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

Saint Elizabeths Hospital
Compliance Report 10

October 10, 2012

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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:	
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:** In addition to continuing to audit these results on a monthly basis and utilizing the current supervisory structure to make continued improvements, the hospital is encouraged to attempt to understand the variability in the rate at which invitations are issued to family members to see if the source of the problem can be better identified and addressed. SEH Response: Data shows continued improvement in the Hospital's efforts to invite family members and community case workers to the IRP conferences; both exceed the 90% threshold, as during this rating period performance improved from 88% in the prior review period for family invitations to 92%, and from 94% for inviting community providers to 96%. Social workers continue to be reminded about their responsibility, with the individual in care's consent, to invite family and community workers and data concerning this is routinely shared with social workers during regular staff meetings. In addition, social work supervisors conducting monthly social work audits are also checking to ensure the record reflects social workers are inviting family to IRP meetings.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
Facility's Findings:
<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C[1]</td></tr>
<tr><td>N</td><td>192</td><td>173</td><td>188</td><td>192</td><td>193</td><td>203</td><td>228</td><td>190</td></tr>
<tr><td>n</td><td>11</td><td>11</td><td>11</td><td>11</td><td>10</td><td>11</td><td>10</td><td>11</td></tr>
<tr><td>%S</td><td>6</td><td>6</td><td>6</td><td>6</td><td>5</td><td>5</td><td>5</td><td>6</td></tr>
<tr><td>%C Data fields: Family Member invited?</td><td>100</td><td>100</td><td>100</td><td>83</td><td>75</td><td>100</td><td>88</td><td>92</td></tr>
<tr><td>%C Data fields: Community support worker invited</td><td>100</td><td>100</td><td>90</td><td>100</td><td>89</td><td>100</td><td>94</td><td>96</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 1 audit per unit per month)
Targeted Sample size is 11, one per unit
See Tab # 7 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data shows continued improvement in performance related to the inviting of family members and community case workers to IRP meetings during this review period with means at 92% and 96% respectively. Audits will continue and given the current level of performance, no additional actions are needed.
</td></tr>
<tr><td>V.A.2.c</td><td>require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;</td><td></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></td></tr>
<tr><td>V.A.2.f</td><td>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.</td><td></td></tr>
<tr><td>V.A.3</td><td>provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the</td><td></td></tr>
</table>

[1] The Hospital is using a weighted mean in calculating all means set forth in this report.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	
B	**Integrated Treatment Teams**	
	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:	
V.B.1	where possible, individuals have input into their treatment plans;	
V.B.2	treatment planning provides timely attention to the needs of each individual, in particular:	
V.B.2.a	initial assessments are completed within 24 hours of admission; (exclude psychiatry)	
V.B.2.b	initial treatment plans are completed within 5 days of admission; and	
V.B.2.c	treatment plan updates are performed 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;	
V.B.6	mechanisms are developed and implemented	

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>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;</td><td></td></tr>
<tr><td>V.B.7</td><td>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></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:

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 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, audits of RN notes related to Transfers and Returns from community hospitals and change of physical status, seclusion and restraint audits, discharge record review audits, transfer audits, substance abuse Intervention audits, emergency involuntary medication audits, history and physical audits, medical transfer audits, TLC group leader observation audits and the post - discharge services audits completed by MHA. Only Psychology modified their audit tools, 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>Effective August, 2012, a new question #7 was added to evaluate if the team is reviewing the comfort plan as part of the IRP conference and updating the IRP if appropriate. As this was a new indicator, there is no data from prior review period for this indicator and data from this period reflects only one month’s performance.</td></tr>
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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Clinical chart audit	Ongoing through review period. Target is 2 per unit per month. Audits were completed for each month during this review period.	In May 2012, instructions for indicator #5 were modified to focus on whether IICs determined to be at moderate or severe risk on the psychiatric update in any category were placed on a high risk list (or whether the clinical formulation explained why not) and whether there are objectives and interventions to address the specific risks. In addition, a new indicator # 10 was added to ensure IRP objectives and interventions were being modified to address changes in functional or risk status. In July 2012, instructions for indicator # 7 were modified to make clear that for IICs that are identified to be at risk for suicide, self-harm, or disorganized, threatening, aggressive or assaultive behavior and physical co-morbidities, the reviewer should ensure that the IIC had non- group, nursing interventions that addressed these issues or a statement in the clinical formulation why none were included.
		Therapeutic progress note audit	Target is 1 note per group leader and individual therapist per four months.	No change.
		CIPA audit	Ongoing throughout review period. Target is 20% of monthly admissions.	No change.
		Psychiatric Update audit	Ongoing through the review period. Target is 2 reviews per unit psychiatrist.	No change.
		Initial History and Physical Audits	Target is 20%	No change.
		Medical transfer audits	Target is 20%	No changes to the tool. A new medical transfer form is expected to be in Avatar by mid October 2012.
		Co-occurring disorder audit	Target is 10%	No change.
		Psychiatry TD audit tool	Ongoing for review period. Target is each case of TD diagnosis every six months.	No change.
		Psychology IPA audits	Ongoing for review period. Target is 20%.	No change.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Psychology Risk Assessment	Ongoing for review period. Target is 1 per psychologist who completes them.	Tool modified in July 2012. Minor revisions to those indicators relating to answers to referral question, methods of assessments, structured risk assessment, and conclusions and recommendations.
		Psychology Evaluation	Ongoing for review period. Target is 1 per psychologist who completes them.	Tool modified in July 2012. Minor revisions to those indicators relating to answer to referral question, tests administered, results of testing, and new section added titled integrated findings.
		IBI/PBS Plan Audit tool	At least a 50% sample	No change.
		BI Progress Note Audit	New tool, 20% sample	No change.
		Neuropsychology assessment audits	Ongoing during review period.	No change.
		Initial Rehabilitation Assessment audit tool	Ongoing for review period. Target is 20%.	No change.
		SWIA audit tool	Ongoing for review period. Target is 20%.	No change.
		SW Update audit tool	Ongoing review period. Target is 1 per social worker.	Time frames in instructions were changed to align with policy, and one question was removed as the topic is covered by IRP observation audits.
		Emergency Involuntary medication audits	Audits began in October 2010. Target is 20%.	No change.
		CINA audits (Part A and Part B)	Ongoing for review period. Target is 20%.	New tool was developed based upon revised CINA that was effective in January 2012. New audit tools for Part A and Part B were developed and implemented for January 2012 CINAs to reflect the new form, so only two months of data from prior review period was available. Six months data available from this review period.
		Nursing Update audits	Ongoing for period. Target is 2 per unit.	New tool was developed and implemented in February 2012 to reflect new Update form. Only one month of data is available from prior review period.
		Change in Physical Status (SBAR) Audit Tool (Nursing)	Beginning February 2012	No change.

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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
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<tr><td>RN Transfer to ER/Hospital Audit Tool</td><td>Beginning February 2012</td><td>No change.</td></tr>
<tr><td>RN Transfer from ER/Hospital to SEH</td><td>Beginning February 2012</td><td>No change.</td></tr>
<tr><td>Nursing Medication and Insulin Administration Audits</td><td>Target is 1 observation per nurse per 6 months</td><td>No change.</td></tr>
<tr><td>Seclusion and restraint audit</td><td>Target is 50% of cases.</td><td>No change.</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>No change.</td></tr>
<tr><td>Inter-unit transfer audit tool</td><td>Ongoing. Target is 20%.</td><td>No change.</td></tr>
<tr><td>Group facilitator observation audit tools (separate tools for process groups and curriculum based groups)</td><td>Ongoing. Target is one per group leader twice per year.</td><td>No change.</td></tr>
<tr><td>DMH post discharge audits</td><td>Monthly</td><td>No change.</td></tr>
</table>
</td></tr>
<tr><td>V.C.</td><td>By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:</td><td></td></tr>
<tr><td>V.C.1</td><td>be derived from analyses of the information gathered including diagnosis and differential diagnosis;</td><td></td></tr>
<tr><td>V.C.2</td><td>include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;</td><td></td></tr>
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V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	
V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	
V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	
V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	
V.C.7	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.	
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. Address the current barriers in Avatar that impede communication among different practitioners and the ability of practitioners to track the status of individuals under their care and their own treatment interventions over time. To begin with, the facility must correct the following specific problems: a) Lack of access by practitioners, in a timely manner, of results of specialty consultations and b) Automatic prescription of current medications of individuals upon their return from outside hospitalization without adequate review of the medication changes at SEH prior to the transfer to outside hospitalization. SEH Response: The Hospital continues to work to improve Avatar so that it better meets the needs of clinicians and the individuals served. A number of improvements are underway, culminating in the roll out of a new system called MyAvatar set for Spring 2013. The MyAvatar design is such that practitioners will have the flexibility to set up "home" views as well as "patient'" views whereby practitioners can see specific information as soon as they logon to MyAvatar. They will be able to move from the home views to various assessments or reports using far fewer "clicks". A user will be able to set the "patient" view so discipline-specific or other discipline information can be accessed from the desktop versus opening each

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		assessment as is now the case. This view will allow users to link directly to specific reports that detail information about internal and external patient care activities. Further, information can be screened by discipline and date – for example, the user will be able to search for medical notes by a particular discipline over a specific time frame. Until MyAvatar is ready for implementation, the Avatar team continues to improve specific aspects in Avatar. The District has requested that NetSmart immediately design a report that will allow users to track specific information about an individual in care through user-selected time parameters. The goal is the creation of a report that could be immediately available when clinicians need it and that would provide specific information, limited by time parameters (i.e. up to 7 days), to include medication (orders and administrations), laboratory results, vital signs, demographics, allergies, diagnosis, and most recent psychiatric and nursing assessments and progress notes within the specified time parameter. This would allow the clinician to quickly assess changes in an individual's condition and possible reasons for any change which can then be provided to an outside facility. ***See Tab #71 Avatar Activity Summary*** A draft of the report has been reviewed by clinical leaders and some adjustments were requested. The report should be ready for testing in mid October 2012; unless substantial issues are found, it could "go live" as early as November 1, 2012. The Hospital also is implementing Point Of Service Scanning for Avatar. Currently, the Hospital uses two systems for its electronic medical record. Avatar includes all automated processes and forms whereby other hard copy forms are scanned into another system called, FileNet. FileNet was initially implemented to capture historical information only and not current documents; however, currently FileNet captures both historical and current documents for which there is no form yet in Avatar. Thus, a user may be required to switch from one system to the other (Avatar to FileNet or vice versa) to get a full clinical picture, with each system having its own sign in features. The Avatar team is rolling out a module called Point of Service (POS) scanning which allows staff to scan, index, and import current information directly into the Avatar application. Beginning October 1, 2012, Psychology began importing all its non-Avatar assessments and reports; this will be expanded for all other hospital created documentation over the next few months. With the full implementation of POS, all current documentation will be centralized and stored in Avatar and users will not be required to move between Avatar and FileNet. Rather, FileNet will only be used to store historical information. It should be noted that there will not be any conversion for this effort; therefore, documents that are already stored in FileNet will continue to remain there. Other Avatar initiatives are listed below: 1. **Vendor Assistance:** NetSmart, the vendor for the system, made an onsite visit to review both Avatar issues experienced by the staff and normal business processes and workflows used at the Hospital that intersect with the use of the Avatar software. This resulted in several recommendations which the Hospital is implementing or will be implementing. 2. **Funding:** Capital Funding in the amount of $ 1.845M for FY12 Avatar enhancements was approved and released; this included funding for management reports, infrastructure upgrades and additional form development. An additional $1.655 M has been requested and tentatively approved over the next 2 years to continue improving the system and its integration with other systems used for patient care. 3. **User Support:** Undertook several activities to improve communication and assist usability of Avatar. These include:

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		• Implemented a Navigating Computers and Information Systems (NCIS) training program that introduces SEH clinicians to the use of computers, accessing networking properties, scanning, and fully utilizing emailing features. • Monthly Nursing User Group meetings (April 18, 2012; June 29, 2012; July 16, 2012; August 9, 2012; September 24, 2012) were held to address nursing specific Avatar issues and to solicit recommendations for improvements. During these sessions, nurse managers were trained on the procedures for completing such nursing processes as entering admissions in Avatar. In addition, these meetings have served as venues for testing the functionality of newly developed forms, identify flaws and/or approve the movement of forms to Avatar LIVE. • Conducted daily onsite/desk side user support to each Hospital unit to provide onsite Avatar assistance. These sessions are also conducted on evening and night shifts monthly. • Began Avatar refresher training to run through the Fall 2012. This training provides refresher training to staff to include specific tips and short cuts that will ensure faster system navigation, as well as covers specific topics/ issues encountered during every day use. Those specific topics include "work-arounds" and known system issues/ errors that occur during every day use of the electronic medical record. Additional material that will be covered includes FileNet and specific info from the Navigating Computers and Information Systems (NCIS) Class. 5. **Enhancements** were completed: • Changes to the Inpatient Progress Notes were implemented to allow Supervisory approvals where necessary and to be discipline specific. Progress notes that are completed by psychiatric residents, psychology interns and externs now require supervisory review and approval to finalize in Avatar. • Nursing Progress Notes automatically default to Final at submission. (completed: July 1, 2012) • The Medical Alert form was implemented in Avatar which allows a Physician to document a medically or behavioral alert. (completed: July 12, 2012) • The TLC Referral form was implemented (completed: August 20, 2012) • The Advance Instruction Personal Comfort Planning assessment was implemented (completed June 29, 2012) • Changes to enhance existing diagnoses consistent with DSM to improve accuracy and clarity (completed May 2012). (Doctors must update diagnoses screens to select the correct diagnosis from the corrected menu). 6. **Finalization** of 12 nursing forms is expected in October 2012. For more information please see ***Tab # 71, Avatar Improvements Summary.*** Finally, practitioners now have access in Avatar

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to all results of specialty consultations other than neurology, but neurology results are sent to the requesting practitioner and scanned into FileNet.

With respect to recommendation #1 b, medical practitioners were advised to place hold orders for all medications involving individuals sent out to another hospital, which then requires the receiving practitioner to review medications after considering the recommendations by the outside treating hospital; a review of the automatic restart functionality is on the Hospital's priority list. In addition, research and assessment of the Avatar Medication Reconciliation processing by Netsmart and IT are currently underway. It is expected that this process with provide clinicians the means to timely review all medication orders and administration actions. The reconciliation functionality will also provide a historical view of the medication orders. Additional evaluation and testing of this feature of Avatar are scheduled to occur over the next 30 days.

2. 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: Ongoing. See data below. V.D.6 was removed at the agreement of the parties so information is not provided on this requirement

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

SEH Response: As the data below reflects the Hospital has increased the capacity for cognitive remediation therapies and co-occurring disorder therapies during this review period.

Cognitive Remediation Therapies/Groups Aug 11		**Cognitive Remediation Therapies/Group March 2012**		**Cognitive Remediation Therapies/Group September 2012**	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
243	1042 (936 enrolled)	245	956 (901 enrolled)	250	1214 (1095 enrolled)

Co-occurring Disorder Therapies/Groups August 11		**Co-occurring Disorder Therapies/Groups March 2012**		**Co-occurring Disorder Therapies/Groups September 2012**	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
60	353(236 enrolled)	56	318 (212 enrolled)	61	334 (264 enrolled)

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

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for those with mild cognitive impairments, a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. ***See Tab # 141 Cognitive Groups Capacity Comparison.*** Groups for those with cognitive impairments are provided by rehabilitation services, co-occurring disorders, nursing, TLC staff, social work, psychiatry, consumer affairs, chaplaincy, and psychology. Schedules are individualized based upon the individual's diagnosis, IPA results, level of functioning, clinical formulation summary, IRP group guide and the needs and choices of the individual. Substance abuse treatment also continues, with a comprehensive array of groups that reflect the individual's stage of change; the readiness ruler assessment was repeated in September 2011 for each individual in care, and adjustments made in their groups based upon the results of the reassessment. On February 29, 2012, the Readiness Ruler was repeated again and adjustments were made to individuals' schedules based upon the results. Capacity of the groups decreased slightly because of a lower census and to decrease the size of the groups to reflect best practices. The Readiness Ruler is being repeated during the writing of this report; adjustments will be made during the Fall as needed.

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

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

Facility's Findings:

HISTORY AND PHYSICAL AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	10	10	10	9	9	9	**7**	**10**
%S	27	33	29	26	26	35	**15**	**29**
%C. # Timely completion	100	100	100	100	100	100	**98**	**100**
%C. # 1 Subsections on basic information completed	100	80	100	100	100	100	**95**	**96**
%C. # 2 Part II of H & P includes completed past medical history	90	80	90	100	100	100	**93**	**93**
%C. # 3 Immunization section is complete	100	80	90	100	100	100	**91**	**95**

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		%C. # 4 H & P includes complete and appropriate description of review of systems	90	90	90	100	100	100	**95**	**95**
		%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings	90	80	70	100	100	100	**95**	**89**
		%C. # 6 Neurological section is completed	70	90	100	100	100	100	**95**	**93**
		%C. # 7 Cranial nerve section is completed	80	70	70	100	100	100	**95**	**86**
		%C. # 8 Assessment section is completed and includes synthesis of relevant findings	100	90	90	100	100	100	**95**	**96**
		%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.	100	90	100	100	100	100	**95**	**98**

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

MEDICAL TRANSFER AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	28	23	18	29	17	21	**22**	**23**
n	5	5	6	5	2	5	**5**	**5**
%S	18	22	33	17	12	24	**18**	**21**
%C. # 1 Subsections on basic information completed	100	100	83	40	50	60	**96**	**75**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses	40	60	50	60	0	40	**93**	**46**
%C. # 3 Reason for medical transfer is clearly indicated on the form	100	100	100	80	100	100	**96**	**96**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.	100	100	100	80	100	100	**96**	**96**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings	100	100	83	80	50	100	**96**	**89**
%C. # 6 All the most recent lab results were provided	100	100	100	60	100	100	**79**	**93**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted	100	100	100	100	100	100	**93**	**100**
%C. # 8 The allergy section is completed fully and accurately	0	20	50	40	50	0	**43**	**25**
%C. # 9 The form includes a brief description of current behavior and responses to treatment	40	40	17	20	0	0	**75**	**21**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer	80	100	83	100	100	100	**82**	**93**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C. # 11 There is a progress note upon the individual's return that includes an analysis of information from the medical facility and an appropriate response by the physician/nurse practitioner.	100	100	100	80	100	100	**100**	**96**

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

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P***	**Mean-C**
N	28	23	18	29	17	21	**19**	**23**
n	7	9	7	11	5	8	**7**	**8**
%S	25	39	39	38	29	38	**37**	**35**
%C. # 1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?	86	100	86	73	60	100	**100**	**85**
%C # 2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?	57	67	86	100	100	88	**86**	**83**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?	100	N/A	0	67	50	50	**100**	**54**
%C #4 Is the assessment of systems completed and synthesized?	86	89	71	36	20	50	**100**	**60**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?	86	100	71	55	80	63	**100**	**74**
%C #6 Does the assessment include auscultation, etc?	57	56	50	9	50	0	**86**	**36**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?	86	89	71	45	80	100	**57**	**77**
%C #8 Was the level of urgency consistent with the clinical presentation?	86	78	100	45	80	88	**43**	**77**
%C #9 Was the course of physical status change adequately described?	71	56	71	27	40	75	**86**	**55**
%C #10 Was the individual's response to alternative interventions documented?	100	N/A	0	38	75	33	**100**	**47**
%C # 11Were changes from the baseline adequately identified and described?	71	89	86	27	60	38	**100**	**60**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?	100	100	0	57	50	40	**71**	**63**

N=Number of transfers to ER/Hospitals
n=number audited
* Data only reflects January and February 2012 for prior review period
See Tab # 104 a Change in Physical Status RN Audit Results

RN TRANSFER TO ER/HOSPITAL FORM AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	28	23	18	29	17	21	**19**	**23**
n	7	10	7	11	5	8	**7**	**8**
%S	25	43	39	38	29	38	**37**	**35**
%C. # 1 Was the form complete, signed and dated?	100	100	100	82	100	100	**71**	**89**
%C. # 2 Is the medical/physical reason for transfer to the ER clearly stated/described?	100	90	100	100	100	100	**86**	**97**
%C. # 3 Are all supporting medical data included, i.e., vital signs, blood glucose, height, weight, etc.?	100	80	86	82	100	88	**14**	**83**
%C. # 4 Is there a detailed description of the individual in care's current behavioral and cognitive status?	100	100	43	36	80	25	**43**	**69**
%C. # 5 If the current behavior or cognitive status is a change from normal presentation, is there a description of how it is different?	100	67	0	45	100	0	**0**	**48**
%C. # 6 Are "At Risk For /Special Conditions" (both existing and new) indicated and consistent with the individual's clinical picture? (If none known, is the box checked?)	100	80	86	55	80	75	**86**	**74**
%C. # 7 Is there a description of the individual's communication needs, including any significant findings?	100	100	86	91	80	63	**86**	**89**
%C. # 8 If applicable, were Special instructions to Enhance Health Care provided?	100	83	25	57	100	50	**100**	**58**
%C. # 9 Is there evidence that all applicable documents were completed/attached?	100	90	100	100	100	100	**100**	**91**

N=ER transfers for month
n=number audited
* Data only reflects February 2012 for prior review period
See Tab # 104 b RN Transfer To ER Audit Results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RN TRANSFER FROM ER DEPARTMENT AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	28	23	18	29	17	21	**19**	**23**
n	7	10	7	11	5	8	**6**	**8**
%S	25	43	39	38	29	38	**32**	**35**
%C. # 1 Is the form completed, signed and dated?	100	100	100	91	100	100	**83**	**98**
%C. # 2 Are vital signs documented?	100	100	100	100	100	100	**100**	**100**
%C. # 3 If the vital signs are outside the known parameters, is there evidence that the General Medical Officer was consulted?	50	N/A	N/A	0	n/a	n/a	**100**	**33**
%C. # 4 If the individual in care reports pain or the RN observes signs of possible pain, was a Pain Assessment Form completed?	N/A	0	100	0	n/a	100	**0**	**33**
%C. # 5 Is there evidence of a completed focused physical assessment including a review of the system related to why the individual in care was initially transferred to the general medical facility?	86	90	57	27	80	38	**83**	**60**
%C. # 6 Is there evidence of review of the discharge diagnosis, treatment and care recommendations from the transferring facility?	100	100	86	82	60	88	**83**	**88**
%C. # 7 Is completion of identification of new risks consistent with the RN's assessment of the individual's current physical status and the medical problems for which the individual was treated?	33	67	25	33	60	17	**83**	**40**
%C. # 8 If applicable, is there completion of any additional risk assessment forms/tools?	N/A	0	0	0	n/a	n/a	**0**	**0**
%C. # 9 Did the registered nurse summarize the assessment findings that have implications for nursing interventions, addressing immediate physical and psychiatric care and treatment?	86	60	57	9	60	25	**17**	**46**
%C. #10 Were objectives identified and immediate nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area 1) (if indicated by assessment)?	0	43	33	13	33	0	**0**	**21**
%C #11 Were objectives identified and immediate nursing interventions developed consistent with identified Medical/Physical Health (IRP Focus Area 11)?	57	50	50	9	20	25	**50**	**34**

N= ER transfers for month
n=number audited
* Data only reflects February 2012 for prior review period

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Tab # 104 c RN Transfer from ER Audit Results

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**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; and the team revised the focus of hospitalization, objectives, as appropriate, to reflect the individual's changing needs.	71	80	90	89	85	73	**86**	**82**
%C # 7 Ensure that each individual's treatment plan identifies diagnoses, treatments and interventions that nursing and other staff are to implement, the related symptoms and target variables to be monitored by nursing and other unit staff and the frequency by which staff need to monitor such symptoms.	95	100	87	95	90	78	**87**	**91**

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: In an effort to increase the focus on meeting those with special needs, the Hospital modified the focus of indicator # 7 of the clinical chart audit during this rating period to focus on evaluating IRP non-group nursing interventions that address those at risk of self harm, suicide, aggression, assaultive behavior and physical co-morbidities. ***See Tab # 8 Clinical Chart Audit form.*** The data suggests generally continued improvement in developing individualized objectives and interventions in IRPs to meet the needs of those with medical or other special needs. Data from clinical chart audits show improved performance, with a mean over 90% for the indicators that related to development of objectives and interventions (indicator # 7 and indicator # 4). However, improvement is still needed with respect to the two indicators relating to the review of IRPs on a more frequent basis if there are clinically relevant changes in the individual's functional status or risk factors.

