommendation:** Continue current practice. SEH Response: Ongoing. PID is maintaining 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.***
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Recommendation:** 1. Work to improve the content of the Performance Improvement Committee minutes so that they clearly identify the issue, why it is an issue, and any resolution agreed upon, including further study or discussion at a later meeting. SEH Response: Minutes were revised beginning with June 2011 and the new format is being piloted. It includes tracking any issues that required follow up. ***See Tab # 116 Performance Improvement Committee Minutes*** 2. Clarify the intent of the phrase in the December PIC minutes that suggests staff will be receiving self-defense training. SEH Response: Completed.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation	**Recommendation:** 1. Work to improve the content of the Performance Improvement Committee minutes so that they clearly identify the issue, why it is an issue, and any resolution agreed upon, including further study or discussion at a later meeting. SEH Response: Minutes were revised beginning with June 2011 and the new format is being piloted. It includes tracking any issues that required follow up. 2. Clarify the intent of the phrase in the December PIC minutes that suggests staff will be receiving self-defense training. SEH Response: Completed.
XIII.C.2	monitoring and documenting the outcomes achieved; and	**Recommendations:** 1. Continue implementation of Performance Improvement projects and monitoring of their effectiveness. SEH Response: Ongoing. See XIII.B.
XIII.C.3	modifying corrective action plans, as necessary.	**Recommendations:** 1. Continue implementation plans for monitoring the effective implementation and sustainability of initiatives to reduce violence and improve 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 implementation of Performance Improvement Initiatives. SEH Response: Ongoing. See XIII.B.

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.	