Saint Elizabeths Hospital
Compliance Office Report (March 2, 2009)

V. Integrated Treatment Planning

Summary of Progress

1. The Hospital continued to refine it interdisciplinary recovery\planning policy to better reflect an individual focused, recovery oriented approach to treatment. Five of eighteen wards began IRP training in September, 2008, five wards began IRP training in January/February, 2009, and the remaining eight wards will begin training in April, 2009. Training, which includes didactic but is mostly observational, mentoring, and review of records, is designed to strengthen IRPs to be more recovery based and individually focused, with an emphasis on the individual's strengths and goals, and includes a specific focus on discharge planning.

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2. The Hospital modified its IRP form to ensure it is consistent with the revised IRP Policy and also developed an Initial IRP Form. The IRP form provides for six focus areas of treatment, around psychiatric/psychological, physical health, legal/forensic (if applicable), substance abuse (if applicable), discharge and community readiness and enrichment. Each focus area will have at least one objective for the person being served and interventions to address each area. Beginning March 3, 2009, the forms are required for all ten units that have had or are having training, and the other units may use them. (An overview of the forms and IRP principles has been provided to all units.)

3. A treatment planning manual has been created. See Separate manual. It includes all relevant policies (Assessment policy, IRP Policy, Transfer Policy, Medical Records Policy and Seclusion and Restraint Policy for Behavioral Reasons) and forms (each disciplines assessment forms and assessment update forms, IRP forms, clinical formulation and clinical formulation update forms, progress note forms, transfer summary forms). It also includes the IRP process monitoring audit tool and will include the clinical chart audit tool once completed. It also includes tip sheets for stage of change, a checklist to ensure the conference covers all relevant issues and a timeline. The manual is available on all units.

4. The Hospital revised the template for the therapeutic monthly progress notes which will be used for the treatment mall and other treatment providers. The note is available in an electronic form and the fields adjust based upon the length of the note. It has been in use for several months.

5. The Hospital modified its IRP Process Monitoring tool to be consistent with the revised Policy and recommendations from the most recent DOJ report. The tool includes indicators and operational instructions. The tool was used for audits conducted in February, 2009. Earlier observations were done from July through September using the previous tool and the results are also found in the attachments. Observations from February indicate more IRP conferences are being timely held, but that the preparation work (completion of assessment and the case formulations) are not yet at the level expected.

6. The Hospital has not yet utilized the clinical chart audit tool. PID is working with direct care staff to finalize the tool, which is expected by end of March, 2009, so that quality content audits can begin in April, or May, 2009.

7. Disciplines (other than nursing) have developed a self audit tool to evaluate the completion of initial

assessments. Social work and rehabilitation services have completed audits and data is available. Psychology has completed its audit, but data should be available during the March 30, 2009 visit.

8. The Comprehensive Initial Psychiatric Assessment includes a risk assessment that evaluates multiple types of risks and requires assessment of mitigating factors and development of precautions. In addition, all admissions are screened for risk and cognitive impairment by psychologists. .

9. The Hospital has completed significant initial work around implementing positive behavioral support, including developing a policy, templates for PBS plans, structural and functional assessments and behavioral guidelines. Both psychology staff training and some unit based training has been initiated.

10. A transfer audit tool was developed for inter unit transfers, and an initial audit was completed.

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.

Findings

See sub cells.

Compliance Status: See sub cells.

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:

Findings

See sub-cells for findings and status.

Compliance Status: See sub cells.

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;

Findings

The Hospital has taken steps to move toward implementation of this requirement; implementation has begun on 10 of 18 units where treatment planning training is underway, although only five units have had sufficient training so that improvement in treatment planning is notable.

The Hospital revised its IRP policy and IRP forms to increase the focus on individualized and integrated treatment, and to incorporate additional recommendations of DOJ. Binder V, Tab # 1, (IRP Policy); Binder V, Tab # 2, (Initial IRP); # 3 (IRP). In addition, the Hospital developed forms titled "Clinical Formulation" and "Clinical Formulation Update", which, when completed, will serve as the case formulation. Binder V, Tab # 4 (Clinical Formulation), Tab #5 (Clinical formulation Update), The new IRP form is expected to prompt treatment staff to develop more individualized focus areas, objectives and interventions.

The Hospital also developed a draft IRP manual that provides a single source of relevant documents and guidance to treatment teams. The manual is still in draft as the Hospital is refining various tools and instruments, but the Manual's key components include relevant policies, a checklist for IRP conferences and well as key forms and

guidelines for the forms. However, until all units have completed training and had some time to implement the new forms, compliance is not likely. Binder V, Tab # 6 (IRP Manual).

The Hospital's Performance Improvement Department (PID) modified its IRP process tool based upon DOJ recommendations, and is observing IRP conferences; available data will be reported in the related sub cells. See Binder V, tab # 7 (IRP Process monitoring tool), tab # 8 (Results of IRP process monitoring). The revised tool incorporates indicators and operational instructions, but it has only been used once in its new format, so additional modifications are anticipated as reviewers identify issues. PID suspended observations in the Fall, 2008 because insufficient training had occurred, and therefore observations using the prior tool were not resulting in particularly useful data; not unexpectedly, treatment teams were not meeting expectations since they had not yet been trained. Observations were restarted in February, 2009, on the ten units which have had some degree of training (Five units have had substantial training, and five units have just begun training, so baseline information for those units will be available.)