Beginning in August 2012, intensive, competency based training was provided to nursing staff around developing individualized goals, objectives and nursing interventions, with a focus on medical needs. To date, 83% of nursing staff have achieved competency in this training. ***See Tab # 102 Designing Individualized Plans for Nursing Care curricula and training data.*** It is expected that this training will continue to strengthen development of objectives and interventions.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		The Hospital is continuing its focus on medical issues. History and Physical audits and Medical transfer audits, as well as the three nursing medical-related audits will continue. The nursing audits suggest that significant improvement is needed in documentation around changes in physical status and in RN transfer out and transfer in notes. Nursing hired a nurse educator with extensive experience around physical health issues (in addition to a second nurse educator with psychiatric experience) who will work with staff on improving physical health assessments, communication with medical practitioners and related documentation. The Hospital also recognized a slight decline on some indicators in the medical transfer audits, which it believes is attributable to the fact physicians are more often using the medical consultation form rather than the transfer form while Avatar finalizes the revised form (the Hospital has asked that the form be divided into two parts, one sending out and one for returning; which is expected to be implemented in Avatar in October 2012. This should resolve the documentation issues.) Concurrent review by utilization review specialists is also occurring, to review timeliness and quality of documentation. Finally, the IRP manual was updated during this period to provide additional examples of objectives and interventions for those with seizure disorders. Clinical chart audits, medical practitioner and nursing medical related audits will continue.
V.D.2	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	
V.D.3	write the objectives in behavioral and measurable terms;	**Recommendations:** 1. Same as above. SEH Response: Same as above. 2. Ensure adequate and timely modification of the IRP objectives to address results of the risk assessments. SEH Response: The Hospital modified its clinical chart audit tool to include a specific indicator and instructions (indicator # 5) that addresses cases in which an individual in care was assessed to be at moderate or severe risk in any category to determine if they were placed on a high risk list (if not, if documentation of why not is included) and if the IRP included IRP objectives and interventions to reduce the risk. In addition, the High Risk policy was substantially revised to specify treatment team actions when an individual in care is assessed to be at moderate or high risk, and includes requirements that the risk be clearly addressed in the IRP or that there be clear documentation if the team elects not to include it in the IRP, with the rationale stated. The supervisory clinical administrator and PID are monitoring to ensure identified risks are either addressed in the IRP or the rationale for not addressing the risks is in the clinical formulation. This is tracked in the High Risk database. As of September 30, 2012, 111 of 279 (40%) individuals in care were on one or more high risk lists. Of the 111, 83 individuals (75%) had at least one of the risks addressed in the IRP, and 56 individuals (or 50%) had all the risks addressed in their IRPS. **Facility's Findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

CLINICAL CHART AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**10**
%C # 5 Review the goals, objectives and interventions more frequently if there are clinically relevant changes in the individual's functional status or risk factors (*Per instructions, indicator applies only to those at moderate or severe risk based upon most recent psychiatric assessment and looks to determine if IIC was placed on high risk list or if not is there documentation as to why not and if objectives and interventions address all risks or if not, there is documentation why not)*	100	90	76	75	75	80	**94**	**81**
%C. #6 The IRP includes objectives written in behavioral and measurable terms	90	91	100	90	100	100	**82**	**95**
%C #9 Review the goals, objectives and interventions more frequently if there are clinically relevant changes in the individual's functional status or risk factors *(Applies to all IICs)*	100	33	94	78	89	67	*	**81**

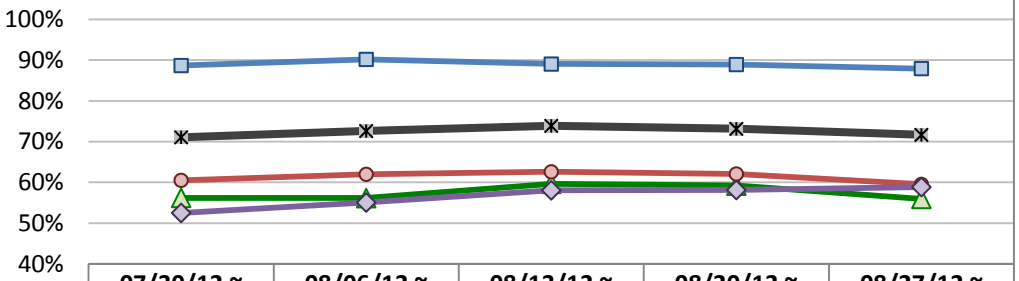
N = All IRP reviews scheduled in the review month
n = number audited
* Indicator was not included for prior review period
** Sample size 2 per unit (22)
Tab # 2, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data suggests additional improvement is needed in meeting this requirement on a consistent basis. A nurse consultant is providing a competency based training for all RNs that is designed to improve the quality of nursing related objectives and interventions in IRPs. Further, the supervisory clinical administrator is monitoring the high risk lists for each unit and is auditing the IRPs to ensure the risks are addressed. As of September 30, 2012, 111 of 279 (40%) individuals in care were on one or more high risk lists. Of the 111, 83 individuals (75%) had at least one of the risks addressed in the IRP, and 56 individuals (or 50%) had all the risks addressed in their IRPS. The revisions to the high risk database now allow managers to track this information and obtain data as often as needed. The supervisory clinical administrator will continue to review IRPs and is working with clinical administrators to ensure all risks are being addressed. Audits will continue.

V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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 with current corrective action plan. SEH Response: Ongoing. Beginning in May 2012 the Hospital began tracking attendance data for all TLC and unit based groups through a newly designed Access database, which allows for weekly tracking on attendance hours and includes other features, such as the ability to track treatment hours of those individuals on the unengaged list or those on a high risk list. The Hospital now has real time data around hours scheduled and hours attended for each individual in care. ***See Tab # 39 Treatment Hours 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:**

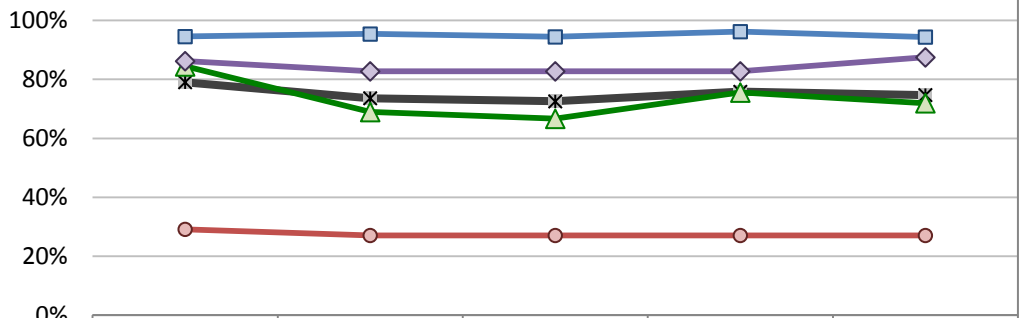
Figure 1. Attendance Rate



	07/30/12 ~ 08/05/12	08/06/12 ~ 08/12/12	08/13/12 ~ 08/19/12	08/20/12 ~ 08/26/12	08/27/12 ~ 09/02/12
All in Care during Week	71%	73%	74%	73%	72%
Admission Units Only	56%	56%	60%	59%	56%
Geriatric Units Only	61%	62%	63%	62%	60%
Long-term Residents Only	89%	90%	89%	89%	88%
Individuals in Unengaged List	53%	55%	58%	58%	59%

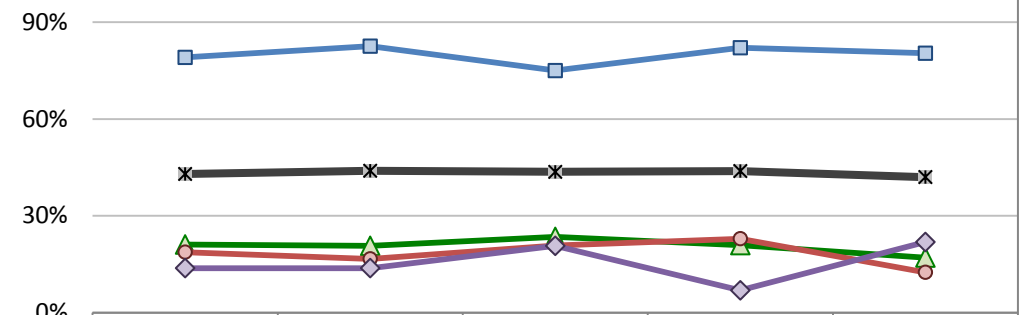
SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Figure 2. Individuals with >=20 Hours of Treatment Scheduled



	07/30/12 ~ 08/05/12	08/06/12 ~ 08/12/12	08/13/12 ~ 08/19/12	08/20/12 ~ 08/26/12	08/27/12 ~ 09/02/12
All in Care during Week	79%	74%	73%	76%	75%
Admission Units Only	84%	69%	67%	76%	72%
Geriatric Units Only	29%	27%	27%	27%	27%
Long-term Residents Only	95%	95%	94%	96%	94%
Individuals in Unengaged List	86%	83%	83%	83%	88%

Figure 3. Individuals with >=20 Hours of Treatment Attended



	07/30/12 ~ 08/05/12	08/06/12 ~ 08/12/12	08/13/12 ~ 08/19/12	08/20/12 ~ 08/26/12	08/27/12 ~ 09/02/12
All in Care during Week	43%	44%	44%	44%	42%
Admission Units Only	21%	21%	23%	21%	17%
Geriatric Units Only	19%	17%	21%	23%	13%
Long-term Residents Only	79%	83%	75%	82%	80%
Individuals in Unengaged List	14%	14%	21%	7%	22%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**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.	100	100	100	100	100	100	**98**	**100**

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: With the introduction of the Access database, the Hospital is now able to quickly and efficiently monitor treatment hours scheduled and attended for all individuals in care. Because treatment hour expectations can differ among individuals based upon such variables as length of stay, diagnosis and reason for hospitalization, the Hospital perfected its monitoring by clustering like units together to track hours scheduled, hours attended and an attendance rate. There are four clusters - - the admissions cluster, the geriatric cluster, long term cluster and the unengaged. Furthermore the Hospital is able to track treatment hours for those on certain high risk lists. Finally, the data also allows the Hospital to calculate an attendance rate, which is defined as the number of groups attended divided by the number of groups scheduled.

For the period of July 30, 2012 through September 2, 2012, the overall attendance rate for all individuals in care was between 71% to 74%, meaning that individuals were generally attending 71% - 74% of the groups for which they were scheduled. Specific hours of groups scheduled and attended are as follows. During the last week of August, of individuals on admissions units, 72% were scheduled for 20 hours or more, and 17% attended 20 hours or more (attendance rate for this cluster was 56%). For those in the geriatric cluster, 27% were scheduled for 20 hours or more of treatment, and 13% attended 20 hours or more (attendance rate for this cluster was 60%). For those in the long term cluster, 94% were scheduled for 20 hours or more, and 80% attended 20 hours or more (attendance rate for this cluster was 88%). Finally, for the unengaged population, 88% were scheduled for 20 hours or more of treatment, and 22% attended 20 hours or more of treatment (the attendance rate for this cluster was 59%)

The Hospital continues to work with the "unengaged" population in an effort to improve their involvement in treatment with some success. ***See Tab # 50 Status Report of the Treatment of Unengaged Individuals in Care.*** The most recent list (September 2012) includes 39 individuals who have been on the list during some part of the period of September 2011 through September 2012. Of these 39, 8 individuals are now engaged in treatment and were removed from the list and two were discharged. The list includes 7 from the prior list who are making progress in their level of engagement. The remaining are having their programming retooled, or are in the process of assessment relating to development or modification of

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		medication or behavioral interventions. The clinical chart audit shows a high level of performance in formulating objectives and in tying the interventions to objectives. See V.D.4. Nursing staff began receiving training around developing and updating nursing related IRP objectives and interventions. As of the writing of this report, 83% of RN staff completed the training; the remaining should complete the training by the end of October 2012. ***See Tab # 102 Nursing Plan of Care Training and Data*** Effective September 2011 and with some additional modifications in March 2012, the TLCs refined its programming in two key areas. On the TLC Intensive, programming around competency to stand trial was substantially changed. Individuals in care here for competency issues will now participate in new programming that includes two to three groups per week (M, T, Th and Fr) and a weekly mock trial (W). On the TLC Transitional, there is expanded and revised discharge focused programming. This includes increased participation by peer transition specialists and new involvement by Consumer Affairs, Social Work and Chaplaincy Departments. Social work has updated the curriculum for each of its groups to be more focused on skill development that will improve transition to the community, Chaplaincy is working to establish linkages with individuals in the community to improve community support and is taking IICs on community trips to various churches or spiritual centers, and Consumer Affairs is working with those reluctant to leave the hospital to help establish community linkages. Since the May 2012 visit, the TLCs implemented in July 2012 the group "Get Ready, Get Set, Go", co-led by psychology and social work. This group targets IICs who are ambivalent regarding discharge, addressing the practical/educational and psychological aspects of reintegrating into the community. The group travels into the community via public transportation at least one time per month. Finally, the Travel Training group has partnered with the public transportation system. Representatives from Metro come to the Hospital to provide educational sessions, and assist with travel experiences in the community.
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;	
V.E.2	monitor, at least monthly, the goals; objectives, and interventions identified in the plan for effectiveness in producing the desired	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	outcomes;	
V.E.3	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;	
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;	
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;	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.A.3	By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;	
VI.A.4	By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;	
VI.A.5	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;	
VI.A.6	By 12 months from the Effective Date hereof, SE shall ensure that:	
VI.A.6.a	Clinically supported, and current assessments and diagnoses are provided fo each individual	
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.	
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 graduate	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 settings), and personality assessments.	
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;	
VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment, and	
VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	
VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	
VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	
VI.B.5	By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians	**Recommendations:**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.</td><td>1. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">RISK ASSESSMENT PEER REVIEW AND AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>4</td><td>0</td><td>0</td><td>2</td><td>2</td><td>1</td><td>1</td><td>2</td></tr>
<tr><td>n</td><td>3</td><td>0</td><td>0</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>%S</td><td>75</td><td>n/a</td><td>n/a</td><td>50</td><td>50</td><td>100</td><td>71</td><td>67</td></tr>
<tr><td>%C # 16 There is a progress note in Avatar documenting delivery of report and feedback to the referral source.</td><td>100</td><td>n/a</td><td>n/a</td><td>100</td><td>N/A</td><td>100</td><td>0</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)
n/a = No assessments available for audit
Tab # 26 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHOLOGICAL EVALUATION PEER REVIEW AND AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>0</td><td>4</td><td>3</td><td>15</td><td>2</td><td>0</td><td>4</td><td>4</td></tr>
<tr><td>n</td><td>0</td><td>2</td><td>3</td><td>5</td><td>1</td><td>0</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>N/A</td><td>50</td><td>100</td><td>33</td><td>50</td><td>N/A</td><td>55</td><td>46</td></tr>
<tr><td>%C # 15 Progress note in Avatar documenting delivery of report</td><td>N/A</td><td>100</td><td>67</td><td>80</td><td>100</td><td>N/A</td><td>64</td><td>82</td></tr>
</table>
N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
n/a= no assessments available for audit
Tab # 26 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data shows improved performance on this indicator in all types of psychological evaluations and the Director of Psychology continues to remind staff of this requirement. This will continue to be monitored through the relevant audits.</td></tr>
<tr><td>VI.C</td><td>Rehabilitation Assessments</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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 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	**Recommendations:** 1. Continue with current corrective action plan. SEH Response: Ongoing. The Social Work Department continues to implement the strategic action plan submitted to DOJ in April 2012. All social work positions have been filled and the two staff who were on FMLA returned to work as of July 2012. However, one worker recently provided his notice that he was resigning effective October 2012 (this worker was not assigned to a unit

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	treatment team about the individual's relevant social factors.	but fills in based upon work pressures). The position is in the recruitment process and it is hoped that it will be filled during November 2012. Despite the social work vacancies for part of the review period, attendance of social workers at IRP conferences during this review period continued to exceed the 90% threshold. In addition, effective in February 2012, the social work initial assessment and social work update forms in Avatar were redesigned and all social work staff were trained on the new forms using actual cases. The revised forms include updates to the portions of the assessments around discharge planning and were designed to improve the clinical flow of the assessments' discharge planning sections. Audit tools and instructions were then updated to reflect the new forms, and in large part performance is improving across all indicators (except one), even with the staffing shortages in Spring 2012. ***See Tab # 28 Social Work Initial Assessment Audit Results, Tab # 30 Social Work Update Audit Results.*** The Social Work Department implemented the CAP action steps related to training. Social workers were provided training around discharge issues and in the completion of the initial social work assessment and social work updates using the new forms. During this training, emphasis was placed on the development and linkages of social work-related objectives and interventions, and how the new forms are more clearly linked to the IRP. Two social work staff completed training with DC Department of Health around assisted living issues. The Social Work Department, with the TLCs, has scheduled recovery model refresher training for October 2012 for treatment teams, TLC and rehabilitation staff which will include detailed information about the community integration curricula being used by the TLCs. The discussion will include the importance of expanding discharge planning beyond housing and financial resources. The participants will learn about other important aspects of discharge planning such as ensuring individuals have community connections, activities to fill their time and ensuring these are incorporated into IRPs. The Social Work Department also updated the curricula used for discharge planning groups. In March, 2012 a travel training group was started with social work and rehabilitation services staff. The group regularly visits the community to learn the metro and other ways to navigate the city. Social work is working with psychology and co-facilitating a group focused on resistance and leaving the Hospital. Weekly meetings with the MHA and the Community Integration Team continue. The Social Work department recently started to build a partnership with the Addiction, Prevention, and Recovery Administration (APRA.) This was started as a result of one of the community Integration meetings. At this time, the Hospital is able to contact APRA and request for that APRA staff come to the Hospital to complete an assessment and provide treatment recommendations. We are working closely with APRA to ensure that the individual's mental health needs are being monitored during any inpatient substance abuse treatment and there are plans in place after substance abuse treatment. The Hospital has been successful thus far in getting APRA out to assess an individual quickly and APRA was able to provide treatment information timely. With the addition of this partnership, the Hospital expects that those who have co-occurring disorders can have stronger discharge plans around their substance abuse needs than previously was the case. Finally, to ensure continued progress is made, social work has implemented the action steps related to audits and are sharing audit results with individual workers during their 1:1 supervision, which are also presented at the monthly social worker meetings as described in the CAP. Additionally, during this review period, social work supervisors completed audits with each staff member so that each could see how supervisors were assessing the worker's documentation and so that workers and supervisors could discuss any issues identified through the audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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.

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	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	8	6	7	7	7	5	**8**	**7**
%S	22	20	20	21	21	19	**21**	**20**
%C # Completed within 5 days of admission	100	100	100	100	100	100	**82**	**100**
%C # 3a SW has reviewed other sources of information such as old records, initial psych assessment etc	88	83	100	100	100	100	**70**	**95**
%C # 3b Review of the individual's history is satisfactory and includes benefits, medical developmental, psychiatric, social history, and substance abuse history.	100	100	100	100	100	100	**100**	**100**
%C # 4a Identifies whether there is a discrepancy or note and if SWIA includes resolution of discrepancy	n/a	50	100	67	100	n/a	**85**	**71**
%C #4b If discrepancy is not resolved, the SWIA documents a plan to resolve the discrepancy.	n/a	50	100	0	n/a	n/a	**75**	**50**
%C # 5 Documents the presenting problem in the individual's own words, one's perceived strengths, their own goals for treatment and discharge.	100	100	100	100	100	100	**100**	**100**
%C # 6a Describes the individual's strengths and limitations	100	100	100	100	100	100	**98**	**100**
%C #6b Has recommendations/interventions that are clinical and specific such as "SW will meet to discuss various housing options three times a week""	88	83	100	100	100	80	**71**	**93**
%C #6c Identifies a group for the individual to participate in, if applicable	57	80	100	100	100	100	**85**	**87**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #6d Overall assessment includes discussion of individual's goals and feelings about community placement	75	100	100	100	100	100	**96**	**95**

N= Number of admissions

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

Tab # 28 SOCIAL WORK AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	233	235	238	248	249	244	**243**	**241**
n	11	11	11	11	12	12	**12**	**11**
%S	5	5	5	4	5	5	**5**	**5**
%C Timely completions	90	100	100	100	100	100	**78**	**98**
%C # 1a Indicates contact with family, significant other and/or guardian	100	67	100	100	88	89	**94**	**90**
%C #1b Indicates the family's, significant other's and/or guardian's support towards individual's progress and discharge plan	100	67	100	100	89	89	**81**	**91**
%C #2a Documents observable/measurable objectives	91	82	100	100	100	83	**81**	**93**
%C # 2b Documents frequency and where progress or lack of progress is	73	64	91	100	92	83	**49**	**84**
%C #2c Documents who is responsible for the intervention and what will be addressed or taught	91	82	100	100	100	100	**76**	**96**
%C # 2d Documents individual's progress to objectives and interventions	91	91	91	100	100	100	**85**	**96**
%C #2e Documents next steps	100	91	100	100	100	100	**82**	**99**
%C # 2f Documents if the individual has made progress, the objective and/or intervention has been revised to move the individual toward discharge	80	50	100	67	100	50	**38**	**81**
%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	86	80	100	88	100	91	**64**	**90**
%C #3a Documents in the individual's own words their expressed goal	100	90	100	100	100	70	**81**	**94**
%C # 4a The individual's strengths and limitations are described	70	27	100	100	100	100	**86**	**84**
%C # 4b Documents the individual's current behaviors and functioning	100	100	100	100	100	100	**95**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #4c Documents a recommendation for groups and/or discussion of day program if applicable	100	82	100	100	100	90	**78**	**95**
%C # 5a Includes anticipated placement for individual (specific or generic)	91	91	100	100	100	92	**88**	**96**
%C # 5b Identifies if the individual has any barriers to discharge or anticipated placement	100	82	100	100	100	100	**95**	**97**
%C #5c Discharge criteria and discharge plan review is present and updated.	73	73	100	100	100	100	**68**	**91**
%C # 6a There is identifying information regarding the community support worker/CSA	100	100	100	100	100	100	**100**	**100**
%C # 6c Description of case manager's/CSA's involvement in discharge planning and contact with individual	100	88	100	100	100	100	**93**	**98**

N= Census at end of month less admissions
n = number audited-target is 1 per social worker (Audit sample plan)
Tab # 28 SOCIAL WORK AUDIT RESULTS

See Also Chapter VII for specific indicators around discharge planning.

Analysis/Action Plans: Data from the audits show continued improvement in social work practice in completing both initial and assessment updates - - in fact, for the combined audits, all indicators but one either were above 90%, stayed the same or improved, which reflect the actions taken by social work leadership to improve its performance. As previously noted, social work implemented modified "light bulb" instructions in Avatar to provide additional guidance to staff in completing the social work initial assessment and the social work update. Social work also worked with Avatar to modify the SWIA and SW Update forms themselves, which went live in February 2012. Audit tools were then modified again to reflect the new forms. Of the 20 indicators in the social work initial assessment audit tool, 15 are above 90%. The only indicators that declined addressed the evaluation of factual discrepancies, and social work supervisors met individually with each staff to review expectations and provide coaching. With respect to the social work updates, performance also significantly improved; sixteen of nineteen indicators met the 90% threshold, and the remaining three were above 80%.

Given the improved performance no additional action steps are needed.

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

1. Fill social work vacancies.

SEH Response: Completed. A social worker resigned in late September 2012 but it is anticipated that the position may be filled during November 2012. Further, that individual was not assigned to a unit, but responded to provide additional support where assigned staff were on leave or workloads were particularly heavy for a particular set of reasons (i.e. unusual number of admissions).

2. Implement and monitor the current strategies and audits in the CAP.

SEH Response: Ongoing. All trainings identified in the CAP were completed, those individuals in care who are resistant to outplacement are paired with a transition specialist and/or are attending those groups that are designed to support individuals who are reluctant to leave the Hospital.

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>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>37</td><td>30</td><td>35</td><td>34</td><td>34</td><td>26</td><td>36</td><td>33</td></tr>
<tr><td>N</td><td>8</td><td>6</td><td>7</td><td>7</td><td>7</td><td>5</td><td>8</td><td>7</td></tr>
<tr><td>%S</td><td>22</td><td>20</td><td>20</td><td>21</td><td>21</td><td>19</td><td>21</td><td>20</td></tr>
<tr><td>%C # 5 Documents the presenting problem in the individual’s own words, one’s perceived strengths, and own goals for treatment and discharge</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 # 6a Describes the individual’s strengths and limitations</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td><td>100</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 6b Has recommendations/interventions that are clinical and specific	88	83	100	100	100	80	**71**	**93**
%C # 6c Identifies a group for the individual to participate in, if applicable	57	80	100	100	100	100	**85**	**87**
%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	75	100	100	100	100	100	**96**	**95**
%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**100**	**100**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	100	**98**	**100**
%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	100	100	100	100	100	100	**87**	**100**
%C # 7d Description of discharge barriers	100	100	100	100	100	100	**100**	**100**
%C # 8a There is identifying information regarding the Community support worker/CSA	100	100	100	100	100	100	**100**	**100**
%C # 8b Documents the dates the CSA was notified of the IRP	86	100	100	100	100	100	**57**	**97**

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

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	11	11	11	11	10	11	**10**	**11**
%S	6	6	6	6	5	5	**5**	**6**
%C # 5 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	88	100	100	100	100	100	**97**	**98**

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	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**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)	86	100	100	81	74	89	**92**	**88**
%C # 4 The IRP has interventions that relate to each objective specifying who will do what, within what timeframe, to assist the individual to meet his /her needs as specified in the objective.	100	100	100	100	100	100	**98**	**100**

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

DISCHARGE MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	17	18	12	11	17	21	**20**	**16**
n	4	4	4	4	4	4	**5**	**4**
%S	24	22	33	46	24	19	**24**	**25**
%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?	100	100	100	100	100	100	**100**	**100**
%C # 21 Identified individual to assist with interventions.	100	100	100	100	100	100	**100**	**100**
%C # 22 Timeframes and duration for completion of interventions	75	75	100	100	100	100	**80**	**92**

N = All discharges of individuals in care with civil legal status in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As the various audit results show, the Hospital continues to improve the effectiveness of discharge planning from the time of admission. In addition to training provided to clinical administrators and social workers during the last review period, social workers also participated in trainings specifically addressing completion of the SWIA and the completion of the Social Work Update. The instructions for each of the social work assessments were updated, and in February, 2012, revised SWIA and SW Updates went live in Avatar; changes to the forms focused on the discharge related sections and on improving the linkages of objectives and interventions relating to discharge in the IRPs. Social workers were provided with examples of discharge criteria and discharge plans to assist workers and teams in addressing discharge issues; the examples are more aligned with the revised social work forms. In December 2011, Social workers also had a dedicated

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		training focused on discharge planning for those with co-occurring disorders, the effectiveness of which can be seen in the audit results from this review period. ***See Tab # 1 IRP Training Material Discharge Documentation examples.*** Two social workers attended training with Department of Health around assisted living and the Social Work Department, with the TLCs, has scheduled recovery model refresher training for October 2012 for treatment teams, TLC staff and rehabilitation staff. This training will include detailed information about the community integration curricula being used by the TLCs. The discussion will include the importance of expanding discharge planning beyond housing and financial resources. The participants will learn about other important aspects of discharge planning such as ensuring individuals have community connections, activities to fill their time and ensuring these are incorporated into IRPs. In regards to the Hospital's efforts to identify nursing homes and/or appropriate resources in the community for our individuals with complicated medical needs, social work staff have attended numerous workgroups and forums to discuss this specialized population. In June 2012, the Assistant Director of Social Work along with the social worker from one of the geriatric units attended training on the admission process for Assisted Living Residences (ALR). The training was provided by the Departments of Health and Health Care Finance. It was attended by the ALR facility operators; staff from DMH and HFA. The training outlined the function and services provided by ALRFs; the admission criteria for consumers; and the admission process. The training was very helpful in understanding the services provided in ALRFs; the staffing and skills of staff, the funding requirements for ALRF residence as well as concerns that ALRF operators had in working with our population. The Hospital shared the supports given to individuals with mental illness in the community; the referral process that it uses for its individuals to determine the level of care. The Hospital learned that very few of its IIC qualify for ALRFs. These staff then presented to all social work staff. The Director of Social Work was invited by the Department of Health Care Finance (DCHF) to present at the HealthCare Delivery Management, Division of Long Term Care, DC Nursing Home Open Forum on July 19, 2012 and presented on the population served by Saint Elizabeths, the Hospital's needs in regards to nursing home level of care, and the Hospital's current challenges in accessing these services. She also presented about what DMH/SEH can do to support the transitions as well as provide training for staff. On August 24, 2012, the Assistant Director of Social Work and Supervisory Clinical Administrator attended a workgroup sponsored by DMH and attended by DMH (CIT, Adult services, SEH), DC Housing, Legal Services for the Elderly, AARP, ULS, Consumer Action Network, and DC Healthcare Finance. The workgroup/discussion focused on moving individuals with co-morbidity (MI and Health problems) to community settings and improving collaboration among housing providers, CSAs, medical providers and the individuals. The group also looked at available resources, strengthening the capacity of these resources to meet the needs of this population and developing more resources for this population, with the goal of providing opportunities for community placements other than in a nursing home and moving them to less restrictive environments where they can thrive safely. This group will continue to meet to develop strategies to move more to the community. On September 13, 2012, the Director of Social Work attended a workgroup with the District of Columbia Hospital Association (DCHA) and the DC Health Care Association around discharge planning and working with the long term care community. Within this workgroup, the Director of Social Work has been assigned to a smaller workgroup focusing on the behavioral needs of the long term care agencies as well as the individuals in these facilities. This group will continue to meet and

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		collaborate on services and needs in the community. Additionally, the Hospital will continue to work with DMH's Integrated Care Division on identifying alternative housing options and how to support those with medical issues and ADL needs in the community. The two teams will work together to articulate the needs of the individuals and how to obtain support through the Elderly and Physical Disabilities waivered program and other community programs. The Hospital will continue with its discipline and discharge audits to identify areas of strengths and areas in need of improvement.
VII.A.1	those factors that likely would result in successful discharge including the individual's strengths, "preferences, and personal goals;	**Recommendations:** 1. See VII.A SEH Response: See VII.A 2, Working with DMH and community providers, identify specialized services to meet the needs of elderly individuals with co-morbid conditions. SEH Response: Two social workers attended training with Department of Health around assisted living and the Social Work Department, with the TLCs, has scheduled recovery model refresher training for October 2012 for treatment teams, TLC staff and rehabilitation staff. This training will include detailed information about the community integration curricula being used by the TLCs. The discussion will include the importance of expanding discharge planning beyond housing and financial resources. The participants will learn about other important aspects of discharge planning such as ensuring individuals have community connections, activities to fill their time and ensuring these are incorporated into the IRPs. In regards to the Hospital's efforts to identify nursing homes and/or appropriate resources in the community for our individuals with complicated medical needs, social work staff have attended numerous workgroups and forums to discuss this specialized population. In June 2012, the Assistant Director of Social Work along with the social worker from one of the geriatric units attended training on the admission process for Assisted Living Residences (ALR). The training was provided by the Departments of Health and Health Care Finance. It was attended by the ALR facility operators; staff from DMH and HFA. The training outlined the function and services provided by ALRFs; the admission criteria for consumers; and the admission process. The training was very helpful in explaining the services provided in ALRFs; the staffing and skills of staff, the funding requirements for ALRF residence as well as concerns that ALRF operators had in working with the Hospital's population. The Hospital shared information about the supports given to individuals with mental illness in the community; and the referral process that used for individuals to determine the level of care. Staff learned that very few of IIC qualify for ALRFs. These staff then presented to all social work staff. The Director of Social Work was invited by the Department of Health Care Finance (DCHF) to present at the HealthCare Delivery Management, Division of Long Term Care, DC Nursing Home Open Forum on July 19, 2012 and presented on the population served by Saint Elizabeths, the Hospital's needs in regards to nursing home level of care, and the Hospital's

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

current challenges in accessing these services. She also presented about what DMH/SEH can do to support the transitions as well as provide training for staff.

On August 24, 2012, the Assistant Director of Social Work and Supervisory Clinical Administrator attended a workgroup sponsored by DMH and attended by DMH (CIT, Adult services, SEH), DC Housing, Legal Services for the Elderly, AARP, ULS, Consumer Action Network, and DC Healthcare Finance. The workgroup/discussion focused on moving individuals with co-morbidity (MI and Health problems) to community settings and improving collaboration among housing providers, CSAs, medical providers and the individuals. The group also looked at available resources, strengthening the capacity of these resources to meet the needs of this population and developing more resources for this population with the goal of providing opportunities for community placements other than in a nursing home and moving them to less restrictive environments where they can thrive safely. This group will continue to meet to develop strategies to move more to the community.

On September 13, 2012, the Director of Social Work attended a workgroup with the District of Columbia Hospital Association (DCHA) and the DC Health Care Association around discharge planning and working with the long term care community. Within this workgroup, the Director of Social Work has been assigned to a smaller workgroup focusing on the behavioral needs of the long term care agencies as well as the consumers in these facilities. This group will continue to meet and collaborate on services and needs in the community.

Additionally, the Hospital will continue to work with DMH's Integrated Care Division on identifying alternative housing options and how to support those with medical issues and ADL needs in the community. The two teams will work together to articulate the needs of the individuals and how to obtain support through the Elderly and Physical Disabilities waivered program and other community programs.

3. Social work should document involvement with family and CSAs in notes after IRP meetings if not in attendance.

SEH Response: Ongoing. Social workers are documenting this and it is being audited through the Social Work Update audit (indicator # 1a, #1b, #6a and #6b.

Facility's findings

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
N	8	6	7	7	7	5	**8**	**7**
%S	22	20	20	21	21	19	**21**	**20**
%C # 5 Documents the presenting problem in the individual's own words, one's perceived strengths, and own goals for treatment and discharge	100	100	100	100	100	100	**100**	**100**
%C # 6a Describes the individual's strengths and limitations	100	100	100	100	100	100	**98**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	75	100	100	100	100	100	**96**	**95**

Analysis/Action Plans: See VII.A.

VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	
VII.A.3	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	**Recommendations:** 1. Fill social work vacancies and maintain adequate staffing. SEH Response: Completed. A social worker resigned effective October 2012 but it is anticipated that the position may be filled in November 2012. Further, that individual was not assigned to a unit, but responded to provide additional support where assigned staff were on leave or workloads were particularly heavy for a particular set of reasons (i.e. unusual number of admissions). 2. SEH Corrective Action Plan, Action Steps should be implemented and monitored. SEH Response: Ongoing. See audit data below 3. See VII.A. and VII.A.1. SEH Response: See VII.A and VII.A.1. **Facility's findings:**

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	8	6	7	7	7	5	**8**	**7**
%S	22	20	20	21	21	19	**21**	**20**
%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**100**	**100**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	100	**98**	**100**
%C # 7c Includes discharge plan (what SEH, CSA etc will take to assist with discharge)	100	100	100	100	100	100	**87**	**100**
%C # 7 d Identifies if the individual has any barriers to discharge to anticipated placement (old tool #9)	100	100	100	100	100	100	**100**	**100**

N= Number of admissions in the month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n = Target is 20% of admissions

Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	233	235	238	248	249	244	**243**	**241**
n	11	11	11	11	12	12	**12**	**11**
%S	5	5	5	4	5	5	**5**	**5**
%C # 5a Includes anticipated placement for individual (specific or generic)	91	91	100	100	100	92	**88**	**96**
%C # 5b Identifies if the individual has any barrier to discharge	100	82	100	100	100	100	**95**	**97**
%C # 5c Discharge criteria (what the individual needs to do) and the discharge plan review (what SEH staff, CSA staff etc will do) is present and updated to show progress or lack of progress toward discharge.	73	73	100	100	100	100	**68**	**91**

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	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**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)	86	100	100	81	74	89	**92**	**88**

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*								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
Individuals in Care – Daily Average	273	265	271	278	282	276	**280**	**274**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Discharges	38	35	27	25	33	39	**39**	**33**
# 30-day Readmissions	2	2	2	0	1	1	**2.5**	**1.3**
% 30-day Readmissions	5.3	5.7	7.4	0.0	3.0	2.1	**6.5**	**4.5**

*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 continues in the 270-280 range; the average daily census was 280 in the prior review period but was 276 during this review period. 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 June 2012 during this review period. The 30 day rehospitalization rate during this review period is 4.1%, which is significantly lower than the 6.5% from the previous review period.

In addition, social work and the clinical chart audits show improved performance around identifying discharge barriers and improving IRPs to address these issues. The SWIA audits showed that 100% of SWIAs audited identified barriers to discharge and resources needed for discharge. This also was an area of strength in the Social Work Update audits, and 97% of cases identified barriers to discharge (indicator # 5b). As noted, training for social workers and clinical administrators around discharge planning was held during the prior review period with a focus on the linkages between the social work update and the completion of the discharge sections of the clinical formulation. Changes were made to the SWIA and Social Work Update forms in Avatar that positively impacted the quality of the social work assessments and how workers address discharge barriers. Social work supervisors also met individually with each worker to "jointly audit" a case. 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:

None.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	8	6	7	7	7	5	**8**	**7**
%S	22	20	20	21	21	19	**21**	**20**
%C # 6a Describes the individual's strengths and limitations	100	100	100	100	100	100	**98**	**100**
%C # 6b Has recommendations/interventions that are clinical and specific?	88	83	100	100	100	80	**71**	**93**
%C # 6c Identifies a group for the individual to participate in, if applicable	57	80	100	100	100	100	**85**	**87**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #6 d Overall assessment includes discussion of individual's goals and feelings about placement in the community	75	100	100	100	100	100	**96**	**95**
%C # 7a Includes anticipated placement for individual (specific or generic)	100	100	100	100	100	100	**100**	**100**
%C # 7b All areas of discharge criteria are described in detail as to what is needed	100	100	100	100	100	100	**98**	**100**
%C # 7c Includes discharge plan (what SEH, CSA etc will do to assist with discharge)	100	100	100	100	100	100	**87**	**100**
%C # 7d Description of discharge barriers	100	100	100	100	100	100	**100**	**100**

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

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**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	86	100	100	81	74	89	**92**	88

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.

VII.B	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.	
VII.C	By 12 months from the Effective Date hereof,	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	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. Fill social work vacancies. SEH Response: Completed. A social worker resigned effective October 2012 but it is anticipated that the position may be filled during November 2012. Further, that individual was not assigned to a unit, but responded to provide additional support where assigned staff were on leave or workloads were particularly heavy for a particular set of reasons (i.e. unusual number of admissions). **Facility's findings:**

IRP OBSERVATION MONITORING AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N	192	173	188	192	193	203	**228**	**190**
n	11	11	11	11	10	11	**10**	**11**
%S	6	6	6	6	5	5	**5**	**6**
%C Data fields: Family Member invited?	100	100	100	83	75	100	**88**	**92**
%C Data fields: Community support worker invited	100	100	90	100	89	100	**94**	**96**

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	Jun	July	Aug	Mean-P	Mean-C
N	37	30	35	34	34	26	**36**	**33**
n	8	6	7	7	7	5	**8**	**7**
%S	22	20	20	21	21	19	**21**	**20**
%C # 6a Describes the individual's strengths and limitations	100	100	100	100	100	100	**98**	**100**
%C # 6b Has recommendations/interventions that are clinical and specific?	88	83	100	100	100	80	**71**	**93**
%C # 6c Identifies a group for the individual to participate in, if applicable	57	80	100	100	100	100	**85**	**87**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 28 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	233	235	238	248	249	244	**243**	**241**
n	11	11	11	11	12	12	**12**	**11**
%S	5	5	5	4	5	5	**5**	**5**
%C # 5a Includes anticipated placement for individual (specific or generic)	91	91	100	100	100	92	**88**	**96**
%C # 5b Identifies if the individual has any barrier to discharge to anticipated placement.	100	82	100	100	100	100	**95**	**97**
%C # 5c Discharge criteria and the discharge plan of review is present and updated to show progress or lack of progress toward discharge.	73	73	100	100	100	100	**68**	**91**

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: Data shows improved performance in both the Social Work Initial Assessments and Social Work Updates on this requirement. See subcells below.

VII.C.1 measurable interventions regarding his or her particular discharge considerations;

Recommendations:

1. Continue to implement and monitor Corrective Action Plan.

SEH Response: Ongoing. See VII.C.

2. Fill social work vacancies.

SEH Response: Completed. A social worker resigned effective October 2012 but it is anticipated that the position may be filled during November 2012. Further, that individual was not assigned to a unit, but responded to provide additional support where assigned staff were on leave or workloads were particularly heavy for a particular set of reasons (i.e. unusual number of admissions).

Facility's findings:

DISCHARGE MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	17	18	12	11	17	21	**20**	**16**

<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>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>%S</td><td>24</td><td>22</td><td>33</td><td>46</td><td>24</td><td>19</td><td>24</td><td>25</td></tr>
<tr><td>%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = All discharges of civil legal status to the community in the month
n = number audited
Target sample is 20%
Tab # 54 DISCHARGE AUDIT RESULTS

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

No recommendations.