The revised IRP process monitoring tool assesses individualized planning through two primary indicators, numbers 8 and 9. The clinical audit tool which is being revised with clinical staff and is expected to be completed by March 30, 2009, will also address this requirement. Observations of treatment plans reveal some notable improvement in individualizing and integrating treatment on units that have had the training, though some units are performing better than others which have had the same training. Overall however, hospital wide, IRP planning is not consistently individualized or interdisciplinary in nature, outcome focused or based upon a case formulation. As suggested by the results of the IRP observations, overall performance on this requirement is in the red or yellow zones, meaning significant improvement is needed. Tab # 8 (IRP Process Observation results).

Compliance Status: Some progress is being made toward the June 2010 compliance target date.

Recommendations			***Responsible Party***	
1) Apr 2008	***1*** *Same as in V.A.2 to V.A.5*		***PID; AS; Dr. Patterson***	
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in V.A.2 to V.A.5.			
	- Status: Same as in V.A.2 to V.A.5.			
	Not Identified			
1) Apr 2008	***2*** *Same as in V.B, V.C, V.D and V.E.*		***CVC; JH;***	
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in V.B, V.C, V.D and V.E		Same as in V.B, V.C, V.D and V.E.	
	- Status: Same as in V.B, V.C, V.D and V.E			
2) Dec 2008	***1*** *Same as in V.A.2 to V.A.5.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in V.A. 2 to V.A.5.			
2) Dec 2008	***2*** *Same as in V.B, V.C, V.D and V.E.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	2 Same as in V.B, V.C, V.D and V.E.			

V.A.2

be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:

Findings

The Hospital continues to be successful in recruiting psychologists and psychiatrists. In FY 2008 (10/1/07 - 9/30/08), ten psychiatrists and 12 psychologists were hired. As of 1/31/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009. See Binder V, Tab # 9 (HR report).

However, despite this success, the Hospital is not meeting required caseload ratios for psychiatrists. Census data from February 18th, 2009 shows that on 11 of 18 units, caseload ratios are met. On seven units, caseload ratios are not met. On three units, the caseload exceeds the standard by one patient. On one unit (CT3A/B), the caseload ratio exceeds the standard by 11 patients, although an additional psychiatrist was hired for one of these units, and began work on February, 23, 2009. The two JHP admissions units have only one full-time psychiatrist, and they exceed caseload ratios by 6 and 8 respectively. See Binder V, Tab # 10 (Caseload Summary Chart)

Although there are no specific requirements of caseloads for psychologists, there currently are sixteen psychologists (not including clinical administrators who are also psychologists) and two supervisors. Each ward is supported by a psychologist. See Binder V, Tab # 11 (List of Psychologists), tab # 11 (Psychology staff ward assignments)

Compliance Status: Progress is made toward the June 25, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Hire adequate psychiatrists and licensed clinical psychologists to assure compliance with this aspect of the DOJ agreement.*	***CVC; Medical; PID; AS; Psychology Department***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Enhance recruitment activities for psychiatrists and psychologists	9/30/2008	Feb 2009 Document: Binder V, tab # 9 (HR Report)	Medical Director, HR Director; Director; Director of Psychology
- Status: Six psychiatrists have accepted offers and will start between 7/1/2008 and 9/30/08. An additional offer is outstanding. Three psychologists were hired since 3/1/08 and recruitment is on-going for two additional clinical administrator psychologists. February 2009: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 1/31/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009 (October 2008)			
2 Produce bi-weekly recruitment status reports for Exec. Staff, using newly created HR database.	7/15/2008	Binder V, Tab # 9 (HR report)	HR Director
- Status: Produce bi-weekly report: A report showing the status of each clinical vacancy is produced at least bi-weekly and provided to the Executive Staff. It also includes new hires and separations. A comprehensive HR database is complete and has the capability of producing targeted reports focusing on specific occupations.			
3 Assess recruitment activities on a quarterly basis and refine strategies as needed	9/30/2008		HR Director
- Status: HR developed an annual recruitment plan which is assessed on an on-going basis.			
Not Identified			

2) Dec 2008 ***1*** *Continue with current efforts to hire requisite number of psychiatrists and psychologists*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with hiring efforts.			
- Status: See prior action steps			

2) Dec 2008 ***2*** *Clarify the differences in responsibilities between clinical administrators and team psychologists when a psychologist fills the position of clinical administrator.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review PDs for treatment team leader psychologist and clinical psychologist to ensure responsibilities are clear.	2/27/2009		Beth Gouse; Rose Patterson
Complete - Status: PDs were reviewed, and roles clarified with treatment team leader psychologists and Psychology Department psychologists			

V.A.2.a

assume primary responsibility for the individual's treatment;

Findings

Expectations of the treatment team leader are set forth in the IRP manual. Binder V, tab # 6 (IRP Manual). Included is a newly developed checklist that was recommended by DOJ and is designed to facilitate the IRP conference. Binder V, tab # 6(IRP Manual) Treatment planning training is nearly completed on 5 units, and is underway on 5 others. The remaining 8 units will begin training by the end of April, 2009.