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>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>18</td><td>12</td><td>11</td><td>17</td><td>21</td><td>20</td><td>16</td></tr>
<tr><td>n</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>%S</td><td>24</td><td>22</td><td>33</td><td>46</td><td>24</td><td>19</td><td>24</td><td>25</td></tr>
<tr><td>%C. # 23 Is there evidence of adequate assistance in transitioning prior to discharge?</td><td>100</td><td>100</td><td>75</td><td>100</td><td>100</td><td>100</td><td>100</td><td>96</td></tr>
</table>
N = All discharges of individuals in care with civil legal statuses in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: The Hospital continues to implement the revised TLC programming and curricula to have a far more robust offering around support for transitioning to the community. The Therapeutic Learning Center continues to enhance groups focusing on community integration. The "Warming Up to New Possibilities" group, led by Consumer Affairs, began monthly trips into the community, utilizing public transportation. In March 2012, the "Spiritual Home" group began monthly
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		trips to visit various religious institutions to assist individuals in establishing religious affiliations and community support. Rehabilitation Services and Social Work have collaborated to begin a Travel Training Program that began in March 2012 to teach skills for travel on the bus and metro-rail system throughout the city. Occupational Therapy has begun community living skills groups for individuals in pre-trial status on the Intensive TLC to enhance independent living skills. As a result of focus group meetings throughout the hospital, new groups were created in September 2011 to address gender specific issues for women. The groups focus on women's health, self-care, grooming, etc. Finally, Social Work continues to enhance its curricula to provide more in-depth lessons on distinct components of discharge planning (e.g., money management, understanding your benefits, etc.). A group "Get Ready, Get Set, Go", co-led by psychology and social work, began in July 2012. This group targets IICs who are ambivalent regarding discharge, addressing the practical/educational and psychological aspects of reintegrating into the community. The group travels into the community via public transportation at least one time per month. The Travel Training group partnered with the public transportation system. Representatives from Metro come to the hospital to provide educational sessions, and assist with travel experiences in the community. Finally in October 2012, refresher recovery training for all treatment teams will be held, and teams will also be provided more detailed information about curricula for the transition to community groups in the TLC. Audits show performance consistently about the 90% mark during both the prior and current review periods. This is further supported by the Hospital's low 30 day rehospitalization rate which was well below the national public rate of 7.84%. The Hospital will continue with monthly audits.
VII.E	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.	**Recommendations:** 1. Implement and monitor the Corrective Action Plan. SEH Response: Ongoing. The Hospital is implementing and monitoring the CAP. **Facility findings:**

DISCHARGE MONITORING AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N	17	18	12	11	17	21	**20**	**16**
n	4	4	4	4	4	4	**5**	**4**
%S	24	22	33	46	24	19	**24**	**25**
%C. # 6 Is there documented evidence of active collaboration with a CSA?	100	100	100	100	100	100	**100**	**100**
%C. # 7 Was the outpatient psychiatrist identified?	50	75	100	100	100	100	**78**	**87**
%C. #8 Was the outpatient/community support worker identified?	100	100	100	100	100	100	**100**	**100**
%C. # 9 Was the next outpatient (medication or therapy) appointment date indicated?	75	75	100	100	100	100	**78**	**91**
%C. # 12 Was the exact type of day services or employment indicated?	100	100	100	100	100	100	**100**	**100**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C. # 13 Were the type and location of substance abuse/addiction services indicated?</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. # 14 If the individual has an active Axis III diagnosis, were ongoing medical needs identified?</td><td>100</td><td>N/A</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C. # 15 Was housing secured?</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. # 16 Was the individual’s benefit information completed?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C. # 17 Were any other specialized services identified?</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. # 18 Was the discharge plan of care signed by the individual or his/her legal representative?</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>%C. # 19 Was a copy of the discharge plan of care given to the individual or the individual’s family or legal representative?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = All discharges in the month
n = number audited
Tab # 54 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: See VII.A. Audits show strong performance in discharge planning. 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.
</td></tr>
<tr><td>VII.F</td><td>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:</td><td></td></tr>
<tr><td>VII.F.1</td><td>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</td><td></td></tr>
<tr><td>VII.F.2</td><td>hiring sufficient staff to implement these provisions with respect to discharge planning.</td><td></td></tr>
</table>

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. SEH Response: See VI.A.1. 2. Improve the risk benefit analysis, as part of the psychiatric update, to justify continued treatment of new generation antipsychotic medications for individuals suffering from a variety of metabolic disorders. SEH Response: Effective with the July 2011 audits, the Hospital revised its CIPA and Psychiatric Reassessment audit tools to consolidate indicators and to restructure the audits to look for more analysis and critical thinking by treating psychiatrists around high risk issues. In the revised Psychiatric Reassessment audit tool there are now three questions (#3, # 4 and #7) that address adverse reactions and high risk medication practices, including evaluating the rationale for polypharmacy or use of new generation antipsychotics for persons suffering from a variety of metabolic disorders, among other high risk practices. The instructions prompt the auditor to consider the rationale, whether it is consistent with the medication guidelines and whether it specifically addresses the risks versus benefits of any high risk regimen. The audit tools track the revised Psychiatric Update form that includes sections on medication response, pertinent laboratory results, medication side effects,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

polypharmacy or use of benzodiazepines in high risk groups.

Audit data from the Psychiatric Update audit shows improvement in the indicator around whether adverse reactions are appropriately noted (indicator # 3), up from 85% to 96%, and continued strong performance in indicator # 7 (plan reflects diagnosis, mental status exam, patient's response to treatment and discusses rationale of any high risk medication regimen) with a mean of 100%. Performance on indicator # 4 (polypharmacy and rationale included) remained the same, at 96%.

The Hospital recently awarded a contract for a diabetes consultant who will review diabetes management protocols and revise them as needed. She will also work with physician and nursing staff around diabetes management issues. The individual started work here in late September 2012 and is working with staff around risks of metabolic disorders secondary to medications. She is expected to facilitate the Hospital's transition to "insulin pen" usage, which more closely reflects outside treatment strategies. She will also assist nursing education in the development of a diabetic teaching curriculum, so that individuals in care can go to groups within the Hospital to learn more about the disease process and its treatment. Finally, she will also help in the development of our formulary for diabetic meds (i.e. insulin types) and will modify and strengthen the protocols we have in place for diabetes management.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	8	8	7	6	7	5	**8**	**7**
%S	22	27	20	18	21	19	**23**	**21**
%C # 9 Does the plan section of the CIPA reflect the diagnosis, mental status examination results, results of risk assessment and does it include an appropriate rationale for prescription of any high risk medication regimen? (Indicator effective July 2011)	100	100	100	100	100	100	**100**	**100**

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

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	233	235	238	248	249	244	**242**	**241**
n	31	31	33	33	30	33	**31**	**32**
%S	13	13	14	13	12	14	**13**	**13**
%C # 3 Are the appropriate adverse reactions noted in the relevant subsection with respect to tx with FGAs or SGAs anti-psychotics?	84	94	97	100	100	100	**85**	**96**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 4 Is polypharmacy (≥ 2 more anti-psychotics or ≥ 4 or more psychotropics) correctly identified and is there an adequate rationale?	90	94	100	97	97	97	**96**	**96**
%C # 7 Does the plan section of the Update reflect the diagnosis, mental status examination results, response to treatment and does it include an appropriate rationale for prescription of any high risk medication regimen?	100	100	100	100	100	100	**99**	**100**

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

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

Overall, the data suggests continuing improvement in documentation around high risk medication practices. Data from the revised audit tool shows excellent performance, and during this review period, all indicators in the Psychiatric Update dealing with risk/benefits of medication regimens are now above the 90% threshold. The audits will continue and the Medical Director/designee will identify practitioner issues through the audits and will review the documentation expectations during his monthly meetings with psychiatrists.

VIII.A.1.e	assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	
VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	
VIII.A.1.g	documentation of reasons for complex pharmacological treatment;	
VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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 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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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: Data shows some improvement in the reporting of ADRs. 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 been wholly effective. As previously reported, the Hospital conducted a thorough Six Sigma study around reporting of ADRs and MVRs which showed significant underreporting of both. Effective in June 2012, two management reports, one that tracks medication discontinuation orders with a reason code of adverse reaction and one that tracks the recording of various types of possible adverse reactions in the Psychiatric Update were available and provide additional mechanisms to identify possible adverse reactions. It is anticipated that with the recent filling of the Chief Pharmacist position in September 2012, these management reports will be reviewed weekly and tracked for completion of needed ADR forms. In addition, in early August, 2012, psychiatrists, medical practitioners and psychiatry residents received refresher training in the ADR process. 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 / Current Review Period** | **Sep-11 / Mar-12** | **Oct-11 / Apr-12** | **Nov-11 / May-12** | **Dec-11 / June-12** | **Jan-12 / July-12** | **Feb-12 / Aug-12** | **Total** | **Mean** **Previous** | 8 | 3 | 9 | 5 | 3 | 3 | **31** | **5.2** **Current** | 7 | 6 | 10 | 11 | 6 | 10 | **50** | **8.3** ***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 / Current Period** | **Sep-11 / Mar-12** | **Oct-11 / Apr-12** | **Nov-11 / May-12** | **Dec-11 / June-12** | **Jan-12 / July-12** | **Feb-12 / Aug-12** | **Total** | **Mean**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Doubtful	**Previous**	1	0	1	0	0	0	**2**	**0.3**
	Current	0	0	3	3	2	1	**9**	**1.5**
Possible	**Previous**	2	0	3	2	1	2	**10**	**1.7**
	Current	2	4	4	3	0	7	**20**	**3.3**
Probable	**Previous**	5	2	5	3	2	1	**18**	**3.0**
	Current	5	2	3	4	4	2	**20**	**3.3**
Definite	**Previous**	0	1	0	0	0	0	**1**	**0.2**
	Current	0	0	0	1	0	0	**1**	**0.2**

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

Severity of ADRs									
Severity Level	**Previous Period**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Total**	**Mean**
	Current Period	**Mar-12**	**Apr-12**	**May-12**	**June-12**	**July-12**	**Aug-12**		
Mild (0)	**Previous**	1	0	4	0	0	0	**5**	**0.8**
	Current	3	0	2	2	2	2	**11**	**1.8**
Moderate	**Previous**	7	3	5	5	3	3	**26**	**4.3**
(1~2)	**Current**	4	6	8	9	4	8	**39**	**6.5**
Severe	**Previous**	0	0	0	0	0	0	**0**	**0.0**
(3~5)	**Current**	0	0	0	0	0	0	**0**	**0.0**

Outcome of Reaction								
Result	Mar	Apr	May	Jun	July	Aug	**Total**	**Mean**
Recovered/resolved Completely	7	6	10	10	5	7	**45**	**7.5**
Recovered/resolved with sequelae	0	0	0	1	1	1	**3**	**0.5**
Recovering/resolving	0	0	0	0	0	0	**0**	**0.0**
Not recovered/not resolved*	0	0	0	0	0	0	**0**	**0.0**
Fatal	0	0	0	0	0	0	**0**	**0.0**
Unknown	0	0	0	0	0	**2**	**2**	**0.3**

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

Reporter Discipline								
Result	Mar	Apr	May	Jun	July	Aug	**Total**	**Mean**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nurse	0	0	0	0	0	1	**1**	**0.2**
Pharmacist	1	1	3	1	0	0	**6**	**1.0**
Medical	2	0	3	3	2	4	**14**	**2.3**
Psychiatrist	4	5	4	7	4	5	**29**	**4.8**

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

SEH Response: No applicable cases.

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

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

f) Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:

i) Date of the ADR;
ii) Brief Description of the ADR;
iii) Outline of ICA findings and recommendations; and
iv) Outline of actions taken in response to the recommendations.

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

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

SEH Response: ***See Tab # 76 Pharmacy and Therapeutics Committee Monthly report and power point training provided to Medical Practitioners, residents and psychiatrists.***

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

corrective/educational actions taken to address these trends/patterns.

SEH Response: The Hospital is completing two DUEs that were initiated during this review period which will be available during the site visit. ***Report Tab # 69 Drug Utilization Evaluations.***

The first DUE is a review of cases in which individuals in care are prescribed on a routine basis the same medication in both depot and oral form. Data has been collected and the report is being finalized for presentation to P & T Committee. The second DUE is a review of individuals prescribed beta blockers to determine who is receiving beta blockers, the reason for the medication and to determine if those with coronary artery disease are being prescribed beta blockers.
Both DUEs will be presented to Pharmacy and Therapeutics Committee for review and recommendations.

Finally, although not a DUE, the PID supported by two medical students, completed a review of STAT/NOW medication (80 events reviewed). The review looked at both physician and nursing documentation as well has treatment team follow up on the STAT/NOW event. The analysis has not yet been completed but is expected by the time of the DOJ visit.

4. Improve mechanisms to capture medication variances, including potential variances and utilize the results of the current six sigma analysis in the process;

SEH Response: Training was provided to psychiatrists, medical practitioners, and residents. Finally, the long awaited PYXIS system is expected to be launched this Fall which should reduce medication variances. The formulary has been loaded into the system and it is being tested for a three week period, with a two week additional period of testing by nursing. After any issues identified in testing are resolved, it will be implemented in a phased approach.

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

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

Total Number of Reported Medication Variances by Month								
Previous Review Period	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Total**	**Mean**
Current Review Period	**Mar-12**	**Apr-12**	**May-12**	**June-12**	**July-12**	**Aug-12**		
Previous	11	14	14	7	8	5	**59**	**9.8**
Current	3	1	9	9	2	9	**33**	**5.5**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Mar	Apr	May	Jun	July	Aug	**Total**	**Mean-P**	**Mean-C**
Administering	0	0	4	3	1	3	**11**	**0.7**	**1.8**
Dispensing	2	1	4	2	0	5	**14**	**1.2**	**2.3**
Monitoring	0	0	0	0	0	0	**0**	**0.0**	**0.0**
Prescribing	1	0	2	2	0	0	**5**	**5.8**	**0.8**
Procurement	0	0	3	1	0	1	**5**	**0.7**	**0.8**
Transcribing/Documenting	0	0	1	3	1	0	**5**	**0.5**	**0.8**
Other/NA	0	0	0	1	1	0	**2**	**0.5**	**0.3**

** 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	Jun	July	Aug	**Mean-P**	**Mean-C**
Potential - A	1	1	1	3	1	4	**0.3**	**1.8**
Potential - B	1	0	2	3	0	4	**5.0**	**1.7**
Potential Subtotal	*2*	*1*	*3*	*6*	*1*	*8*	**5.3**	**3.5**
Actual - C	1	0	3	3	1	1	**3.8**	**1.5**
Actual - D	0	0	3	0	0	0	**0.2**	**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**
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	0	6	3	1	1	**4.0**	**2.0**
# 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	Jun	July	Aug	**Total**	**Mean-P**	**Mean-C**
Administering	0	0	3	1	1	3	8	**0.7**	**1.3**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Dispensing	2	1	3	2	0	5	13	**1.2**	**2.2**
Monitoring	0	0	0	0	0	0	0	**0.0**	**0.0**
Prescribing	1	0	2	2	0	0	5	**5.8**	**0.8**
Procurement	0	0	1	1	0	1	3	**0.7**	**0.5**
Transcribing/Documenting	0	0	0	2	0	0	2	**0.5**	**0.3**
Other/NA	0	0	0	1	1	0	2	**0.5**	**0.3**

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 summarized in the minutes, and a more full description of each medication variance case is handed out and reviewed at each meeting.

g) Evidence of corrective actions to address patterns and trends identified in medication variances.

SEH Response: The Hospital continues to focus on medication variances involving missing medication administration documentation. Each month, a report is prepared by the Office of Statistics and Reporting concerning aspects of ADR and MVR data which is submitted to the Pharmacy and Therapeutics Committee. ***See Tab # 76 Pharmacy and Therapeutics Committee Monthly Report.*** This Hospital expects to begin implementation of PYXIS this fall, which should also reduce medication administration and other medication errors.

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 0.33 % in February, 2012 to 0.27% in August 2012. The percentage of nurses with no missing documentation was 61% in February 2012 and 67% in August 2012. (In August 2012, 29% missed documentation in 1-10 doses, and only 4% had

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		between 10 and 50 doses with missed documentation.) Information is tracked by individual nurse on a monthly basis, and nursing uses this data to monitor performance as well as to identify those in need of retraining. ***See Tab # 76 P and T Committee Data and Tab # 90 Medication Administration Documentation Data Report.*** 6. Revise the process of mortality review process to include a systemic review of clinical history and circumstances leading up to mortality, the risk factors that may be contributing to the mortality and other factors that may be targeted for performance improvement. SEH Response: During this rating period, there were two deaths of SEH individuals, both of whom were suffering from terminal illnesses. 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. ***See Tab # 130 Mortality reports.*** Both Hospital mortality reports were finalized and submitted to DMH for review. The Mortality Review policy was revised during the prior review period to clarify the purpose of a mortality review (to establish what happened, how it happened and why it happened, so that recommendations can be made and actions taken to minimize or prevent a recurrence), and to identify proposed risk reduction recommendations and issues for performance improvement. No changes were made during this period.
VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units	
VIII.A.4	SEH shall ensure that individuals in need are - provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	
VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	
VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	
VIII.A.4.c	integrate psychiatric and behavioral treatments.	
VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	
VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected. to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;[2]	
VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which	

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	reinforcers for the individual were chosen and what input the individual, had in their development, and the system for earning reinforcement;	
VIII.B.1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not ,the use of aversive contingencies;	
VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	
VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	
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.	
VIII.B.2	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.	
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.	
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	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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. Maintain current level of practice. SEH Response: Current practice maintained. 2. Continue to present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. 3. 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: Ongoing. Increased focus in being placed on those who attend the TLCs but remain unengaged. Changes were made to the treatment scheduling database that improves data collection for the unengaged. First, those individuals are now "identified" In the database so that their overall hours can be tracked from week to week, and staff can monitor on a daily or weekly basis which groups, if any, they attend with any regularity. Second, the Hospital has created a separate cluster which tracks scheduling and attendance for the unengaged to compare with other clusters (admissions, long term, and geriatric). For example, during the last week of August 2012 (review period ends August 31), the attendance rate for the unengaged (the number of groups the unengaged attended versus scheduled) was 59%, as opposed to 56% for those in the admissions cluster, 60% for those in the geriatric cluster, and 88% for those in the long term cluster. The Hospital now is able to monitor the hours scheduled for the unengaged (88% are scheduled for 20 hours a week) and hours attended (22% attended 20 hours per week). Finally, the Hospital can, and does, track the attendance rate by unengaged individual. Further, the Hospital is tracking each unengaged individual's attendance rate as one measure of the individual's progress; if their rate of attendance improves, it suggests the interventions to increase engagement are effective. ***See Tab # 39***

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
Treatment Hours Report and Tab # 50 Status of Unengaged Individuals in TLCs.

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>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>192</td><td>173</td><td>188</td><td>192</td><td>193</td><td>203</td><td>228</td><td>190</td></tr>
<tr><td>n</td><td>21</td><td>22</td><td>23</td><td>21</td><td>23</td><td>18</td><td>19</td><td>21</td></tr>
<tr><td>%S</td><td>11</td><td>13</td><td>12</td><td>11</td><td>12</td><td>9</td><td>8</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>71</td><td>80</td><td>90</td><td>89</td><td>85</td><td>73</td><td>86</td><td>82</td></tr>
<tr><td>%C # 7 Ensure that each individuals IRP identifies the diagnoses, treatments and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other unit staff; and the frequency by which staff need to monitor such symptoms.</td><td>95</td><td>100</td><td>87</td><td>95</td><td>90</td><td>78</td><td>87</td><td>91</td></tr>
</table>
N = All IRP reviews scheduled, IRP database 9/23/10
n = number audited
Tab #2 CLINICAL CHART AUDIT RESULTS.

Analysis/Action Plan: Data from the clinical chart audit shows improvement in modifying treatment based upon an individual's response to treatment and performance is now above the 90% threshold. See Tab # 2, Clinical Chart Audit Results The Hospital is continuing to provide coaching to each treatment team by IRP observers and clinical chart auditors. See Tab # 1 for IRP Training Materials and Data. This continues to be a focus for clinical 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.	**Recommendations:** 1. Evaluate and resolve current barriers to improvements on new forms. SEH Response: Avatar is finalizing 12 nursing related forms and several other forms for use by medical practitioners. Delays in getting the forms into Avatar were initially attributable to delays in release of the capital dollars to allow work to proceed, and then in part due to the complexity of the forms which were not submitted by Nursing to Avatar until late May 2012. The nursing forms include the RA Care Documentation form (to fix minor fixes to form), Advanced Comfort Plan (completed), Smoking Assessment, RN Change in Physical Status form, Nursing Progress Update form, CINA Parts A and B, Fall Risk Assessment, Braden Scale form, Pain Management Flow, Seizure Observation Form, RN Transfer Out Form, and the RN Return from Community Provider Form. These forms were revised in May 2012 and resubmitted to Avatar for development. Most of these forms (except the Nursing Update) are in testing as of the writing of this report with go LIVE dates to follow successful testing, projected for October 2012. The Comfort Plan form went live in the Summer 2012. In the meantime, nursing staff are using the revised forms and medical records staff are scanning them into FileNet. ***See Tab# 22 for CINA and other Forms, Tab # 24 for Nursing Update Form and # 87 SBAR RN Change in Physical Condition Assessment Form, RN Transfer Out form and RN Return Form and Instructions.*** Because the content of these forms will not change from paper to

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Avatar, extensive training will not be needed. Other non-nursing but related forms with the Avatar team for development during this review period included the Medical Practitioner Transfer Out Form and the Medical Practitioner Reassessment Upon Return from Community Provider Form. While this was pending, medical practitioners were using a standard medical consultation form supplemented by medication and laboratory information in completing information to accompany an individual in care to the ER, because the transfer form in Avatar took a long period to populate medication and lab information. The Medical Transfer out form and the Return Forms that are to be completed by the medical practitioner are being tested and should go live in early October 2012. Finally, Medical Affairs requested changes to the existing Medical Consultation Form, to have it split it into two parts, one for consultation requests and one for consultation results. This is targeted for completion in October 2012. 2. Ensure reliable and valid audit findings that are displayed so that trends can be identified and improvement actions focused. SEH Response: Ongoing. Audits are now completed by a single Assistant Director of Nursing (for Quality Improvement) to ensure interrater reliability and the number of audits is also increased. Data are now presented for the period since January 2012, and include trending information. By the next review, data will also be presented by comparing six month means as with all other audits required for this Agreement. ***See Tab # 3 CINA Audit Results, Tab #4 Nursing Update Audit Results, Tab # 104 Audit Results (Change in Physical Condition, RN Transfer To Note and RN Transfer From Note*** Data is presented at nurse manager meetings. In addition, unit based data will be provided in sixth month intervals for each audit tool. 3. Nurse Managers (NM) should continue form review with unit RNs with an emphasis on clinical assessment based on synthesis of data versus form completion alone. SEH Response: Ongoing. During this review period, extensive competency based training around documentation and assessment has been undertaken. The nursing consultant developed a training module that reviews how RNs should synthesize and analyze data from the assessments, which then sets the priorities for IRP planning and nursing interventions. This training focuses on each type of assessments, including CINA Parts A and B, the Nursing Update and the Change in Physical Status. The training also helps nurses to identify what issues are preventing the individual from reaching his or her goal and focuses on how IRP interventions link to the individual's recovery. The training also includes development of objectives and interventions, incorporates strategies from the comfort plan and provides examples. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** Staff are required to achieve competency by completing assessments and writing objectives and interventions. Nurse Managers were trained first, followed by day, evening and concluding with night shift staff. Eighty three percent of staff have successfully completed this training. Staff who failed to achieve competency were provided 1:1 meetings with the trainers (consultant and Hospital's new nurse educator) to review their tests and why they did not pass. These staff were then retested. In addition, the nurse educator is meeting with each RN, to give them specific feedback on their results. Finally the consultant provided each nurse manager with the scores of each of their employees so they are aware of each employee's strengths and areas of challenge.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Form review is also being reinforced by the Chief Nurse Executive during her 1:1 supervision with nurse managers. Together, they are reviewing two nursing updates and 2 IRPS on each unit every two weeks. This should assist nurse managers in their review process with their line staff. With respect to the transfer out forms, the CNE is requiring nurse managers to maintain a tracking log for transfer out and transfer forms that will ensure the forms are completed.

Finally, the nursing consultant will restart her one-to-one coaching with nurse managers in October 2012.

4. Ensure that committee minutes accurately reflect all parts of a QA/PI process relative to Code Blue drills including routine evaluation of the frequency and findings as well as designation of responsibility and monitoring of actions to resolve trends.

SEH Response: The Hospital's Morbidity and Mortality Committee, as well as its Performance Improvement Committee, reviewed the data from both mock and actual code blues, the Hospital's Emergency Medical Services Policy as it relates to Code Blue drills and discussed code blue issues at its September 2012 meeting. The data suggest that staff perform better in actual code blues compared with mock code blues. The Committee determined that a combination of 12 mock/actual code blues would be completed each quarter, one per shift per hospital zone (transitional side Units 1A, 1B, 2A and 2B, Intensive Side Units 1C, 1D, 2C and 2D, Intensive Side 1E, 1F, 1G and the intensive TLC and administrative areas and transitional TLC). Nursing would be responsible for code drills on the evening and night shifts, and Medical Affairs for day shift drills. It was agreed that for all actual code blues, the forms required by the policy would be completed and provided to PID/OSR for data analysis and trending; in the past this was not happening, so that data could not be analyzed on a regular basis or presented to the Morbidity Committee or PIC. The revised audit tools were presented. ***See Tab # 125 Mock/Actual Code Blue Data and Minutes***

Facilities Findings:

HISTORY AND PHYSICAL AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	37	30	35	34	34	26	**36**	**33**
n	10	10	10	9	9	9	**7**	**10**
%S	27	33	29	26	26	35	**15**	**29**
%C. # Timely completion	100	100	100	100	100	100	**98**	**100**
%C. # 1 Subsections on basic information completed	100	80	100	100	100	100	**95**	**96**
%C. # 2 Part II of H & P includes completed past medical history	90	80	90	100	100	100	**93**	**93**
%C. # 3 Immunization section is complete	100	80	90	100	100	100	**91**	**95**
%C. # 4 H & P includes complete and appropriate description of review of systems	90	90	90	100	100	100	**95**	**95**
%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings	90	80	70	100	100	100	**95**	**89**
%C. # 6 Neurological section is completed	70	90	100	100	100	100	**95**	**93**
%C. # 7 Cranial nerve section is completed	80	70	70	100	100	100	**95**	**86**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 8 Assessment section is completed and includes synthesis of relevant findings	100	90	90	100	100	100	**95**	**96**
%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.	100	90	100	100	100	100	**95**	**98**

See TAB # 52 HISTORY AND PHYSICAL AUDIT RESULTS

MEDICAL TRANSFER AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N	28	23	18	29	17	21	**22**	**23**
n	5	5	6	5	2	5	**5**	**5**
%S	18	22	33	17	12	24	**18**	**21**
%C. # 1 Subsections on basic information completed	100	100	83	40	50	60	**96**	**75**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses	40	60	50	60	0	40	**93**	**46**
%C. # 3 Reason for medical transfer is clearly indicated on the form	100	100	100	80	100	100	**96**	**96**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.	100	100	100	80	100	100	**96**	**96**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings	100	100	83	80	50	100	**96**	**89**
%C. # 6 All the most recent lab results were provided	100	100	100	60	100	100	**79**	**93**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted	100	100	100	100	100	100	**93**	**100**
%C. # 8 The allergy section is completed fully and accurately	0	20	50	40	50	0	**43**	**25**
%C. # 9 The form includes a brief description of current behavior and responses to treatment	40	40	17	20	0	0	**75**	**21**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer	80	100	83	100	100	100	**82**	**93**
%C. # 11 There is a progress note upon the individual's return that includes an analysis of information from the medical facility and an appropriate response by the physician/nurse practitioner.	100	100	100	80	100	100	**100**	**96**

SEE TAB # 62 MEDICAL TRANSFER AUDIT RESULTS

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	28	23	18	29	17	21	**19**	**23**
n	7	9	7	11	5	8	**7**	**8**
%S	25	39	39	38	29	38	**37**	**35**
%C. # 1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?	86	100	86	73	60	100	**100**	**85**
%C # 2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?	57	67	86	100	100	88	**86**	**83**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?	100	N/A	0	67	50	50	**100**	**54**
%C #4 Is the assessment of systems completed and synthesized?	86	89	71	36	20	50	**100**	**60**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?	86	100	71	55	80	63	**100**	**74**
%C #6 Does the assessment include auscultation, etc?	57	56	50	9	50	0	**86**	**36**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?	86	89	71	45	80	100	**57**	**77**
%C #8 Was the level of urgency consistent with the clinical presentation?	86	78	100	45	80	88	**43**	**77**
%C #9 Was the course of physical status change adequately described?	71	56	71	27	40	75	**86**	**55**
%C #10 Was the individual's response to alternative interventions documented?	100	N/A	0	38	75	33	**100**	**47**
%C # 11Were changes from the baseline adequately identified and described?	71	89	86	27	60	38	**100**	**60**
%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?	100	100	0	57	50	40	**71**	**63**

N=Transfers to ER or Hospitals
n=cases audited
* Data from prior review period reflects only one month, February 2012
SEE TAB # 104 RN SBAR AUDIT RESULTS

RN TRANSFER TO ER/HOSPITAL FORM AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P***	**Mean-C**
N	28	23	18	29	17	21	**19**	**23**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	7	10	7	11	5	8	**7**	**8**
%S	25	43	39	38	29	38	**37**	**35**
%C. # 1 Was the form complete, signed and dated?	100	100	100	82	100	100	**71**	**89**
%C. # 2 Is the medical/physical reason for transfer to the ER clearly stated/described?	100	90	100	100	100	100	**86**	**97**
%C. # 3 Are all supporting medical data included, i.e., vital signs, blood glucose, height, weight, etc.?	100	80	86	82	100	82	**14**	**83**
%C. # 4 Is there a detailed description of the individual in care's current behavioral and cognitive status?	100	100	43	36	80	25	**43**	**69**
%C. # 5 If the current behavior or cognitive status is a change from normal presentation, is there a description of how it is different?	100	67	0	45	100	0	**0**	**48**
%C. # 6 Are "At Risk For /Special Conditions" (both existing and new) indicated and consistent with the individual's clinical picture? (If none known, is the box checked?)	100	80	86	55	80	75	**86**	**74**
%C. # 7 Is there a description of the individual's communication needs, including any significant findings?	100	100	86	91	80	63	**86**	**89**
%C. # 8 If applicable, were Special instructions to Enhance Health Care provided?	100	83	25	57	100	50	**100**	**58**
%C. # 9 Is there evidence that all applicable documents were completed/attached?	100	90	100	100	100	100	**100**	**91**

N=ER transfers for month
n=number audited
* Data from prior review period reflects only one month, February 2012
SEE TAB # 104 RN TRANSFER TO AUDIT RESULTS

RN TRANSFER FROM ER DEPARTMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P***	**Mean-C**
N	28	23	18	29	17	21	**19**	**23**
n	7	10	7	11	5	8	**6**	**8**
%S	25	43	89	38	29	38	**32**	**35**
%C. # 1 Is the form completed, signed and dated?	100	100	100	91	100	100	**83**	**98**
%C. # 2 Are vital signs documented?	100	100	100	100	100	100	**100**	**100**
%C. # 3 If the vital signs are outside the known parameters, is there evidence that the General Medical Officer was consulted?	50	N/A	N/A	0	n/a	n/a	**100**	**33**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C. # 4 If the individual in care reports pain or the RN observes signs of possible pain, was a Pain Assessment Form completed?	N/A	0	100	0	n/a	100	**0**	**33**
		%C. # 5 Is there evidence of a completed focused physical assessment including a review of the system related to why the individual in care was initially transferred to the general medical facility?	86	90	57	27	80	38	**83**	**60**
		%C. # 6 Is there evidence of review of the discharge diagnosis, treatment and care recommendations from the transferring facility?	100	100	86	82	60	88	**83**	**88**
		%C. # 7 Is completion of identification of new risks consistent with the RN's assessment of the individual's current physical status and the medical problems for which the individual was treated?	33	67	25	33	60	17	**83**	**40**
		%C. # 8 If applicable, is there completion of any additional risk assessment forms/tools?	N/A	0	0	0	n/a	n/a	**0**	**0**
		%C. # 9 Did the registered nurse summarize the assessment findings that have implications for nursing interventions, addressing immediate physical and psychiatric care and treatment?	86	60	57	9	60	25	**17**	**46**
		%C. #10 Were objectives identified and immediate nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area 1) (if indicated by assessment)?	0	43	33	13	33	0	**0**	**21**
		%C #11 Were objectives identified and immediate nursing interventions developed consistent with identified Medical/Physical Health (IRP Focus Area II)?	57	50	50	9	20	25	**50**	**34**

N= ER transfers for month
n=number audited
* Data from prior review period reflects only one month, February 2012
SEE TAB # 104 RN RETURN AUDIT RESULTS

Analysis/Action Plan: The data show that medical practitioners' performance in completing documentation around transfers out for medical reasons and returns declined somewhat during this period, and that substantial improvement is needed in nursing documentation around medical transfers and changes in physical assessments. This latter finding is not unexpected as the training around documentation of assessments (CINA Part A and Part B, Nursing Update and Change in Physical Status, as well as IRP objectives and interventions for nursing) was not begun until August (it is expected to be completed in October for all nursing staff). See also response to recommendation # 3 in this cell. It is expected that the training, individual sessions with nurses to review test results and renewed coaching of nurse managers will result in improved documentation that will be reflected in the audit results.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		The decline in performance around completion of medical transfer out form is largely due to the fact that in many cases, practitioners used the medical consultation form instead of the medical transfer form because of the long processing times to complete the transfer form; the medical consultation form lacks all the prompts included in the transfer out form. Remedying these issues in Avatar was a major focus during this review period, and the revised form (which will load medication and lab information more quickly) is being tested as of the writing of this report. Additionally, all medications of an individual sent to the ER or to a community medical center for assessment or treatment are now placed "on hold" until his or her return. This way, the receiving medical practitioner here at the Hospital will review the results of the community assessment and enter orders that address those recommendations, as appropriate. As noted in the last report, the Hospital created a format for a progress note to be completed by general medical officers or nurse practitioners upon an individual's ***return from*** a community hospital for treatment or evaluation. The Avatar version of the form is in testing and should be implemented in Avatar in early October 2012 ***See Tab # 59 Format for Notes by Medical Practitioner Upon Return from Community Provider.*** The "return" physician's note is designed to ensure SEH staff review the results of the evaluation/treatment provided in the community, are familiar with the results of any testing or laboratory work completed by the provider, review the medications prescribed and symptoms targeted and make appropriate recommendations for the individual's plan of care at SEH. It currently is being audited as part of the medical transfer audits. Short and long term changes to Avatar designed to improve communication and assessment were implemented or are in development. ***See Tab # 071 Avatar Power Point for Night Staff All Staff and b Summary of Avatar Activities*** Perhaps most importantly, NetSmart is currently developing a new report that is tailored to ensuring doctors and nurses have a quick but effective way to assess changes in an individual's condition over a recent time period. The report will allow clinical staff to retrieve basic demographic information, recent medication history (both orders and administrations), laboratory results and progress notes by discipline or time frame. This report is intended to bridge the period until MyAvatar, the upgraded system, is rolled out in April 2013. As of this report, no date is yet available for the chronological care report to go live but a draft of the report was presented to clinical leaders and it is anticipated that the report will be available for testing in the next 30 days. Nursing continued to implement audits for CINA Parts A and B and the three medically related nursing forms (Change in Physical Status, RN Transfer to ER/Hospital and RN Transfer from ER/Hospital). ***See Tab # 23 CINA Audit Forms, Tab # 25 Nursing Update Audit Forms, Tab # 88 Audit Tools for the Change in Physical Status form, the RN Transfer to Medical Facilities and the RN Transfer From Medical Facilities Form; Tab # 104 Audit results for Change in Physical Status form, the RN Transfer to Medical Facilities and the RN Transfer From Medical Facilities Form.*** The data suggest that significant improvement in how nurses document information around changes in physical status and transfers is needed, but it should be noted that the training for nursing staff around documentation requirements and development of IRP objectives and interventions only began in August 2012, so nursing expects to see notable improvement over the next review period. The Hospital is implementing its 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 Hospital procedure, individuals requiring insulin more than once daily will be placed on short acting insulin and prn Lantus using a specific protocol. Nurse managers are also observing at least one medication or insulin administration per RN

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		every six months, (due in October 2012) and data is collected. The Hospital also hired a nurse educator who will focus on physical issues in addition to the new nurse educator that specializes in psychiatric issues. Finally, the diabetes consultant began work on September 20, 2012. Her primary role is to facilitate our transition to "insulin pen" usage in the hospital, which more closely reflects outside treatment strategies. She will also assist nursing education in the development of a diabetic teaching curriculum, so that individuals in care can go to groups within the Hospital to learn more about the disease process and its treatment. Finally, she will also help in the development of our formulary for diabetic meds (i.e. insulin types) and will modify and strengthen the protocols we have in place for diabetes management.
VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Recommendations:** 1. Nurse Managers (NM) should continue form review with unit RNs with an emphasis on clinical assessment based on synthesis of data versus form completion alone. SEH Response: During this review period, beginning in August 2012, extensive competency based training around documentation and assessment was begun. The nursing consultant developed a training module that reviews how RNs should synthesize and analyze data from the assessments, which then sets the priorities for IRP planning and nursing interventions. This training focuses on each type of assessment, including CINA Parts A and B, the Nursing Update and the Change in Physical Status. The training also teaches nurses how to identify what issues are preventing the individual from reaching his or her goal and focuses on how IRP interventions link to the individual's recovery. The training includes development of objectives and interventions, incorporates strategies from the comfort plan and provides examples. Staff are required to achieve competency by completing assessments and writing objectives and interventions. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** Nurse Managers were trained first, followed by day, evening and night shift staff; 83% of staff have completed the training and achieved competency. Staff who failed to achieve competency were provided 1:1 meetings with the trainers (consultant and Hospital's new nurse educator) to review their tests and why they did not pass. These staff were then retested. In addition, the nurse educator is meeting with each RN, to give them specific feedback on their results. Finally the consultant provided each nurse manager with the scores of each of their employees. See also response to recommendation #3 below. Form review to assess quality is also being reinforced by the Chief Nurse Executive during her 1:1 supervision with nurse managers. Together, they are reviewing two nursing updates and 2 IRPS on each unit every two weeks. This should assist nurse managers in their review process with their line staff. With respect to the transfer out forms the CNE is requiring nurse managers to maintain a tracking log for transfer out and transfer forms that will ensure the forms are completed. The forms are also audited each month. Finally, the nursing consultant will restart her coaching with nurse managers in October 2012. 2. Continue Nurse Manager mentoring and support. SEH Response: Ongoing. See also response to recommendation #1 above. 3. Explore and resolve factors that contribute to an absence of nursing interventions in the IRPs, especially interventions to address violence and physical health status.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: It was determined that in some cases, nursing staff were not proactive in identifying nursing interventions as part of the IRP conference. Nursing staff in late February 2012 began to bring comfort plan strategies to the IRP (which was also added to the IRP observation audits in August 2012) as part of the nursing report but they were still not bringing other nursing objectives or interventions to IRPs on a routine basis. (While nurse managers had been trained in the IRP process, line nursing staff had not received dedicated training on IRP objectives and interventions). In August 2012, training for registered nurses was developed by the Nurse Consultant to support RNs in development of skills related to: a) synthesizing assessment data to support prioritization of risk issues and focus areas; b) identification of factors and barriers contributing to or supporting continuation of identified psychiatric and medical/physical issues; c) identifying the individual's functioning level as relates to focus areas; d) writing clear, descriptive summary focus statements; e) writing individualized objectives that are directly linked to prioritized focus issues and reflect the individuals level of functioning; f) writing nursing interventions that support the individual in care to meet his/her objectives; g) preparing for and participating in IRP meetings to assure effective nursing plans of care are included in the IRP; h) applying knowledge learned in training to all assessment situations, including admission assessments (CINA), Nursing Update, Change in Physical Status, Change in Psychiatric Status, Transfer to ED/Hospital, Transfer Back to SEH from ED/Hospital. Training took place during August and September 2012 and will be completed for all RNs by early October 2012. The training consists of a PowerPoint presentation to develop basic knowledge of the above and writing practice scenarios to develop skills in writing focus statements/summaries, objectives and interventions for admission assessment, nursing update and return from hospital situations. Special emphasis has been on addressing risk associated with aggression/violence and medical/physical conditions. Each RN wrote objectives and interventions for each of the scenarios then shared them to the group and gave each other feedback. The RNs have been very engaged in the learning process and eager to share their writing samples and ask for feedback. The last portion of the training is completion of a written test to measure competency. The first portion of this test is an objective test of knowledge and critical thinking. The second portion is application of knowledge that requires the RN to review admission assessment data for one CINA Part A and Part B, write a summary, identify risk areas and write objectives and interventions consistent with the identified risk areas. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** The consultant who is leading the nursing training also met with clinical administrators to discuss the training's content and to explain what clinical administrators should expect from nursing staff around nursing related IRP objectives and interventions. 4. Resume consultant support for nursing. SEH Response: Ongoing. 5. See VIII.D.9 and VIII.11 SEH Response: See VIII.D 9 and VIII.D. 11

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	11	11	11	11	10	11	**10**	**11**
%S	6	6	6	6	5	5	**5**	**6**
%C # Data fields Presence of RN in IRP meetings	100	100	100	100	100	100	**95**	**100**
% C # 7 The treatment team reviews the comfort plan and objectives and interventions as appropriate						82		**82**

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

INITIAL NURSING ASSESSMENT AUDIT RESULTS Part A March 2012-August 2012								
	Mar	Apr	May	Jun	July	Aug	**Mean-P***	**Mean-C**
N	37	30	35	34	34	26	**32**	**33**
n	9	6	7	6	6	5	**18**	**7**
%S	24	20	20	18	18	19	**55**	**20**
%C #1 Were all areas of CINA-Part A completed, signed and dated within 8 hours of admission?	67	67	100	50	50	60	**31**	**67**
%C #2 Did assessment include the individual's explanation of reason/events leading to admission?	78	83	71	67	33	100	**69**	**72**
%C #3 Did assessment include a report of the individual's understanding of mental illness and what helps?	89	100	71	60	17	100	**71**	**74**
%C #4 Was the mental health and behavioral screening section completed and is it internally consistent?	89	33	14	50	33	20	**41**	**44**
%C #5 If the Psychiatric Risk Screen was positive for current thoughts/feelings of self harm or suicide, did the RN place the individual on 1:1 arms length and notify the psychiatrist?	0	N/A	N/A	0	0	100	**40**	**14**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #6 If the Psychiatric Risk Screen was positive for current thoughts of violence/harm to others, did the RN place the individual on 1:1 line of sight and call the psychiatrist?	0	50	N/A	0	N/A	100	**13**	**25**
		%C #7 Are the implications for risk for use of seclusion and/or restraint identified?	86	100	100	50	25	50	**78**	**73**
		%C #8 If the Fall Risk Screen was positive for one or more risk factors, did the RN complete the Fall Risk Assessment-Morse Fall Scale?	0	0	20	33	33	50	**25**	**19**
		%C #9 If the Morse Fall Scale indicates the individual is at risk for falls, did the RN place the individual on fall precautions and notify the MD?	0	0	N/A	0	0	N/A	**33**	**0**
		%C #10 If any risk factors for potential for choking were checked, did the RN place the individual on choking precautions and notify the GMO and Nutrition Services?	0	N/A	0	0	0	50	**33**	**11**
		%C #11 Does the completed assessment accurately identify psychiatric/behavioral and medical/physical risks?	67	50	29	33	17	40	**40**	**41**
		%C #12 Is completion of risk screens consistent with assessment data?	56	50	14	17	17	20	**43**	**31**
		%C #13 Does the completed CINA Part A reflect that the RN used all available sources for assessment including his/her own observations?	100	83	86	67	83	80	**83**	**85**
		%C #14 Did the Nursing Summary reflect RN review and analysis of all assessment areas?	100	67	43	0	33	20	**49**	**49**
		%C #15 Were objectives and interventions developed for all identified psychiatric/behavioral foci that have implications for nursing care during the next 7 days, including specific interventions for indentified violence risk, suicide risk, cognitive deficits, hyperactivity, withdrawn/isolative behavior?	67	83	43	50	0	0	**43**	**45**
		%C #16 Were objectives and interventions developed for all identified medical/physical foci that have implication for nursing care during the next 7 days, such as falls, choking, medical conditions?	67	67	33	50	0	20	**50**	**42**
		%C #17 If the individual was placed on any level of special observations, were appropriate interventions integrated into the plan of care?	100	100	20	0	33	33	**38**	**56**
		%C #18 Do the interventions in the plan of care reflect integration of the Comfort Plan?	89	83	29	50	17	20	**31**	**51**
		N=Number of admissions								