The Hospital modified its IRP Process Monitoring Observation tool to reflect indicators and operational instructions and to capture data on this requirement. Binder V, Tab # 7 (IRP Process Monitoring Tool) The data from the most recent IRP observations shows that in 85% of IRP observations, a person was identified to be responsible for facilitating the meeting. See Binder V, Tab # 7 (Results of IRP Observation, February, 2009). The clinical administrator by position description is responsible for scheduling and coordinatin the meeting. As was the case in prior reports, those treatment team leaders which have had some treatment planning training are more effective in leading the conferences. No comprehensive IRP conferences were observed during the most recent observations. The Process Observations of IRP reviews attempted to evaluate the timeliness of assessments, however, the data is not valid as raters interpreted the question differently. This will be clarified before the audits begin in March, 2009.

Finally, data from the reviews show that the facilitator encouraged participation from all disciplines in 84% of cases, but that presentation of present status occurred only in 53% of cases and conferences are still not interdisciplinary in nature (37%) and a template is not being used (31% of cases), The data reflects only one set of observations in the last five months and observations were largely limited to the units that have had some degree of training, so results are somewhat skewed when compared with units that have had no training.

IRP observations occurred in July, August and September, 2008 and results were analyzed. Binder V, Tab # 8 (IRP Process Monitoring Results, Nov, 2008). Those results reflect the previous instrument. A decision was made to suspend observations beginning in October because it was clear that insufficient training had occurred and therefore the observations, based upon the new model for IRP planning, were not effective in measuring progress. Once the Hospital received a copy of the report and modified the IRP process monitoring tool, observations were restarted and will continue.

Compliance Status: Minimal progress is made toward the June 25, 2010 compliance date.

Recommendations	Responsible Party
1) Apr 2008 **1** *Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences.*	***CVC; JH; AS; Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize contract for consultation and training on Treatment Planning.	7/25/2008		DMH Contracts
Complete - Status: Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009.			
2 Provide Executive Staff, Program related Senior Staff and Clinical Administrators orientation and overview of treatment planning initiatives	6/30/2008		Chief of staff
Complete			
3 Expand training on treatment planning gradually throughout summer and fall to include at least 50% of treatment teams by end of calendar year, and all treatment teams by March, 2009	3/31/2009	Binder V, Tab # 2, # 3 (IRP forms-comprehensive and review) and Tab # (IRP manual)	Chief of staff
- Status: February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			

1) Apr 2008 ***2*** *Organize treatment planning conferences around a template that includes:* ***JH; BG;***

- *a Interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness;*
- *b Current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses and how and when to make changes in treatment and risk factors for exacerbation;*
- *c Discharge readiness and barriers to discharge; medication side-effects; and,*
- *d If applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise treatment planning policy to incorporate recommendations and obtain Executive staff approval.	7/31/2008	Binder V, Tab # 1 (IRP Policy (revised).	Director, Policy; CEO
Complete - Status: Policy was revised and approved by Executive staff; February 2009 Update: IRP Policy revised based upon DOJ report 2			
2 Create treatment plan protocol that reflect recommendations and policy	7/16/2008	Binder V , Tab # 6 (IRP manual)	Chief of staff
- Status: Conference protocol was drafted and staff are using it. Consultant A. Adkins provided comments which were incorporated. February 2009 Update: Conference Protocol revised per DOJ Report 2 Comments.			

1) Apr 2008 ***3*** *Provide treatment teams with training in how treatment planning is different from both assessment and treatment.* ***CVC; JH; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with vendor to provide competency based training to treatment teams that differentiates assessment, treatment planning and treatment	8/1/2008		DMH Contracts; Chief of Staff
- Status: Vendor identified and negotiations underway. Feb Update: Treatment planning training underway.			
2 Develop schedule with selected vendor to ensure at least 50% of treatment teams begin training by December, 2008, and remainder by March 31, 2009	12/31/2008		Chief of Staff; Civil and Forensic Directors
- Status: February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP 7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009			
3 Begin training for 4 teams; 4 additional teams to begin training in September, 2008	8/1/2008	Binder V, Tab # 12 (IRP training outline)	Chief of Staff, Forensic and Civil Directors
- Status: February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009			

1) Apr 2008 ***4*** *Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room.* ***CVC; JH; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with vendor to provide competency based training to treatment teams that differentiates assessment, treatment planning and treatment.	8/1/2008		DMH Contracts; Chief of Staff
- Status: Vendor identified and negotiations underway			
2 Develop schedule with selected vendor to ensure at least 50% of treatment teams begin training by December, 2008, with remaining teams to begin training by March 31, 2009	12/31/2008	Binder V, tab # 12 (IRP training outline)	Chief of staff; Civil and Forensic Directors
- Status: February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009			

3 Begin training for 4 teams in July, 2008, expand to 4 additional teams by September, 2008.	8/1/2008	Binder V, Tab # 12 (Training outline)	Chief of staff, Forensic and Civil Directors

- Status: February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP 7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009

2) Dec 2008 ***1*** *1. Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior action steps.			

2) Dec 2008 ***2*** *2. See all recommendations in V.B.1*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.B.1			

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;

Findings

In most case, the individual is attending the treatment plan conference, but the degree of participation varies widely. The new IRP process monitoring tool tracks both the participation of family members and community members and the individual. Binder V, tab # 7 (IRP process monitoring tool, indicators 7 and 8). Data shows the individual attended 95% of IRP conferences, and that family attended 10% of conferences, community workers attended 25% and other non Hospital personnel attended 20% of conferences. Binder V, tab # 8 (IRP Process Monitoring results, February, 2009). Further, data suggests that the treatment teams engaged the person in discussing objectives and interventions (82%), but did not do well in providing the individual with options around interventions (47%), and only performed marginally around reviewing barriers to discharge in each focus area.

These items were also tracked in the prior observations. According to those results, the individual attended in 97% of cases, family in 14% of cases, and 34% of community members were present in those conferences. Binder V, tab # 8 (IRP Process Monitoring results, November 2008). The earlier review also found that family members were invited in about 80% of cases. The prior review rated the quality of individual participation as marginal, as there was little discussion of life goals, strengths treatment objectives or interventions with the individual. These data may serve as a baseline to evaluate the quality of training, but reflect practice pre training.

IRP conferences were held in 81% of cases as scheduled; cancellations were largely due to court hearings and medical appointment for the individual. Binder V, tab # 8 (IRP Process Monitoring results, February, 2009)

IRP training includes training around engagement of the individual, as recommended by DOJ. Binder V, tab # 12 (IRP training curricula)

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Provide treatment teams with training in effective ways to engage individuals and their families in the treatment planning conference.* ***Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 See V.A.2.a			See Binder V, Tab # 12 (training outline)	
- Status: See V.A.2.a				
1) Apr 2008	***2*** *See cell V.A.2.a, Recommendation 4.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See V.A.2.a, Recommendation 4.			See V.A.2.a, Recommendation 4	
- Status: See V.A.2.a, Recommendation 4				
2) Dec 2008	***1*** *1. Continue with all past recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps.				
2) Dec 2008	***2*** *2. See recommendations in Section V.B.1*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps , Section V.B.1				

V.A.2.c

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;

Findings

Data reported in July, 2008 for the period of April - May, 2008, shows that progress notes were completed prior to the treatment plan conference by registered nurses in 31% of cases, by psychiatry in 19% of cases, and by social work in 13% of the cases. Data from the IRP process review for the July through September period showed that progress notes were completed prior to the IRP conference by nursing and psychiatry in 76% of cases, and by social work in 67% of cases. Data from the February 2009 observations around timeliness of assessments prior to IRP conferences appears to be invalid due to differing interpretations of the tool; this will be resolved prior to the next observations.

Several steps have been taken around completion of assessment updates prior to IRP conferences. The Assessment policy was revised to clarify documentation requirements before IRP conferences. Binder V, tab # 13 (Assessment policy). The IRP manual includes a timeline for pre IRP activities, which includes timelines for completing assessments prior to the IRP conference. Observations have noted some reduction in the amount of assessment occurring in the IRP conference (on those units that have had training), and a new strategy was added that is designed to also help - clinical administrators will meet with individuals before the IRP conferences to prepare them for the conference. See Binder V, tab # 6 (IRP manual). Other strategies include the clinical formulation/update which is to be completed before the IRP conference, which is based upon the results of the assessments/updates. Those are not yet implemented across the Hospital - the 5 units that have nearly completed training are using the new clincial evaluation and IRP forms. It is expected that the five units that have begun training will be routinely using the forms by the March, 2009 visit.

Finally, self audits by psychiatry, psychology, social work, nursing and rehab services are expected to also assist in ensuring assessments are completed prior to the IRP conference. Psychology, social work and rehabilitation services are the only disciplines yet completing self audits, but they are just focused on the Initial assessment and not the monthly notes. As they expand audits and other disciplines implement them, progress should be accelerated. Binder V tab # 14(Rehab self audit data). Tab # 15 (social work self audit data). (Psychology self audit data is not yet available but is expected by the March, 2009 visit.)

Rehabilitation services has implemented a "rounds" where they discuss the status of individuals up for IRP

conferences. This, with the revised monthly therapeutic progress note, is also expected to improve the update of interventions. Binder V, tab # 17 (Therapeutic monthly progress note)

Compliance Status: Some progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *See cell V.A.2.a, Recommendations 1 through 4.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps and status related to cell V.A.2.a, Recommendations 1 through 4.		See V.A.2.a	

- Status: See status related to V.A.2.a

1) Apr 2008	***2*** *Develop and implement a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about next steps when treatment has been successful or further assessments/changes to treatment when treatment has been unsuccessful. .*	***CVC; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Progress note template that can be used by all Mall groups and other groups as well.	6/30/2008	Binder V, Tab # 17 (Therapeutic Monthly Note Template)	Chief of staff

Complete - Status: Progress note template drafted and in use.
February 2009 Update: Recommendations in most recent DOJ report reflected in revised template.

1) Apr 2008	***3*** *Develop and implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates:* *a The name of the group/individual treatment;* *b The name of the group/individual treatment provider;* *c The name of the individual patient;* *d The short-term goal for which the individual has been assigned to the modality;* *e The number of attended sessions and offered sessions;* *f The quality of the individual's participation; and* *g The individual's progress toward achieving the stated short-term goal*	***CVC; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop progress note template for use by Treatment mall and other groups.	6/30/2008	Binder V, Tab # 17 (Therapeutic progress note template)	Chief of staff

Complete - Status: February 2009 Update: Recommendations in most recent DOJ report reflected in revised template.