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n=number audited
*Mean-P reflects only 2 months data
See Tab # 3 CINA AUDIT RESULTS

INITIAL NURSING ASSESSMENT AUDIT RESULTS Part B
March 2012-August 2012

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	37	30	35	34	34	26	**32**	**33**
n	9	7	6	7	6	5	**17**	**11**
%S	24	23	17	21	18	19	**53**	**32**
%C #1 Were all sections/questions of the assessment completed within 24 hours of admission?	56	100	83	71	33	60	**59**	**67**
%C #2 If the risk screen indicates the individual has a history of trauma and/or abuse/neglect, did the RN develop fn objective and intervention to minimize potential for re-traumatization while in the hospital?	17	20	0	17	0	0	**11**	**13**
%C #3 Is the assessment of Learning Needs adequate to provide guidance to staff working with the individual?	67	86	83	57	67	80	**82**	**78**
%C #4 Did the RN summarize the medical/physical and psychiatric/behavioral findings that have implications for nursing care and treatment?	89	100	50	86	17	40	**56**	**68**
%C #5 Was data from CINA Part A considered and integrated in assessment and development of additional objectives/interventions in Part B?	78	86	50	71	33	20	**59**	**65**
%C #6 Is there evidence that additional information learned since the CINA – Part A was completed is incorporated into the Plan of Care?	78	86	60	86	17	80	**41**	**58**
%C #7 Were objectives indentified and nursing interventions developed for Psychiatric/Psychological Health (IRP Focus Area I) that have implications for nursing care during the next 5 days?	67	86	67	71	33	40	**50**	**60**
%C #8 Were objective identified and nursing interventions developed for Medical/Physical Health (IRP Focus Area II) that have implications for nursing care during the next 5 days?	67	86	50	57	17	40	**52**	**58**
%C #9 Were the nursing interventions specific and tailored to the individual needs of the individual in care?	56	86	33	71	17	40	**50**	**56**
%C #10 Were the interventions consistent with the functional level of the individual in care?	67	86	50	71	33	40	**56**	**62**
%C #11 If the registered nurse was unable to complete a section of the assessment, was the reason noted?	100	0	0	N/A	0	N/A	**100**	**50**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #12 Do the interventions in the plan of care reflect integration of the Comfort Plan?	67	71	67	71	17	60	**44**	**56**

N=Number of admissions
n=number audited
* Mean-P reflects only two months data
See Tab # 3 CINA AUDIT RESULTS

NURSING UPDATE ASSESSMENT AUDIT RESULTS
March 2012-August 2012

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	225	230	232	241	243	230	**236**	**234**
n	37	22	22	22	22	22	**22**	**25**
%S	16	10	9	9	9	10	**9**	**10**
%C # 1 Was the Nursing Update note completed within established timelines (every 7 days for first 60 days and every 30 days thereafter)?	91	100	95	100	100	100	**95**	**98**
%C #2 Was there assessment data present addressing each nursing treatment intervention?	82	86	68	64	50	45	**59**	**66**
%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?	91	95	82	86	86	77	**68**	**86**
%C # 4 Are individualized strengths identified for the individual in care?	100	100	95	100	95	100	**86**	**98**
%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?	60	80	32	27	27	29	**17**	**36**
%C # 6 Does the RN summarize the current health and wellness challenges that have implications for nursing care?	95	100	86	95	91	82	**95**	**91**
%C # 7 Does the RN summarize the current psychiatric/mental health challenges that have implications for nursing care?	91	100	82	95	91	91	**82**	**92**
%C # 8 Does the note include individual's understanding of and thoughts/feelings about the IRP?	76	77	77	73	41	45	**86**	**65**
%C # 9 Does the RN assessment reflect review of recent lab results and assessment tool ratings, i.e., Braden scale, Choking and Swallowing, Morse Falls Rating, etc.?	73	59	73	73	57	64	**77**	**66**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?	95	95	86	100	91	86	**33**	**92**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?	77	82	82	91	86	91	**33**	**85**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?	91	100	95	95	82	91	**33**	**92**

N= End of month Census less new monthly admissions
n= number of updates audited
* Mean-P reflects only one month data
See Tab# 4 NURSING UPDATE AUDIT RESULTS

RN CHANGE IN PHYSICAL STATUS (SBAR) AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	28	23	18	29	17	21	**19**	**23**
n	7	9	7	11	5	8	**7**	**8**
%S	25	39	39	38	29	38	**37**	**35**
%C #1 Does the RN adequately describe the reason for the contact, i.e., the presenting physical problem/symptoms?	86	100	86	73	60	100	**100**	**85**
%C #2 Are vital signs and other supporting physical data provided, i.e., blood glucose, weight?	57	67	86	100	100	88	**86**	**83**
%C #3 If applicable, is there a summary of treatment, palliative measures or other nursing interventions tried prior to calling?	100	N/A	0	67	50	50	**100**	**54**
%C #4 Is the assessment of systems completed and synthesized?	86	89	71	36	20	50	**100**	**60**
%C #5 For any indicator checked on the assessment of systems, is there a corresponding description/elaboration documented, including indication of the severity and intensity of the problem?	86	100	71	55	80	63	**100**	**74**
%C #6 Does the assessment include auscultation, etc?	57	56	50	9	50	0	**86**	**36**
%C #7 Are the RN recommendations or requests of the physician consistent with his/her assessment data?	86	89	71	45	80	100	**57**	**77**
%C #8 Was the level of urgency consistent with the clinical presentation?	86	78	100	45	80	88	**43**	**77**
%C #9 Was the course of physical status change adequately described?	71	56	71	27	40	75	**86**	**55**
%C #10 Was the individual's response to alternative interventions documented?	100	N/A	0	38	75	33	**100**	**47**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #11 Were changes from baseline adequately identified and described?	71	89	86	27	60	38	**100**	**60**
%C #12 Were appropriate temporary support measures put in place prior to physician seeing individual?	100	100	0	57	50	40	**71**	**63**

N=Transfers to ER
n= cases audited
* Mean-P reflects only 1 month data
See Tab # 104 SBAR AUDIT RESULTS

Analysis/Action Plan: Data shows that the attendance of the registered nurse at the IRP continues to improve and exceeds the 90% threshold for the third consecutive review period. ***See Tab # 7 IRP Observation Monitoring Results.*** Nursing staff are now bringing comfort plan interventions to the IRP conferences (included in IRP observation audits beginning in August 2012) to inform the team and the IRP. In addition, training of RNs around synthesis of information in assessments and development of IRP objectives and interventions began in August 2012. That contract also includes evaluation of nurse training offerings and training program, developing a house recovery audit, continuing coaching for nurse managers, coaching and support on implementing the recovery model on units and the TLCs, unit organization and management coaching, consulting on development and implementation of a fall prevention program, supporting development of a nursing QA system and audits, and consulting on development of competency audit tools, among other things.

As of the writing of this report, the Hospital completed eight months of audits of the new the CINA form (Part A and B) using the new audit forms and seven months of data from audits of the new Nursing Update form using the new audit tool. ***See Tab ## 3 CINA Audit Results and Tab 4 Nursing Update Audit Results*** Nursing will continue to monitor the quality of these forms and will take actions as appropriate. In addition, utilization review specialists complete a concurrent review on a sample of CINAs and Nursing Updates in an effort to improve documentation; results are provided monthly to the CNE. The Hospital also is implementing a number of other strategies to improve nursing practice and skills. ***See Tab # 99 for Recovery Training Information and Data and Tab # 109 for Safety Care Training Data. See discussion about relating to training around documentation and development of IRP objectives and intervention and Tab # 102.***

Increasing the number and ratio of RNs is critical to improved practice. The Hospital is aggressively implementing a staffing plan that ensures a 50% RN mix and nursing care hours. The Plan reflects full funding for the additional 31 RN positions needed to meet the 50% RN mix; nursing care hours are averaging between 5.5 hours and 6.1 hours during the period of March through August 2012. See section VIII.D.11 for specifics around staffing. The District made a net gain of 32 RNS since the prior visit and recruitment to fill those positions is continuing. The Hospital is monitoring separations as well. Of the separations, just under half were terminations.

Table 1: RNs hired since March 2012

Month	March	April	May	June	July	Aug	Sept	Total
New Hires	10	7	4	6	3	9	8	47
Separations	6	2	5	4	2	2	4	25

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Net Gain for Month	4	5	-1	2	1	7	5	32	

Table 2: Staffing and Funding Levels for Direct Care RNs and Supervisors as of September 30, 2012

	A	B	C	D	E	F	*G*	H	I
	Total # Needed for 50% Mix and 6 NCHPPD	**Total FY 12 Funded Positions**	**Total Filled FTEs (D+E+F)**	**Total On Units**	**Total in Training**	**Total Not Available to the Units**	***Currently Vacant (B-C)***	**FY 12 Funded Vacancies**	**FY 12 Shortage in Funded positions (A-B)**
NM	N/A	14	14	14	0	0	1	0	0
RNs	199.5	199.5	170	154	8	9	31	31	0
RAs & LPNs	199.5	199	199	186	0	12	1	1	0

The medication administration and insulin administration audits are scheduled for October 2012. 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 for August 2012 was at 0.27%, with 67% of nurses with no missed documentation and 29% with between 1 and 10 doses missing. ***See Tab # 103 Medication Administration Documentation Data.***

In an effort to strengthen nursing's role in IRP planning, a major effort to train all nurses is underway. The training focuses on designing recovery oriented plans for nursing care and takes the nurse through writing assessments (CINA, Nursing Update and Changes in Physical Status), including the role of synthesizing and analyzing the information. The training focuses nursing on the why of symptoms/behavior and how the results of assessment should impact IRP objectives and interventions. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** The training requires the individual to achieve competency by writing objectives and interventions and each nurse sits down with the trainer or a nurse educator to review his or her results. Those who fail also meet with the trainer to review the issues and must retake the test in order to achieve competency; 83% have achieved competency. Further, each nurse manager was provided with the test results from his or her staff and is meeting with the trainer for additional coaching to ensure that what staff learned in the training is implemented.

With respect to behavioral interventions, the PBS team is providing periodic coaching to TLC nursing staff relating to those individuals whose participation in the TLC programming is marginal, reinforcing prior PBS training. TLC staff receive the shift progress notes that include the interventions to use for specific behaviors. The percentage of active staff that have completed Collaborative Problem- Solving Training overall is up, 78% of non nursing clinical staff has completed the training compared with 69% as of the last review, 86% of day shift nursing staff compared with 62% as of the last review, 67% of evening nursing staff, compared with 49 % of nursing evening shift during the last review, and 56% of night shift staff, down from 72% of night nursing shift from last review period. ***See Tab # 66 Collaborative Problem Solving Training***

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	**Recommendations:** Identify and take actions necessary to meet the requirements of this provision.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	SEH Response: Ongoing. Audits are being conducted monthly for CINA (Part A and Part B) and Nursing Update, Changes in Physical Status (SBAR), RN Transfer to ER/Hospital and RN Transfer from ER/Hospital. ***See Tab # 23 CINA Audit Form; Tab # 24 Nursing Update Audit Forms; Tab # 88 Audit Forms for Change in Physical Condition (SBAR), RN Transfer To ER/Hospital, and RN Return from ER/Hospital Audit Form.*** See also VIII.D.1 for audit results. **Analysis and action steps:** See generally response to VIII.D.1.
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Recommendations:** Continue to monitor medication administration. SEH Response: Ongoing. The Hospital continues to monitor missed medication administration documentation. ***See Tab # 90 Missed Medication Administration Documentation Report*** Further, the medication and insulin administration audits will be completed in October, 2012. Data from these audits may be available by the time of visit. **Analysis/Action plan:** The Hospital continues to monitor the rate of missed documentation for routinely scheduled medications; the rate improved for the third consecutive review period. ***Tab # 90 Medication Administration Documentation Report.*** In August 2011, 57% of nurses had no missed documentation, 36% had between 1 and 10 missed documentations, and 7% had between 11 and 50 missed documentations. No nurses had more than 50 missed documentations. The missing documentation rate was at 0.36% in August 2011. In February 2012, 61% of nurses had no missing documentation, 33% had >1 but < 10, 6% had >10 but < 50, and 0% had more than 50 missing documentations. The positive trend continued during this period. In August 2012, the missed documentation of administration rate was at .27%, 67% of nurses had no missing documentation, and 29% had between 1 to 10 administrations missing documentation. Information is also tracked by unit. This monitoring is shared with Pharmacy and Therapeutics Committee, and will continue. In addition, nurse managers are continuing their observations of medication or insulin administration at least once every six months for every RN. The audits will be completed in October 2012 and results should be available by the review visit.
VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	
VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors	
VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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 D.2., D.3, and D.9 SEH Response: See VIII.D.2, VIII.D.3 and VIII.D.9. **Facility's findings:**

NURSING UPDATE ASSESSMENT AUDIT RESULTS
March 2012-August 2012

	Mar	Apr	May	Jun	July	Aug	Mean-P*	Mean-C
N	225	230	232	241	243	230	**236**	**234**
n	37	22	22	22	22	22	**22**	**25**
%S	16	10	9	9	9	10	**9**	**10**
%C # 1 Was the Nursing Update note completed within established timelines (every 7 days for first 60 days and every 30 days thereafter)?	91	100	95	100	100	100	**95**	**98**
%C #2 Was there assessment data present addressing each nursing treatment intervention?	82	86	68	64	50	45	**59**	**66**
%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?	91	95	82	86	86	77	**68**	**86**
%C # 4 Are individualized strengths identified for the individual in care?	100	100	95	100	95	100	**86**	**98**
%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?	60	80	32	27	27	29	**17**	**36**
%C # 6 Does the RN summarize the current health and wellness challenges that have implications for nursing care?	95	100	86	95	91	82	**95**	**91**
%C # 7 Does the RN summarize the current psychiatric/mental health challenges that have implications for nursing care?	91	100	82	95	91	91	**82**	**92**
%C # 8 Does the note include individual's understanding of and thoughts/feelings about the IRP?	76	77	77	73	41	45	**86**	**65**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 9 Does the RN assessment reflect review of recent lab results and assessment tool ratings, i.e., Braden scale, Choking and Swallowing, Morse Falls Rating, etc.?	73	59	73	73	57	64	**77**	**66**
%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?	95	95	86	100	91	86	**33**	**92**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?	77	82	82	91	86	91	**33**	**85**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?	91	100	95	95	82	91	**33**	**92**

N=Target population needing updates
n=number audited
* Prior period reflects only one month of data
Tab # 4 NURSING UPDATE AUDIT RESULTS

Analysis and Action Plan: Audits of the nursing update continue to be implemented. Data shows some improvement on many indicators but overall significant improvement is needed. It should be noted that the training which, *inter alia*, focused on the synthesis and analysis of information as part of nursing assessments did not begin until August, so the Hospital expects that much improvement will be observed during future audits. Audits will continue. In the event improvement is not noted, nursing will implement additional action steps.

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: It was determined that in some cases, nursing staff were not proactive in identifying nursing interventions as part of the IRP conference in large part due to an absence of training on development of nursing objectives and interventions. Nursing staff in late February 2012 began to bring comfort plan strategies to the IRP as part of the nursing report but they were still not bringing other nursing objectives or interventions to IRPs on a routine basis. (While nurse managers had been trained in the IRP process, line nursing staff had not received dedicated training on IRP objectives and interventions). Therefore, a consultant was hired to develop and implement a training program for developing individuals nursing plans of care. The Hospital continues to work with nursing staff on improving their assessments to make them more relevant to the development of nursing related objectives and interventions that can be reflected in the IRP. In August 2012, training for registered Nurses was developed by the Nurse Consultant to support RNs in development of skills related to: • synthesizing assessment data to support prioritization of risk issues and focus areas • identification of factors and barriers contributing to or supporting continuation of identified psychiatric and medical/physical issues • identifying the individual's functioning level as relates to focus areas

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

- writing clear, descriptive summary focus statements
- writing individualized objectives that are directly linked to prioritized focus issues and reflect the individuals level of functioning
- writing nursing interventions that support the individual in care to meet his/her objectives
- preparing for and participating in IRP meetings to assure effective nursing plans of care are included in the IRP
- applying knowledge learned in training to all assessment situations, including admission assessments (CINA), Nursing Update, Change in Physical Status, Change in Psychiatric Status, Transfer to ED/Hospital, Transfer Back to SEH from ED/Hospital.

Training of RNs has taken place during August, September 2012 and is concluding in October 2012. The training consists of a PowerPoint presentation to develop basic knowledge of a-h above and writing practice scenarios to develop skills in writing focus statements/summaries, objectives and interventions for admission assessment, nursing update and return from hospital situations. Special emphasis has been on addressing risk associated with aggression/violence and medical/physical conditions. Each RN wrote objectives and interventions for each of the scenarios then shared them to the group and gave each other feedback. The RNs have been very engaged in the learning process and eager to share their writing samples and ask for feedback. The last portion of the training is completion of a written test to measure competency. The first portion of this test is an objective test of knowledge and critical thinking. The second portion is application of knowledge that requires the RN to review admission assessment data for one CINA Part A and Part B, write a summary, identify risk areas and write objectives and interventions consistent with the identified risk areas. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** The consultant who is leading the nursing training also met with clinical administrators to discuss the training's content and to explain what clinical administrators should expect from nursing staff around nursing related IRP objectives and interventions.

2. Proceed with planned nursing consultative services as agreed.

SEH Response: Ongoing. The consultation restarted at the end of July 2012.

Facility Findings:

NURSING UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P***	**Mean-C**
N	225	230	232	241	243	230	**236**	**234**
n	37	22	22	22	22	22	**22**	**25**
%S	16	10	9	9	9	10	**9**	**10**
%C #2 Was there assessment data present addressing each nursing treatment intervention?	82	86	68	64	50	45	**59**	**66**
%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?	91	95	82	86	86	77	**68**	**86**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?	60	80	32	27	27	29	**17**	**36**
%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?	95	95	86	100	91	86	**33**	**92**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?	77	82	82	91	86	91	**33**	**85**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?	91	100	95	95	82	91	**33**	**92**

N=Population due an update
n=number audited
* Mean-P had reflected only one month of data
Tab # 4 NURSING UPDATE AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	21	22	23	21	23	18	**19**	**21**
%S	11	13	12	11	12	9	**8**	**10**
%C. #7. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms	95	100	87	95	90	78	**87**	**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	Jun	July	Aug	**Mean-P**	**Mean-C**
N	192	173	188	192	193	203	**228**	**190**
n	11	11	11	11	10	11	**10**	**11**
%S	6	6	6	6	5	5	**5**	**6**
%C RN attendance at IRP	100	100	100	100	100	100	**95**	**100**
%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	100	100	100	100	100	100	**97**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 7 The treatment team will review the comfort plan and update necessary objectives and interventions as appropriate.						82		**82**

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: The Hospital continues to work with nursing staff on improving their assessments to make them more relevant to the development of nursing related objectives and interventions that can be reflected in the IRP. In August 2012, training for registered Nurses was developed by the Nurse Consultant to support RNs in development of skills related to:

- synthesizing assessment data to support prioritization of risk issues and focus areas
- identification of factors and barriers contributing to or supporting continuation of identified psychiatric and medical/physical issues
- identifying the individual's functioning level as relates to focus areas
- writing clear, descriptive summary focus statements
- writing individualized objectives that are directly linked to prioritized focus issues and reflect the individuals level of functioning
- writing nursing interventions that support the individual in care to meet his/her objectives
- preparing for and participating in IRP meetings to assure effective nursing plans of care are included in the IRP
- applying knowledge learned in training to all assessment situations, including admission assessments (CINA), Nursing Update, Change in Physical Status, Change in Psychiatric Status, Transfer to ED/Hospital, Transfer Back to SEH from ED/Hospital.

Training has taken place during August, September 2012 and concluding in October 2012. The training consists of a PowerPoint presentation to develop basic knowledge of the above and writing practice scenarios to develop skills in writing focus statements/summaries, objectives and interventions for admission assessment, nursing update and return from hospital situations. Special emphasis has been on addressing risk associated with aggression/violence and medical/physical conditions. Each RN wrote objectives and interventions for each of the scenarios then shared them to the group and gave each other feedback. The RNs have been very engaged in the learning process and eager to share their writing samples and ask for feedback. The last portion of the training is completion of a written test to measure competency. The first portion of this test is an objective test of knowledge and critical thinking. The second portion is application of knowledge that requires the RN to review admission assessment data for one CINA Part A and Part B, write a summary, identify risk areas and write objectives and interventions consistent with the identified risk areas. To date, approximately 133 RNs have completed the training and met competency. Approximately 83% of the total number of RNs have met competency. Training for night nurses and the few remaining day and evening nurses will be completed by early October. It is expected that this training will lead to improved assessments. Audits will continue and if improvement is not noted, additional corrective actions will be identified and implemented.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		In addition, the Hospital modified the instructions for indicator # 7 of the Clinical chart audit, beginning in July 2012, so that the reviewer will focus on individuals identified at risk for suicide, self-harm, disorganized, threatening, aggressive or assaultive behavior and/or physical co-morbidities and whether the IRPs include non group nursing interventions or some justification in the clinical formulation why there is none.
VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Recommendations:** 1. See VIII.D.2, D.3, and D.9.a. SEH Response: See VIII.D.2, VIII.D.3, VIII.D.4, and VIII.D.9.a. **Facility's Findings:**

NURSING UPDATE ASSESSMENT AUDIT RESULTS
March 2012-August 2012 Tool

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N	225	230	232	241	243	230	**236**	**234**
n	37	22	22	22	22	22	**22**	**25**
%S	16	10	9	9	9	10	**9**	**10**
%C #2 Was there assessment data present addressing each nursing treatment intervention?	82	86	68	64	50	45	**59**	**66**
%C # 3 Did the note reflect evaluation of effectiveness of specific nursing interventions, e.g., individual's response to interventions, improvement or lack of improvement?	91	95	82	86	86	77	**68**	**86**
%C # 5 If RN assessment indicates no improvement or identified new medical/physical or behavioral foci, are new/additional treatment objectives and/or interventions developed?	60	80	32	27	27	29	**17**	**36**
%C # 10 Is there evidence that the Comfort Plan was reviewed and , if indicated, revised?	95	95	86	100	91	86	**33**	**92**
%C # 11 Is there evidence that the RN reviewed and integrated data from RA Care Documentation Note?	77	82	82	91	86	91	**33**	**85**
%C # 12 Does the note reflect individual in care's attendance at treatment modalities?	91	100	95	95	82	91	**33**	**92**

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

CLINICAL CHART AUDIT RESULTS

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>192</td><td>173</td><td>188</td><td>192</td><td>193</td><td>203</td><td>228</td><td>190</td></tr>
<tr><td>n</td><td>21</td><td>22</td><td>23</td><td>21</td><td>23</td><td>18</td><td>19</td><td>21</td></tr>
<tr><td>%S</td><td>11</td><td>13</td><td>12</td><td>11</td><td>12</td><td>9</td><td>8</td><td>10</td></tr>
<tr><td>%C. #7. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms</td><td>95</td><td>100</td><td>87</td><td>95</td><td>90</td><td>78</td><td>87</td><td>91</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 returned this indicator to the clinical chart audits to identify areas and or units in which additional training or coaching may be needed during the upcoming review period. Performance is above the 90% threshold so no additional steps are indicated.
</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, 3, and 9.a.