1) Apr 2008 ***4*** *Develop and implement an auditing tool that monitors for all aspects of the progress note template.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop progress note template.	6/30/2008	Binder V, tab # 17 (Therapeutic monthly note template)	Chief of staff
Complete - Status: February 2009 Update: Recommendations in most recent DOJ report reflected in revised template.			
2 Develop auditing tool and operational instructions that reflect requirements of progress notes as defined by template.	9/15/2008	Binder V Tab # 18(List of tools to be developed); Tab # 19(SW Progress Note audit tool)	QID Director
- Status: February 2009 Update: Hospital is working with consultant around the redesign of treatment mall, and plan is to conduct audits to monitor progress notes. In the meantime, social work will begin conducting audits of progress notes completed by those disciplines.			
3 Train auditors on auditing tool and begin progress note audits.	10/14/2008		QID Director
- Status: No action taken. Audits will begin once tool developed.			
4 Collect and analyze data from audits and issue reports to Senior staff; First report within 45 days of 1st audit.	11/17/2008		Director, Monitoring Systems
- Status: No action taken			

1) Apr 2008 ***5*** *Train all auditors to acceptable levels of reliability.* ***PID; with assistance***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps V.A.2.c recommendation 4		See action steps V.A.2.c recommendation 4	
- Status: See action steps V.A.2.c recommendation 4			

1) Apr 2008 ***6*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.A.2.c recommendation 4.		See action steps in V.A.2.c recommendation 4.	
- Status: See action steps in V.A.2.c recommendation 4.			

2) Dec 2008 ***1*** *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with actions steps			

2) Dec 2008 ***2*** *Revise Mall Treatment Note Template to accurately assess all the elements in Recommendation 3 above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise mall treatment progress note	2/3/2009	Binder V, Tab # 17 (Revised therapeutic monthly note template)	Beth Gouse
Complete			

V.A.2.d **Findings**

require that the treatment team functions in an interdisciplinary fashion;

IRP trainers continue to work with teams around operating in an interdisciplinary as opposed to multi-disciplinary fashion. The IRP observation tool evaluates the interdisciplinary manner of a treatment team and looks to the presentation of assessments, present status. Binder V, tab # 7 (IRP Process tool). Data of February reviews shows that in 50% of cases, team members gave a concise presentation of present status and focused on the specific interventions they are providing and the individual's response thereto. In 60% of cases, the team members gave their perspectives regarding the individual's response to objectives and focus areas. Presentation of an assessment ranged from 83% of social workers to just 25% of rehabilitation services staff.

As noted previously, the observations only involved units with some degree of training, so the data does not yet represent the general Hospital practice. Observations will expand to all units over the next few months.

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *See cell V.A.2.a, Recommendations 1 through 4.*	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps and status related to cell V.A.2.a, Recommendations 1 through 4.		See action steps and status related to cell V.A.2.a, Recommendations 1 through 4	
	- Status: See action steps and status related to cell V.A.2.a, Recommendations 1 through 4			

1) Apr 2008	***2*** *Develop and implement a Treatment Team Process Monitoring Audit tool that assesses teams for their compliance to newly trained processes in how to organize and execute a treatment planning conference.*	***PID; BG; with consultants***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify previously provided IRP process tool to reflect recommendations and findings for baseline report.	4/30/2008	Binder V, Tab # 7 (Revised ITP Process tool)	Chief of Staff, QID Director
	Complete - Status: February 2009 Update: Tool revised incorporating comments from DOJ report 2 and piloted. February 2009 update: Tool modified to reflect DOJ report 2 comments.			
2	Pilot revised tool and modify as needed; February 2009 Update: Tool revised, and operational instructions developed.	6/2/2008	See action step 1	QID director
	Complete - Status: IRP tool was piloted and revised, operational instructions developed,			
3	Train auditors on new tool.	6/16/2008		QID director
	Complete - Status: Auditors trained. In an effort to improve inter-rater reliability, auditors will be meeting periodically to assess scoring consistency.			
4	Begin auditing process and provide report to senior staff	6/16/2008	Binder V, Tab # 8 (IRP Process results)	QID Director; Director, Monitoring systems
	Complete - Status: February 2009 update: Revised tool tracks more closely with IRP training being provided units. Tool is first being used on the units previously identified that have had training, and use will expanded to other units as they are trained.			

1) Apr 2008 ***3*** *Train auditors to acceptable levels of reliability on the above-described tool.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to V.A.2.d. recommendation #2		See action steps to V.A.2.d. recommendation #2	
- Status: See action steps to V.A.2.d. recommendation #2			

1) Apr 2008 ***4*** *See cell V.A.2.a, Recommendation 9.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps relating to cell V.A.2.a.		See action steps relating to cell V.A.2.a.	
- Status: See action steps relating to cell V.A.2.a.			

1) Apr 2008 ***5*** *Aggregate, trend and provide data to hospital administration, discipline chiefs and treatment teams as part of a process of ongoing performance improvement.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Collect data and analyze for the hospital administration on bi-monthly basis on ongoing basis; Trend Analysis includes updated information on participation. Additional information will be included and/or additional reports published as audit process continues. Upon initiation of AVATAR Phase II in Winter 2008-2009, additional data sources will be available.	7/16/2008	Binder V, Tab # 20 (Bi Monthly Trend Analysis)	OMS Staff
Complete			
2 Providing technical assistance to the Administration for data review			OMS Staff
Complete - Status: This is ongoing process			
3 Analyze results of IRP monthly treatment planning process audits and provide report to senior staff. First audits using revised tool completed in June, 2008, for 20% sample.		Binder V, Tab # 8 (IRP process results)	OMS Staff
Complete - Status: February 2009: IRP process audits were suspended pending IRP training, but were restarted in February for the five units for which training was completed. Additional units will be added as training is implemented.			