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

Facility’s Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>192</td><td>173</td><td>188</td><td>192</td><td>193</td><td>203</td><td>228</td><td>190</td></tr>
<tr><td>n</td><td>21</td><td>22</td><td>23</td><td>21</td><td>23</td><td>18</td><td>19</td><td>21</td></tr>
<tr><td>%S</td><td>11</td><td>13</td><td>12</td><td>11</td><td>12</td><td>9</td><td>8</td><td>10</td></tr>
<tr><td>%C. #7. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement; the related symptoms and target variables to be monitored by nursing and other staff and the frequency by which staff need to monitor such symptoms</td><td>95</td><td>100</td><td>87</td><td>95</td><td>90</td><td>78</td><td>87</td><td>91</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
* Not audited during prior review period
Tab # 2 CLINICAL CHART AUDIT RESULTS
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>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. Fulfill agreements regarding expedited RN hiring, filling of non-nursing positions, availability of consultant services to the CNE.

SEH Response: Ongoing. Recruitment is continuing but the District has not met the timeframes it targeted.

<u>Table 1: RNs hired since September 2011</u>
<table>
<tr><th>Month</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>March</th><th>Total</th></tr>
<tr><td>New Hires</td><td>10</td><td>7</td><td>4</td><td>6</td><td>3</td><td>9</td><td>8</td><td>47</td></tr>
<tr><td>Separations</td><td>6</td><td>2</td><td>5</td><td>4</td><td>2</td><td>2</td><td>4</td><td>25</td></tr>
<tr><td>Net Gain for Month</td><td>4</td><td>5</td><td>-1</td><td>2</td><td>1</td><td>7</td><td>5</td><td>32</td></tr>
</table>
<u>Table 2: Current Staffing and Funding Levels for Direct Care RNs and Supervisors</u>
<table>
<tr><th></th><th>A</th><th>B</th><th>C</th><th>D</th><th>E</th><th>F</th><th>G</th><th>H</th><th>I</th></tr>
<tr><td></td><td>Total # Needed for 50% Mix and 6 NCHPPD</td><td>Total FY 12 Funded Positions</td><td>Total Filled FTEs (D+E+F)</td><td>Total On Units*</td><td>Total in Training</td><td>Total Not Available to the Units</td><td>Currently Vacant (B-C)</td><td>FY 12 Funded Vacancies</td><td>FY 12 Shortage in Funded positions (A-B)</td></tr>
<tr><td>NM</td><td>N/A</td><td>14</td><td>14</td><td>14</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

RNs	199.5	199.5	170	154	8	9	31	31	0
RAs & LPNs	199.5	199	199	186	0	12	1	1	0

.

In addition to filling the nursing positions, the District agreed to fill the other 29 critical positions by July 31, 2012. Ten (10) of the 29 positions were filled and on board as of July 31, 2012. An additional three (3) positions were filled and on board in August. Eighteen of the positions were filled as of September 30, 2012 and an additional 5 have EOD dates in October 2012. The remaining six positions are in some stage of the recruitment process. ***See Tab # 35 Status report on the Critical Non-nursing vacancies.***

2. Provide an administrative support position to the nursing office on evening shift.

SEH Response: A position has been identified, and recruitment is anticipated for October 2012.

3. Continue efforts to reduce 1:1s, agency use, and overtime.

SEH Response: The Hospital is continuing to address these issues. While there will continue to be a contract with SAR, reliance on outside nurses is significantly reduced as the Hospital continues to fill all nursing vacancies. The Medical Director, Director of Psychiatry and the Chief Nurse Executive continue to work to reduce 1:1s and to make 1:1s safer. It has implemented a fall protocol on the two geriatric units (1A and 1B) to reduce use of 1:1s for fall prevention, and 1:1 arms length is no longer used for those individuals in care on 1:1 for violence. Instead, the Hospital is using 1:1s line of sight for those individuals and shifting the focus from observation to engagement. Overall, use of 1:1s is down. Overtime is down significantly; In FY 12 (ending Sept 30, 2012) , Nursing spent $2,218,580 compared to $3,922,026 in FY 11, which represent a 43% decrease.

4. Closely monitor and adjust report production to ensure accuracy and actionable data.

SEH Response: The NCHPPD report has been corrected and is being utilized. The CNE worked with the Office of Statistics and Reporting to develop a new database for the management of NCHPPD that reflects census, staffing by position, SAR and overtime, the number of 1:1 staff, falls, medical leaves and restraint and seclusion. Data from the March 2012 through August 2012 shows nursing care hours per patient day has fluctuated during the review period with a low average of 5.5 in March 2012, to a high of 6.1 in April 2012; most months have been in the 5.8 range. For the audits, interrater reliability issues were resolved when responsibility for completion of the audits was placed with the Director of Nursing Quality Improvement, who now conducts all nursing related audits.

5. Develop a strategy to ensure that staffing changes are not made in response to normal variation.

SEH Response: The Agency Director has agreed to this principle.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis and action steps. There continues to be a shortage of RN staff to meet the 50% mix but efforts continue to fill all RN vacancies. Data from the March 2012 through August 2012 shows nursing care hours per patient day has fluctuated during the review period with a low average of 5.5 in March 2012, to a high of 6.1 in April 2012; most months have been in the 5.8 range. Hiring will continue.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.	**RESTRAINTS, SECLUSION, AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS**	
	By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	
X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	
X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Recommendations:** Maintain compliance. SEH Response: Compliance maintained. **Analysis/Action Plans:** There were no incidents of prone restraint, or prone transportation during this reporting period. See section X.B. 1 for data on the use of less restrictive interventions.
X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Recommendation:** 1. SEH should expedite efforts to eliminate *Safety Care* physical interventions that could pose risk to individuals and staff. Augment *Safety Care* program content with examples and role play scenarios similar to situations that occur at SEH, especially on the admission units. SEH Response: The Hospital has eliminated 7 holds from the *Safety Care* training. These include leg wrap, reverse escort, all IM injections, 2 person seated stability hold, 3 person supine stability hold, 3 person supine hold with IM injection, and removed leg wrap from chair stability hold. The Hospital recently modified the *Safety Care* curricula to include additional scenarios for role-playing that include incidents that are relevant to its population. These include denial of privileges and food restrictions. ***See Tab # 109 c New Scenarios for Safety Care role playing.*** 2. Ensure that disciplines who have not yet attended training do so. SEH Response: Data from Safety Care training shows an overall compliance rate of 90%, with 88% of existing employees and 100% of new employees having completed Safety Care training:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SAFETY CARE TRAINING EXISTING EMPLOYEES

Discipline	# Required	# Attended	Total # Competent	% Attended	% Competent /% of Attendees Competent
Chaplain	2	2	2	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	6	5	5	83%	83%/100%
Dietary	2	2	2	100%	100%/100%
Medical	12	10	10	83%	83%/100%
Nurse Manager & Supervisor	16	14	14	88%	88%/100%
Nursing - RN	125	110	110	88%	88%/100%
Nursing - LPN	29	27	27	93%	93%/100%
Nursing - RA	170	153	153	90%	90%/100%
Psychiatry	45	33	33	73%	73%/100%
Psychology	17	16	16	94%	94%/100%
Rehabilitation	18	16	16	89%	89%/100%
Social Work	12	12	12	100%	100%/100%
Treatment Mall	5	5	5	100%	100%/100%
Clinical (Other)	9	9	9	100%	100%/100%
Security	10	5	5	50%	50%/100%
Total	**490**	**431**	**431**	**88%**	**88%/100%**

See Tab # 109 b

SAFETY CARE TRAINING NEW EMPLOYEES

Discipline	# Required	# Attended	Total # Competent	% Attended	% Competent /% of Attendees Competent
Chaplain	5	5	5	100%	100%/100%
Clinical Administrator	N/A	N/A	N/A	N/A	N/A
Dentistry	4	4	4	100%	100%/100%
Dietary	N/A	N/A	N/A	N/A	N/A
Medical	1	1	1	100%	100%/100%
Nurse Manager & Supervisor	1	1	1	100%	100%/100%
Nursing - RN	36	36	36	100%	100%/100%
Nursing - LPN	N/A	N/A	N/A	N/A	N/A
Nursing - RA	N/A	N/A	N/A	N/A	N/A
Psychiatry	11	11	11	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Psychology	14	14	14	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Social Work	2	2	2	100%	100%/100%
Treatment Mall	N/A	N/A	N/A	N/A	N/A
Clinical (Other)	1	1	1	100%	100%/100%
Safety	2	2	2	100%	100%/100%
Total	**78**	**78**	**78**	**100%**	**100%/100%**

See Tab # 136 New Employee Training Data

3. Revise on-line *Seclusion and Restraint* training to ensure full alignment with policy, emphasis on individualized interventions including integrating the content of comfort plans, and attention to trauma.

SEH Response: Training expects to have this completed in October 2012.

Facility's Findings

As the data shows, overall compliance with seclusion and restraint training for existing employees improved from 77% during the prior review period to 95% during this review period; compliance rate for new employees was 100%.

Restraint or Seclusion for Behavioral Reasons: Existing Employees					9/30/12
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	2	2	2	100%	100%/100%
Clinical Administrator	12	11	11	92%	92%/100%
Dentistry	7	7	7	100%	100%/100%
Dietary	2	1	1	505	50%/100%
Medical	12	11	11	92%	92%/100%
Nursing - Nurse Manager/Supervisor	16	15	15	94%	94%/100%
Nursing - RN	125	116	116	93%	93%/100%
Nursing – LPN	29	29	29	100%	100%/100%
Nursing – RA	170	165	165	97%	97%/100%
Psychiatry	48	45	45	94%	94%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Psychology	19	18	18	95%	95%/100%
Rehabilitation	18	18	18	100%	100%/100%
Social Work	12	11	11	92%	92%/100%
Treatment Mall	5	5	5	100%	100%/100%
Clinical (Other)	11	8	8	73%	73%/100%
Other non-clinical staff	10	10	10	100%	100%/100%
Total	**498**	**472**	**472**	**95%**	**95%/100%**

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

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

See Tab # 109 Restraint and Seclusion Training Curricula and Data

Restraint or Seclusion for Behavioral Reasons: New Employees 9/30/12

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	5	5	5	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	36	36	36	100%	100%/100%
Nursing - RA	0	n/a	n/a	n/a	n/a
Psychiatry	11	11	11	100%	100%/100%
Psychology	14	14	14	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Social Work	2	2	2	100%	100%/100%
Clinical (other)	1	1	1	100%	100%/100%
Safety	2	2	2	100%	100%/100%
Total	**78**	**78**	**78**	**100%**	**100%/100%**

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

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

See Tab # 136 New Employee Training Data

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Safety care training was implemented beginning in September 2011. As of September 29, 2012 431 existing staff and 78 new staff completed the training; 90% of all required staff have completed Safety Care training.

Collaborative Problem Solving Training				**9/30/12**
	Clinical Staff	Nursing-Day	Nursing-Evening	Nursing- Night
Total # to be trained	93	135	125	111
Total # Trained	73	116	84	62
% Trained	78%	86%	67%	56%

See Tab # 66 Collaborative Problem-solving Training Information

Recovery Training (includes new and existing nursing staff) 8/31/2012					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent**
Nurse Mgr & Supervisors	16	16	16	100%	100%/100%
RN	152	152	152	100%	100%/100%
LPN	29	29	29	100%	100%/100%
RA	170	170	170	100%	100%/100%
Total	**367**	**367**	**367**	100%	100%/100%

See Tab # 99 Recovery Training Information

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

SECLUSION AND RESTRAINT COMPARISON DATA		
Discipline	**% Compliant Prior review period Seclusion and restraint training**	**% Compliant Current review period Seclusion and restraint training**
Nurse manager	93%	94%
RN	87%	93%
LPN	87%	100%
RA	87%	97%
Psychiatrist	95%	94%
Safety	0%	100%

As of March 2012, the restraint and seclusion training curricula was modified to remove aspects covered in Safety Care, reflect changes in policy and eliminate the module relating to application of restraints which is now part of Safety Care training. The online training was updated and is expected to be available through the intranet in October 2012. ***See Tab # 109 Seclusion and Restraint and Safety Care Curricula and Data.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		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 also being done during evening and night shifts and these efforts will continue. The Hospital continues to implement the Collaborative Problem-solving training. The majority of staff on all units on all shifts has completed the CPS training.
X.A.3	the use of side rails on beds, including a plan:	
X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	
X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification .of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	
X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	
X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Recommendations:** 1. Identify and resolve barriers to ensure that comfort plans are consistently integrated into IRPs and that IRPs consistently contain individualized biopsychosocial interventions when individuals are at risk for violence and/or have engaged in a behavior that involves environmental damage, threatening, aggressive, or assaultive behavior. SEH Response: The Hospital has undertaken several steps to implement this recommendation. First, nursing staff now bring comfort plans to the IRP conference for review with the treatment teams. Further, beginning in August, a new indicator was added to the IRP observation audits that tracks whether the teams are reviewing the comfort plan and are updating objectives and interventions as appropriate; the percentage compliance was at 85% in August, the first month data was collected. ***See Tab # 6 IRP Observation Audit Tool and Tab # 7 IRP Observation Audit Results.*** Third, training for all RNs is underway that is designed to improve the RN's skills in developing objectives and interventions for a nursing plan of care. The training specifically focuses on development of objectives and interventions for those with behavioral issues. ***See Tab # 102 Designing Individualized Plans for Nursing Care.*** Finally, the Hospital modified instructions in indicators # 5 and # 7 of its Clinical Chart audit to ensure the reviewers are assessing whether the IRPs for those at risk of violence or aggressive behavior have objectives and interventions, including non-group nursing interventions, designed to address the risk.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2. When individuals are placed on 1:1 or 2:1 to manage risk of violence, senior clinical leaders should conduct a joint review to ensure that biopsychosocial interventions are being initiated to address the root cause of the behavior that increases the risk for violence.

SEH Response: Each Monday morning, the Hospital's clinical leadership (Medical Director, Director of Psychiatry, Chief Nurse Executive, Chief of Staff, Supervisory Clinical Administrator, Director of Social Work, Chief Psychologist and Director of Treatment Services) meet to discuss issues related to specific individuals in care or related to events that occurred the prior week. The staff review those on 1:1 or 2:1, possible treatment strategies that could be tried and settle upon a course of action. Among the changes that have resulted from these meetings is a significant reduction of use of 1:1s for fall prevention and changes in practice around use of 1:1s for violence - - from 1:1 arms length to 1:1 line of sight. Other strategies the Hospital is using include increasing the frequency of mentoring of teams, and mentors now participate in the unit partnerships and will lead unit "debriefings" held after significant incidents. Finally, the Hospital is continuing its use of CCTs and SERC to provide clinical support to teams. ***See also Tab # 117 Violence Reduction Strategies***

3. Explore the use of restraints rather than metal handcuffs when transporting individuals in Class A status to another hospital or Emergency Department for care. Provide direction for observation, monitoring, and documentation in these circumstances.

SEH Response: This has not been completed.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Mar	Apr	May	Jun	July	Aug	**Mean-P**	**Mean-C**
N	3	1	3	3	4	1	**4**	**3**
n	3	1	3	3	4	1	**3**	**3**
%S	100	100	100	100	100	100	**68**	**100**
%C # 2 Documentation reflects that individual posed an imminent danger to self or others if not restrained or secluded	100	100	100	100	100	100	**100**	**100**
%C # 3 Documentation reflects r/s used to ensure safety of individuals or others, after less restrictive interventions have been considered and documented	100	100	100	100	100	100	**100**	**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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th>Mar~12</th><th>Apr~12</th><th>May~12</th><th>June~12</th><th>July~12</th><th>Aug~12</th></tr>
<tr><td>Restraint</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.3%</td><td>0.6%</td><td>0.3%</td></tr>
<tr><td>Seclusion</td><td>1.0%</td><td>0.3%</td><td>1.3%</td><td>0.7%</td><td>0.3%</td><td>0.0%</td></tr>
</table>
NPR Rate percent of individuals restrained=5.3%
NPR Rate percent of individuals secluded=2.2%
See PRISM Report, Tab # 43

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

<table>
<tr><th colspan="7">RATE OF RESTRAINT OR SECLUSION HOURS</th></tr>
<tr><th></th><th>Mar~12</th><th>Apr~12</th><th>May~12</th><th>June~12</th><th>July~12</th><th>Aug~12</th></tr>
<tr><td>Restraint</td><td>0.000</td><td>0.000</td><td>0.000</td><td>0.005</td><td>0.001</td><td>0.010</td></tr>
<tr><td>Seclusion</td><td>0.019</td><td>0.004</td><td>0.031</td><td>0.057</td><td>0.005</td><td>0.000</td></tr>
</table>
NPR restraint hours rate =0.46
NPR seclusion hours rate – 0.41
See PRISM Report, Tab # 43

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

The Hospital recently modified its Safety Care curriculum to eliminate the teaching of seven holds not being used by the Hospital and to add scenarios that reflect incidents which are more likely to occur in this setting. To date, 90% of staff have completed Safety Care training. See X.A.2 for Training Data on Safety Care. In addition, 100% of nursing staff completed Recovery training. See Tab # 99 Recovery Training Outline and data Nursing staff were trained on use of the comfort plan and setting of objectives and interventions, and now bring comfort plan interventions to the IRPs. (This was added to IRP observation audits beginning August 1, 2012). It appears that these initiatives are positively impacting the use of alternatives to restraint or seclusion, although it is too early to determine if the comfort plan form and increased attention to its content has improved staff’s use of the interventions identified in the comfort plan itself.
</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></td></tr>
<tr><td>X.B.3</td><td>are not used as part of a behavioral intervention; and</td><td></td></tr>
<tr><td>X.B.4</td><td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td><td></td></tr>
<tr><td>X.C</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that a physician’s order for seclusion or restraint include:</td><td></td></tr>
<tr><td>X.C.1</td><td>the specific behaviors requiring the procedure;</td><td></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>X.C.2</td><td>the maximum duration of the order;</td><td></td></tr>
<tr><td>X.C.3</td><td>behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;</td><td></td></tr>
<tr><td>X.C.4</td><td>ensure that the individual's physician be promptly consulted regarding the restrictive intervention;</td><td></td></tr>
<tr><td>X.C.5</td><td>ensure that at least every 30 minutes, individuals in seclusion or restraint must be reinformed of the behavioral criteria for their release from the restrictive intervention;</td><td></td></tr>
<tr><td>X.C.6</td><td>ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;</td><td>Recommendation:

1. Explore and resolve barriers to conducting debriefings.

SEH Response: The data shows improvement in treatment teams conducting debriefings following incidents of seclusion or restraint, with improvement from a mean of 53% during the last review period to a mean of 79% during this review period. In other words, of the 15 restraint/seclusion incidents, 11 of the 14 (one case was inapplicable) had debriefings and teams completed the debriefing forms. In one of the cases in which a debriefing was not held within 24 hours, the IIC had been transferred to a community hospital for medical treatment. In a second, the IRP was held 6 days after the event, and in the third case, the IRP was held 13 days after the event.

2. See X.B.1

SEH Response:

Facility’s Findings:

<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>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>3</td><td>1</td><td>3</td><td>3</td><td>4</td><td>1</td><td>4</td><td>3</td></tr>
<tr><td>n</td><td>3</td><td>1</td><td>3</td><td>3</td><td>4</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>68</td><td>100</td></tr>
<tr><td>%C # 6 Treatment team debriefing held within 24 hours or next business day of termination of r/s event</td><td>67</td><td>100</td><td>100</td><td>67</td><td>75</td><td>100</td><td>53</td><td>79</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: Data shows performance improved during this review period, with timely debriefings after 12 of 15 incidents of restraint or seclusion; in one of those cases, the IIC had been transferred to a medical facility and was not at the Hospital to participate in the debriefing. Clinical administrators continue to be reminded of ensuring compliance with this requirement. See Tab # 42 Treatment Team Debriefing Form.</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></td></tr>
<tr><td>X.C.8</td><td>ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.</td><td>Recommendation:

1. See X.A.2

SEH Response: See X.A.2.

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>July</td><td>Aug</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>3</td><td>1</td><td>3</td><td>3</td><td>4</td><td>1</td><td>4</td><td>3</td></tr>
<tr><td>n</td><td>3</td><td>1</td><td>3</td><td>3</td><td>4</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>68</td><td>100</td></tr>
<tr><td>%C # 8 individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.</td><td>67</td><td>100</td><td>100</td><td>100</td><td>50</td><td>100</td><td>76</td><td>80</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 45 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The Hospital’s performance on this indicator is improving as more staff have completed Safety Care training. Effective March 2012, Safety Care training includes application of restraints and related competencies, and the seclusion and restraint training was updated to focus on policy requirements. The revised curricula will become available on line in October 2012. These steps should result in continued improvement in meeting this requirement. See Tab # 109 Seclusion and Restraint and Safety Care Curricula and Data</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,</td><td></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Recommendation:** Maintain compliance. SEH Response: There were three cases that met this requirement. In one case, the psychiatrist reviewed the case the day of the third event and documented the review and the Director of Psychiatric Services reviewed the case within 6 days of the third event. In a second case, an IRP was held within 5 calendar days (and on the third business day) after the third event. In the third case, an IRP was held on the 5th business day after the event.
X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Recommendations:** 1. Monitor the use of EIM as well as changes into the IRP. SEH Response: The Hospital has been monitoring the use of EIM in two ways, first through data obtained from Avatar that tracks medications ordered on a STAT or NOW basis and for which nursing indicates administration was involuntary, and through reviews of all UIs that indicate medication was administered involuntarily. Up to August 2012, this information was shared each month with Pharmacy and Therapeutics Committee and reported in the PRISM report. As a result of this monitoring, the Hospital determined that it is likely that the number of EIMs is being underreported for a couple of reasons. First of all, the current medication order and administration documentation process in Avatar is contributing to nursing's inability to enter accurate and timely documentation of administration of STAT or NOW medication orders in a drop down field, which is the source for automated identification of EIM. Under Avatar's current configuration, nursing is unable to enter administration results in eMar through the drop down menu without Pharmacy verification of the orders. As set up in Avatar, all orders, including STAT and NOW orders , must be verified by Pharmacy *before* the nurse can record medication administration through the drop down menu; for STAT or NOW orders, this verification and subsequent nursing documentation all must occur within 24 hours or the administration results cannot be recorded on eMar. In those cases where the Pharmacy is unable to immediately verify the STAT or NOW order and the nurse is not on duty again within the 24 hour period, this nurse cannot indicate through the drop down menu if the medication was administered involuntarily or not. Since that is source for the data, some instances of EIM are not being captured. In addition, a technical glitch in communication between Avatar and Worx (Pharmacy information management system) has been identified as a factor that sometimes hinders the pharmacy's verification of orders in Avatar. As a result, some of the STAT orders do not have automated administration records available at all. It should be noted, however, that the administration ***is*** being captured as nurses are making progress notes or completing the text field in the administration record, and in most cases, through record reviews, the Hospital can determine if the administration was voluntary or involuntary.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

In part because of this issue, PID, with support of some medical students, reviewed 80 events of NOW or STAT orders. The audit included a review of whether the type of administration (involuntary or voluntary) was indicated and if so where – through the eMar administration record or through a note. As of the writing of this report, the audits are completed and data analysis is underway. The Hospital expects that the final report will be available by the time of the visit. In the meantime, the Medical Director and Chief Nurse Executive met with representatives from nursing, pharmacy and others; the decision is to ask NetSmart to permit medication administration recording of STAT medication prior to pharmacy verification.

Under the Hospital's revised High Risk Policy, PID monitors the use of more than three EIMs in a four week period as it constitutes a threshold event. When the threshold is reached, PID alerts the treatment team and the Supervisory Clinical Administrator, who then reviews the case to determine if the IRP is updated. This information is reported back to PID and is tracked through the high risk database. However, the Hospital is aware that this information is probably underreported.

Facility's Findings:

Data available to date from eMar shows the following:

	Mar~12	Apr~12	May~12	June~12	July~12	Aug~12
# Unique EIM events	9	1	5	1	8	2
# Unique IIC given EIM	6	1	3	1	7	2

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

	Mar	Apr	May	Jun	July	Aug	Mean-P	Mean-C
N # of EIM events during the month	9	1	5	1	8	2	**3**	**4**
# of Unique Patients Given EIM	6	1	3	1	7	2	**2**	**3**
# Total EIM ordered/administered	13	2	8	1	15	3	**5**	**7**
n	2	0	0	1	6	1	**2**	**2**
%S	22	0	0	100	75	50	**69**	**38**
%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	n/a	n/a	100	100	100	**100**	**100**
%C 1b the medication is a standard treatment for the individual's diagnosis, symptoms or conditions	100	n/a	n/a	100	100	100	**100**	**100**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>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. It will also work to resolve the issues with Avatar so that nurses will be able to timely enter administration details in the drop down screen thereby improving the Hospital’s tracking of more than three incidents of emergency involuntary medication.</td></tr>
<tr><td>X.F.2</td><td>a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and</td><td>Recommendations:
1. See F.X.1

SEH Response: See X.F.1.

Facility’s Findings:

<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N # of EIM events during the month</td><td>9</td><td>1</td><td>5</td><td>1</td><td>8</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td># of Unique Patients Given EIM</td><td>6</td><td>1</td><td>3</td><td>1</td><td>7</td><td>2</td><td>2</td><td>3</td></tr>
<tr><td># Total EIM ordered/administered</td><td>13</td><td>2</td><td>8</td><td>1</td><td>15</td><td>3</td><td>5</td><td>7</td></tr>
<tr><td>n</td><td>2</td><td>0</td><td>0</td><td>1</td><td>6</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>22</td><td>0</td><td>0</td><td>100</td><td>75</td><td>50</td><td>69</td><td>38</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>n/a</td><td>n/a</td><td>100</td><td>100</td><td>100</td><td>55</td><td>100</td></tr>
<tr><td>%C 2 b that assessment was within 1 one of the EIM administration</td><td>100</td><td>n/a</td><td>n/a</td><td>100</td><td>100</td><td>100</td><td>55</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 indicate declining performance. The Medical Director has discussed his findings with the involved physicians. The Hospital will continue monitoring this through audits.</td></tr>
<tr><td>X.F.3</td><td>the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as</td><td>Recommendation:

See X.F.1 and X.E.

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

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>appropriate.</td><td>
<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N # of EIM events during the month
# of Unique Patients Given EIM
Total EIM ordered/administered</td><td>9
6
13</td><td>1
1
2</td><td>5
3
8</td><td>1
1
1</td><td>8
7
15</td><td>2
2
3</td><td>3
2
5</td><td>4
3
7</td></tr>
<tr><td>n</td><td>2</td><td>0</td><td>0</td><td>1</td><td>6</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>%S</td><td>22</td><td>0</td><td>0</td><td>100</td><td>75</td><td>50</td><td>69</td><td>38</td></tr>
<tr><td>%C 3 a The review indicates that the treatment team timely reviewed three or more emergency involuntary administration in 4 week period and</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
<tr><td>%C b modified the IRP or medication regimen in a timely manner or documented reasons why modification was not clinical appropriate</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
<tr><td>%C c implemented the revised plan, if applicable</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr>
</table>
N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 140 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

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

1. See X.A.2.

SEH Response: See X.A.2.

2. Ensure continued competency-based training for EIMs.

SEH Response: Ongoing. The Hospital also modified the portion of the restraint and seclusion training to increase focus on EIMs to improve the accuracy of reporting. See Tab # 109 Restraint and Seclusion Training Information
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XI.	**PROTECTION FROM HARMH**	
	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 (9/29/12)
Continuing employees

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	2	2	2	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	7	7	7	100%	100%/100%
Dietary	2	2	2	100%	100%/100%
Medical	12	12	12	100%	100%/100%
Nursing - Nurse Manager	16	16	16	100%	100%/100%
Nursing - RN	125	125	125	100%	100%/100%
Nursing - LPN	29	29	29	100%	100%/100%
Nursing - RA	170	169	169	99%	99%/100%
Psychiatry	48	48	48	100%	100%/100%
Psychology	19	18	18	95%	95%/100%
Rehabilitation	18	18	18	100%	100%/100%
Social Work	12	12	12	100%	100%/100%
Treatment Mall	5	5	5	100%	100%/100%
Clinical (Other)	11	11	11	100%	100%/100%
Non-Clinical/Administrative	178	178	178	100%	100%/100%
Total	**666**	**664**	**664**	**99%**	**99%/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 — **9/29/12**

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	5	5	5	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	36	36	36	100%	100%/100%
Psychiatry	11	11	11	100%	100%/100%
Psychology	14	14	14	100%	100%/100%
Rehabilitation	1	1	1	100%	100%/100%
Social Work	2	2	2	100%	100%/100%
Clinical (other)	1	1	1	100%	100%/100%
Non-clinical	10	9	9	90%	90%/100%
Total	86	85	85	99%	99%/100%

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

See Tab # 136 for new employee training data

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 substantially revised its High Risk Indicator Tracking and Review policy. ***See Tab # 129 High Risk Tracking and Review Policy.*** The initial version of the Policy included 8 categories of behavioral and 8 categories of medical high risks, and specified criteria for placement on a list and criteria for removal from a list. In March 2011, the Hospital identified individuals who met the criteria and began tracking them. The Performance Improvement Committee reviewed the policy and recommended changes in February 2012. The changes included adding a high risk category for fire starters and modifying some of the time frames for getting off a high risk list as well as some language "clean up" on technical aspects of the policy. Then, in July 2012 following the May visit by DOJ, the policy was more significantly modified to reinforce the role of the treatment team in identifying risk earlier. Definitions were clarified. Treatment teams are required to assess IICs on an ongoing basis for risk, utilizing information from the discipline assessments, history and review of UIs. To assist the teams and ensure linkages between the assessments and the high risk list, a report is run each week (this began in late May/early June 2012) identifying those IIC who were assessed to be at severe or moderate risk of injury to self or others from the CIPA and the Psychiatric Update. Those individuals assessed to be a severe risk are automatically placed on the appropriate risk list until he or she meets the criteria for removal, and those assessed to be at moderate risk are, within seven days, to be evaluated by the team and PID is to be notified of the team's decision. The psychiatrist is

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		responsible for documenting the rationale for inclusion or non inclusion on a high risk list for those assessed to be at a moderate level of risk. Similarly, PID tracks the high risk thresholds and looks for trigger events. The Policy now defines a threshold to include 3 or more major UIs. Any individual placed on a list should have their IRP reviewed to ensure that it addresses all identified risks or indicates a rationale for deferring addressing the risk. Other key changes to the Policy include changes to the criteria for placement on a high risk list and removal from a list. The Director of Psychiatric Services continues to review those cases where an IIC meets a high risk threshold. PID continues to send out weekly updates to the high risk lists, and now reviews the lists with each team during the unit partnership meetings. Other changes include time frames for placement on and removal from a list. In addition to changes to the Policy, the Hospital also improved the High Risk Tracking Database. The following changes to the database were completed: • Enabled to track the history of high risk identification by each risk: each risk has its start date and end date and the length of time for placement on a particular risk list is automatically calculated. In the past, if somebody has multiple high risks identified, we couldn't track when each risk was identified. • Linked the high risk database with UI database and created a screen to review the history of unusual incidents for each individual, including those reported in previous hospital stays. In the past, PID had to run and search UI database to review the history of UIs. • The number of UIs and major UIs for the past 30 days for each individual is automatically calculated on the screen. • A report identifying individuals meeting the threshold of >=3 major UIs for 30-days is automatically generated in the high risk database. In the past, the Risk Manager had to run multiple reports from the UI database, manually review/count the records, and edit the report on a weekly basis. • Made it easier to document and search follow-up actions and recommendations, track review by Director of Psychiatric or Medical Services, track IRP updates, CCTs and SERCs. • Increased the reporting capacity of the database. We also began tracking treatment hours for those on a high risk through linking high risk and treatment scheduling databases. The improvements to the database has improved the Hospital's ability to track individuals on more than one high risk list, as well as it ability to track if each of the risk is addressed in the IRP or clinical formulation. As of September 30, 2012, 111 IICs (40% of the Hospital population) were identified as meeting one or more high risks. Monitoring of those with three or more major UIs is now down through the revised High Risk database, which is linked to the UI database. As of September 2012, of the 111 individuals on one or more high risk lists 83 (75%) had at least one risk addressed in the IRPs and 50% had all risks addressed in the IRP. During the course of the review period, 103 individuals were added to one or more risk lists, and 69 were removed from any high risk list. ***Tab # 128 Summary of High Risk Indicator Lists.*** During this review period, 16 individuals met criteria for CCT, 4 were held and the CCTs for the remaining 12 were deferred by the Director of Psychiatric Services. Over the Fall, 2011 the Hospital implemented Safety Care training for all clinical staff, and in December 2011 began training

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

nursing staff on the recovery model. Beginning in November 2011 the Hospital began to see a decline in physical assaults which has generally continued; assaults are also at levels lower than at the same time last year.

	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12
Phys assaults	52	64	45	27	28	22	46	24	39	31	40	34
Psych Emergency	41	47	24	16	12	10	15	6	18	6	5	7
Injury	34	46	30	30	25	20	39	22	21	23	33	31

The Hospital is continuing to monitor this data closely, and assault data is presented monthly to the Risk Management and Safety Committee. ***See Tab 124 Risk Management Committee Minutes*** It also has developed a comprehensive, interdisciplinary approach to improving safety and will continue monitoring trends around violence. ***See Tab # 117 Strategies to Address Violence at the Hospital.***

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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:	
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. Revise SEH policy to reflect the language of the Settlement Agreement as it pertains to removing an employee named in a serious and credible abuse, neglect, exploitation allegation or when an individual in care is seriously injured. SEH Response: Completed. Beginning in July 2012, even before the policy was signed off on, staff against whom the immediate investigation suggest a serious, credible allegation of abuse or neglect has been made are removed from all patient contact until the end of the investigation. 2. Take steps to advise staff members of the change in procedures that will result from this change in policy. SEH Response: The policy is posted on the intranet and is reviewed with teams during the unit partnership. 3. Consider adding a question/statement to the investigation face sheet that would explain why the named employee was not removed from contact with individuals in care. SEH Response: Completed. **Facility's findings:**

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Report Delay of Abuse and Neglect Incidents

Report Gap (Days)	Previous Review Period (Sep 11~Feb 12)						Current Review Period (Mar 12~Aug 12)						Previous Total	Current Total
	2011-9	2011-10	2011-11	2011-12	2012-1	2012-2	2012-3	2012-4	2012-5	2012-6	2012-7	2012-8		
<=1 day (on time)	**5**	**3**	**3**	**3**	**0**	**1**	**5**	**6**	**3**	**2**	**3**	**5**	**15**	**24**
>1 & <=5 days	**0**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**
>5 & <=10 days	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**2**	**3**
>10 days	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**1**	**2**	**3**
Total abuse/neglect UIs	**6**	**5**	**4**	**4**	**1**	**2**	**7**	**7**	**4**	**2**	**4**	**6**	**22**	**30**
Timely reporting (<=1 day)	***83%***	***60%***	***75%***	***75%***	***0%***	***50%***	***71%***	***86%***	***75%***	***100%***	***75%***	***83%***	***68%***	***80%***
Reports Delayed (>1 day)	***1*** ***17%***	***2*** ***40%***	***1*** ***25%***	***1*** ***25%***	***1*** ***100%***	***1*** ***50%***	***2*** ***29%***	***1*** ***14%***	***1*** ***25%***	***0*** ***0%***	***1*** ***25%***	***1*** ***17%***	***7*** ***32%***	***6*** ***20%***

See Tab # 121 UI Monthly Report.

Analysis/Action Steps: Overall the number of abuse/neglect reports submitted timely fell, from 68% in the prior period to 80% during this period. It should be noted that at this time, the Hospital still measures timeliness from the date of the incident, not from the date of discovery, so that the 80% statistic somewhat overstates the percentage of abuse or neglect incidents involving a delay.

The Risk Manager continues to emphasize the importance of adherence to the Hospital policy that staff shall be free of retaliation when reporting an allegation of A/N/E. This is included in the training on reporting abuse and neglect. There is no evidence that any retaliation occurred during this review.

As evidenced by the data described above, the Risk Manager's actions to ensure that staff are compliant with their duty to report UIs of all types has been effective. The Risk Manager continues to review collateral hospital reports such as the 24 Hour Nursing Report as a means of checks and balance to ensure that incidents of any type noted in the reports have corresponding UIs if required by the policy.

XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	
XII.A.4	adequate training for all staff on recognizing and reporting incidents;	

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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 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	

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	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.	
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.	
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 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	

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	with explanations given for changing/not changing. the individual's current treatment regimen.	
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:** **Current recommendations:** 1. At the weekly Partnership meetings, in addition to reviewing the current HR list for the unit, ask the team to identify persons who should be added to the list. This may encourage clinicians to view risk assessment as a continuous function that should not rely principally on responding to incidents. SEH Response: Ongoing. Please note that Unit partnership meetings are monthly, not weekly. High Risk lists are updated weekly. PID and unit mentors review the list with each team monthly, discussing the appropriateness of each person on the list, whether they still should be on the list, and if there are individuals in care who are not on any list but should be on a list. The list of UIs for individuals on the unit is also provided and reviewed. 2. Assess closely the effectiveness of the review process for those specific individuals whose risk of violence remains high over an extended period of time. SEH Response: Ongoing. The Hospital has undertaken several steps to implement this recommendation. First, the High Risk Database is now linked with the UI database, and treatment hours for those on a high risk list is also tracked through the treatment scheduling database. This allows the Hospital to assess if the individual is attending groups, what groups he or she is attending and if he or she is continuing to engage in reportable behavior. Further, the Hospital is now including in the High Risk Database the Director of Psychiatric Services' recommendations for individuals who meet a high risk threshold, and the Supervisory Clinical Administrator is tracking whether violence risk is addressed in the IRP, and reporting the results of her review to PID. Each unit has a clinical mentor who is a member of the management structure who meets monthly with the team to discuss any issues (they also often attend the unit partnership meetings) and also provide clinical coaching to the team in the event of a particular issue or challenging individual. Finally, PID is developing an audit tool that will assess whether the Director's recommendations have been implemented (or if not, is there a rationale in the record) and if they have been effective. It hopes to begin audits late this Fall. 3. Implement, as planned, the recommendations in the Physical Assaults Injuring Staff report. SEH Response: Ongoing. Teams have all been retrained on the High Risk Policy, and in addition the revised policy was reviewed with psychiatrists and medical practitioners at a monthly meeting, as well as with clinical administrators and nurse managers. Second, a weekly report is run and circulated that tracks all those assessed during the prior week to be at severe or moderate risk based upon the CIPA or Psychiatric Update. The IRP observation audit tool was modified effective with August 2012 audits and the clinical chart audits continue to monitor the accuracy of the Clinical Formulation. The UI and High Risk databases are now linked. Two recommendations are still being evaluated by Medical Affairs, but all others have been implemented or are being implemented. ***See also Tab # 117 Strategies to Address Violence***

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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:	
XIII.B.1	disseminating corrective action plans to all persons responsible for their implementation;	
XIII.B.2	monitoring and documenting the outcomes achieved; and	
XIII.B.3	modifying corrective action plans, as necessary	
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation	
XIII.C.2	monitoring and documenting the outcomes achieved; and	
XIII.C.3	modifying corrective action plans, as necessary.	
XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Recommendation:** 1. Replace plastic bags with paper or waxed paper bags to eliminate this self-harm hazard. SEH Response: The Hospital is assessing the feasibility of this recommendation. 2. Ensure that specific info regarding the nature of the problem that occasioned the Medical Director's note is included in each note.

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		SEH Response: Ongoing. Beginning with July 2012, the Director of Psychiatric Services includes in his note a brief description of the UIs that preceded his review. 3. Identify and implement a procedure for auditing effective implementation of the recommendations made at the second and third level reviews. SEH Response: PID is developing an audit tool that will assess whether the Director's recommendations have been implemented (or if not, is there a rationale in the record) and if they have been effective. It hopes to begin audits late this year. **Facility findings:** The Hospital continues its performance improvement activities. These include such activities as producing monthly PRISM reports, an annual consumer satisfaction survey, the annual Trend Analysis, monthly Pharmacy and Therapeutics Committee Reports, monthly UI reports, and some 30 discipline or program audits, most of which occur monthly (See V.B.9). In addition, the unit partnership activities continue and have been expanded to include regular discussions around the high risk lists and training on policy changes. The High Risk list is reviewed with each unit during the partnership meeting, UI information is available and the team discusses the need for each individual's appropriateness for continued placement on the High Risk list as well as whether other individuals should be added. PID also monitors implementation of recommendations for improvement made by Committees, Executive Staff, Office of Risk Management, DMH Office of Accountability and other sources. PID participates with nursing in auditing crash carts and in checking to ensure the approved restraints are on units per policy. It also participates in the Fall Reduction Sub Committee (a subcommittee of Risk Management) and provides staff support to the PIC and Risk Management Committee. Each review period, the PID and OSR conduct a "deep dive" assessment on a particular topic. The first two looked at violence and the most recent study is looking at the use of STAT and NOW medications. This recent study included, *inter alia*, a review of 80 STAT/NOW events covering a three month period, and included reviews of key indicators such as assessment by a physician before or within an hour of administration, physician documentation as to reason for order, whether alternative interventions were tried, nursing documentation as to reasons for administration and results of administration, effectiveness of medication and if the administration was voluntary or involuntary. The results are currently being analyzed and should be available in early November, 2012. QI is occurring throughout the Hospital. Hospital committees now routinely look at data - - for example the Risk Management Committee looks at assault, fall and injury data at each meeting. PIC reviews similarly data, as well as infection control data. Treatment hour data is now available on a weekly basis and is available in both a summary format and by individual in care. Treatment hour data for those individuals who are "unengaged" or on a high risk list is tracked. The Hospital conducts a readiness ruler assessment for those with substance abuse diagnoses three times a year to assess progress and their stage of change. In October 2012, the TLC and Psychology department began an Outcome Measures Project for the groups offered in the TLCs. This is a long-term project to assess the efficacy of treatment groups offered and promote evidence-based practice in the TLC by incorporating assessment into the treatment process and looking at data to

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		determine IICs' progress within specific treatments and toward their individual treatment goals. An initial survey was administered on October 1 to get a sense of the IICs' likes/dislikes about the TLCs and global characteristics of the different groups they attend (e.g. do you like having handouts in group, do you like groups with manuals, etc.). Future outcome data will be gathered that will be helpful in guiding clinical decisions, improving groups offered, and understanding the TLC's areas of effectiveness and areas for improvement on a programmatic level. The pilot clinical outcome survey will be conducted at the end of December and will be a random sampling of the different types of groups offered in the TLC based on the types of treatment clusters that are offered (e.g. violence reduction, illness management, community re-entry, etc.). These two pilot measures will help us determine the most effective process for gathering meaningful outcome data for our IICs and our treatment functions and for fine-tuning the data-gathering process. The Hospital conducts 12 actual/mock code blue drills each quarter, with one per shift per zone in the Hospital; data is analyzed and presented to the Hospital's mortality and morbidity committee each quarter. The consumer food work group continues its work. See Also discussion of High Risk and database in Chapter XII.

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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 environmentally hazardous and unsanitary	.

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	conditions in all living units and kitchen areas.	