2) Dec 2008 ***1*** *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior action steps.			

2) Dec 2008 ***2*** *Be certain that auditing tool is revised according to recommended revisions to Treatment Conference Protocol.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update IRP Process audit tool to reflect updated IRP conference protocol and DOJ Report 2	2/25/2009	Binder V Tab # 7 (IRP Process tool, amended)	PID
Complete			

V.A.2.e

verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and

Findings

Progress has been made on integrating psychiatric and behavioral modalities.

First, psychology staffing now allows for psychologists to be assigned to units, and data from IRP observations shows psychologists in attendance at 60% of IRP conferences, as opposed to 45% during the prior observation period. Binder V, tab # 8 (IRP Process observation, February 2009), tab # 8 (IRP Process observation, November 2008) . Each unit in both forensic and civil services has a psychologist assigned to it, although some psychologists are covering more than one unit. See Binder V, Tab # 11(Ward assignments for all units).

Second, all patients on admission are now receiving a psychological screening which assesses risk and cognitive functioning. See Tab # 24 (Initial Psychological Assessment, A and B). A psychologist now discusses (and documents the discussion) the results of the initial psychological assessment with the psychiatrist, and are available on the units and during IRPs to interpret results.

Third, while behavioral plans have been developed since DOJ's last visit, it is recognized that these plans do not meet the DOJ requirements. However, substantial work has been undertaken to develop skills so the new plans will meet DOJ standards. Working with a consultant, psychology has developed a policy and procedure governing behavioral treatment programs, a template for behavioral guidelines, and templates for structural and functional assessments. Binder V, tab # 21(policy and procedure governing behavioral treatment programs), tab # 22 (template for behavioral guidelines), tab # 23 (templates for structural and functional assessments). These assessments, when implemented, will address the psychiatric and behavioral integration. In addition, the consultant is working with psychology staff to update previously developed plans to meet DOJ requirements.

In addition, the consultant has begun training psychology staff, RMB-3 unit staff, and provided an overview of PBS to all direct care clinical staff. All patients on admission are now receiving a psychological screening which assesses risk and cognitive functioning. See Tab # 24 (Initial Psychological Assessment).

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Compliance Status: Some progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and implement corrective actions to ensure proper integration of psychiatric and behavioral treatment modalities.*	***Medical; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Psychological evaluations will be signed by the team leader following discussion with the treatment team to assure that behavioral recommendations are integrated with psychiatric recommendations.	8/29/2008		Medical Director, Director of Psychology; Chief of staff

- Status: Contract with Dan Arnheim, behavioral consultant, will include training psychology staff on how to focus discussion in treatment planning on the integration of behavioral and pharmacological interventions.
February 2009 Update: New consultant Angela Adkins began consultation in Fall, 2008 and is working psychology staff and RMB 3 and 4 ward staff to train staff on behavior plans. In addition, she presented an overview of PBS to all clinical staff (it was videotaped) which covered the relationship between psychiatric and behavioral treatment modalities.

2 Training on treatment planning will include a component on building the treatment team's capacity to appropriately integrate psychiatric and behavioral treatment modalities.	8/31/2008	Binder V, Tab # 24 (Initial Psychological Assessment); Tab # 25 (Psychological evaluation)	Beth Gouse

Complete - Status: February 2009 Update: This is touched somewhat in the IRP training, but a decision was made to use the new consultant Angela Adkins instead. She began consultation in Fall, 2008 and is working psychology staff and RMB 3 and 4 ward staff to train staff on behavior plans. In addition, she presented an overview of PBS to all clinical staff (it was videotaped) which covered the relationship between psychiatric and behavioral treatment modalities. Further, psychologists are now meeting with treatment teams to report results of evaluations and screenings.

3 Psychologists are assigned to the majority of treatment units and it is expected there will be a psychologist on each unit by October 2008. This will provide for regular opportunity to review whether patients with behavioral problems need to have a behavioral support plan implemented.	10/31/2008	Binder V, Tab # 11 (Ward assignments by discipline)	Medical Director, Rose Patterson

- Status: The Chief of Psychology is in the process of interviewing for three additional positions. Selections are expected by August 31, 2008. February 2009 Update:

1) Apr 2008 *2 Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant above.* ***AS; Chief Nurse Executive; HR Director; Discipline directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Improve staffing. See V.A.2 rec.1.		See V.A.2	Chief Nurse Executive; HR Director; Discipline directors

- Status: See V.A.2

2 Identify contractor with capacity to work with treatment teams around behavioral supports and integration into treatment plans to supplement treatment planning training.	9/30/2008	Binder V, Tab # 26 (PBS training related curriculum)	CEO

- Status: February 2009 Update: Contract with Angela Adkins in place and she is working with RMB 3, the behavioral unit and with psychology staff around behavioral plans..

2) Dec 2008 *1 Develop and implement corrective actions to ensure proper integration of psychiatric and behavioral treatment modalities.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps		Binder V, Tab # (Psychological evaluation form page 3/4)	

- Status: A form has been developed that ensures treatment team understands and receives information from psychological assessments

2) Dec 2008 ***2*** *Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant in the previous report.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			

V.A.2.f

require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.

Findings

The IRP observation process is the method through which the Hospital monitors implementation of this requirement (Indicator One). Binder V, tab # 7 (IRP Process Monitoring tool). Data from the February 2009 review show that in 76% of cases, the IRP conference was scheduled within the time frame required by Hospital policy. Binder V, tab # 8 (IRP Process Monitoring Results, February, 2009). Eighty one percent of conferences were held as scheduled.

Data from the previous review showed that in 93% of cases, someone was identified to schedule the IRP conference, and that in 85% of cases, the IRP was timely scheduled (at that time, it was a 90 cycle), but only 63% of the IRPs occurred as scheduled. Binder V, tab # 8 (IRP Process monitoring results November, 2008).

The IRP Policy was revised and establishes clear responsibility for scheduling IRP meetings (the Clinical Administrator), as well as the time frames for IRP conferences. Additional clinical administrators have been hired which is expected to facilitate the scheduling of IRP meetings. Binder V, tab # 11 (Civil and Forensic ward assignments)

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify closed discharge review tools to include assessment of IRP	6/16/2008	Binder V, tabs # 7 (IRP Process tool Revised), # 8 (IRP Observation Results -July- Sept, 2008) and Tab # 8 (IRP Observation results February)	QID Director
Complete - Status: Tool modified, then slightly revised after initial reviews using new tool. Data from review using new tool is not yet available. February 2009 Update: IRP process reviews continued through September using old tool but were discontinued as IRP training had only just begun, and thus review were premature (prior reviews were sufficient to obtain baseline). Reviews restarted in February for the units that have had some training.			
2 Conduct review of 20% of charts of patients discharged in April and May, 2008 and publish results	7/16/2008	Binder V, tabs # 7 (IRP Process tool Revised), # 8 (IRP Observation Results -July- Sept, 2008) and Tab # 8 (IRP Observation results February)	QID Director; Director, OMS
Complete - Status: Records reviewed, results published. February 2009 Update: IRP reviews continued through September using old tool but were discontinued as training had only just begun, and thus review were premature (prior reviews were sufficient to obtain baseline). Reviews restarted in February for the units that have had some training			

3	Conduct observations of 20% of treatment plans scheduled in month of June and produce report	7/16/2008	Binder V, tabs # 7 (IRP Process tool Revised), # 8 (IRP Observation Results -July- Sept, 2008) and Tab # 8 (IRP Observation results February)	QID Director

Complete - Status: Attempts made to review 20% of all treatment plans scheduled. High rate of cancellations (27%). February 2009 Update: IRP reviews continued through September using old tool but were discontinued as training had only just begun, and thus review were premature (prior reviews were sufficient to obtain baseline). Reviews restarted in February for the five units that have completed training, and will begin in March for those units where training began in January.

4	Include assessment of IRP timeliness in the discharge review tool	12/17/2008	Binder V, Tab # 27 (Discharge Record review results)	PID

Complete

1) Apr 2008 ***2*** *Present data graphically as a process monitoring variable that can be trended.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue to use graph and charts in the monthly trend analysis	7/15/2008	Binder V, Tab # 20 (Bi Monthly trend analysis); Tab # 8 (IRP Process Observations -July - Sept), Tab # 8 (IRP process review - Feb, 2009)	OMS

Complete - Status: Trend analysis continues.

2	Ensure results of active and closed record audits include graphs and are trended	7/15/2008	See Binder V, tab # 27 (Discharge Records Audit Results); See Tab # 8 (IRP audit results)	

Complete - Status: Ongoing

1) Apr 2008 ***3*** *Make results available to hospital administration, discipline chiefs and treatment teams as a part of an ongoing performance improvement process.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide all reports to Senior staff, and post reports on the internet; .	7/21/2008	Binder V, Tab # 20 (Trend analysis); Tab # 8 (IRP Audit results)	OMS Director

Complete - Status: Reports are provided to senior staff; Posted on internet as well

1) Apr 2008 ***4*** *Train auditors to acceptable levels of reliability.* ***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Enter into contract with Consultant to work with staff to develop capacity to train auditors.	6/24/2008	Binder V, Tab # 28 (CV, Michael Hartley)	Chief of staff, DMH contracts

Complete - Status: Consultation began 6/2008; February 2009 update; New PID Director hired who will train auditors to ensure reliability

2	Consultant to work with QID director to develop training skills that will ensure auditing results are reliable	9/30/2008		QID director; Chief of staff

- Status: February 2009 update; New PID Director hired who will train auditors to ensure reliability

3	Develop indicators and operational instructions, working with consultant	8/29/2008		Chief of staff

- Status: IRP process observation tool provided to consultant. Working with consultant to prioritize development of instructions and indicators. February 2009 update; New PID Director hired who will train auditors to ensure reliability

1) Apr 2008 ***6*** *See cell V.A.2.a, Recommendation 9.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to cell V.A.2.a	See action steps to cell V.A.2.a		
- Status: See action steps to cell V.A.2.a			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps.			

V.A.3

provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;

Findings

Training in IRP development is largely completed for 5 units and is underway for an additional 5 units. All units will begin training by end of April, 2009. See Binder V, tab # 12 (training curricula for IRP)

Compliance Status: Some progress has been made.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See cell V.A.2.a, Recommendation 1.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See actions steps cell V.A.2.a, Recommendation 1.	See V.A.2.a, Recommendation 1		
- Status: See cell V.A.2.a, Recommendation 1			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps			

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

Findings

The Hospital IRP policy was modified per DOJ recommendations and provides for a treatment team that includes all Settlement Agreement (SA) identified disciplines. Binder V, tab # 1(IRP Policy). All units now have a psychiatrist, social worker, nurse, psychologist and clinical administrator assigned, although some psychologists cover more than one unit, as there are several nurse manager vacancies as well. Binder V, tab # 11 (Ward assignments, civil and forensic services).

IRP process monitoring from the period July to September, 2008, shows that IRP conferences include core treatment team members as follows: 97% patient, social worker 86%; RN 97%; psychiatrist 100% and clinical administrator 93% of the time. Binder V, Tab # 8 (Results of IRP process monitoring observations, Nov 2008). Data from the February 2009 observations show that IRP conferences include core treatment team members as follows: 95% patient, social worker 80%; RN 75%; psychiatrist 95% and clinical administrator 100% of the time. Binder V, Tab # 8 (Results of IRP process monitoring observations, Feb 2009).

Staffing ratios for psychiatry are met on 11 units and not met on 7 units, although a new psychiatrist started on February 23, 2009, so additional unit will meet staffing requirements. On three units, the caseload exceeds the standard by one patient. On one unit (CT3A/B), the caseload ratio exceeds the standard by 11 patients. The two

JHP admissions units have only one full-time psychiatrist, and they exceed caseload ratios by 6 and 8 respectively. See Binder VIII, Tab # 23 (Caseload Summary Chart); Tab # 23 (AVATAR caseload report)

Compliance Status: Some progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Provide data on the hospital's current progress toward achieving stable core team membership.*	***CVC; JH; PID; AS; Chief Nurse Executive; Discipline directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Fill critical vacancies in nursing, psychiatry, psychology and social work	7/31/2008	Binder V, Tab # 9 (HR hiring status report); tab # 11 (List of core team members by unit Forensic and Civil). Feb 2009 Status Document: Report of clinical hires: 8-2008 through 1-2009, Tab # 9	HR Director, Medical Director; Civil and Forensic Services Directors
- Status: The hospital filled many of its key management positions including the Director of Consumer Affairs, Director of Medical Affairs, Chief Nursing Executive, Chief Administrative Officer, Director of Co-Occurring Disorders, and has confirmed acceptances on several other key vacancies. February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists and 109 licensed and paraprofessional nursing staff were hired. As of 1/31/09, 2 psychiatrists and 1 psychologist and 17 licensed and paraprofessional nursing staff have been hired in FY 2009.			
2 Provide bi-weekly HR report to managers in order to track vacancies and recruitment	7/7/2008	Binder V Tab # 9 (Bi-Weekly Vacancy Report)	HR Director
Complete - Status: Produce bi-weekly report: A report showing the status of each vacancy is produced at least bi-weekly and provided to the Executive Staff. It also includes new hires and separations. A comprehensive HR database is in the final stages of development and will have the capability of producing targeted reports focusing on specific occupations.			
3 HR will provide on-board strength analysis by month for all clinical position types for FY 2008 through June 30, 2008.	7/7/2008	Feb 2009 Status Document: Report of clinical hires: 8-2008 through 1-2009, Tab # 9	HR Director
Complete - Status: February 2009 Status: In FY 2008, 109 licensed and paraprofessional nursing staff were hired and an additional 17 have been hired as of 1/31/09 in FY 2009.			
4 HR will provide a listing of all active Hospital positions for FY 2008 as of June 30th.	7/7/2008	Binder V Tab # 9 (Listing of active positions)	HR Director
Complete - Status: 52 positions were abolished this fiscal year leaving 1001 FTE positions available for recruitment			

1) Apr 2008	***2*** *Recommendations regarding the level of staffing for psychiatrists can be found in cell VIII.A.3.*	***Medical; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 HR will provide a report that lists all positions hired during FY 2008 through June 30th. Report will be updated every two weeks	7/7/2008	Feb 2009 Status Document: Report of clinical hires: 8-2008 through 1-2009, Tab # 9	Human Resources
Complete - Status: February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 1/31/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009.			

2 HR will provide a report listing all vacancies during FY 2008 though June 30th.	7/7/2008	Tab #9, (HR Report)	Human Resources

- Status: 8 new psychiatrists and one new General Medical Officer joined the hospital. Two additional psychiatrists have agreed to join the hospital by July 2009.
February 2009 Status: As of 2/13/09, there are 83 vacant positions. In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 2 psychologists have been hired in FY 2009.

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps.			

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.

Findings

See findings in V.A.2.f.

Compliance Status: See compliance status in V.A.2.f

Recommendations	***Responsible Party***
1) Apr 2008 ***1*** *See recommendations in cell V.A.2.f.*	***JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps relating to recommendations in cell V.A.2.f.	See cell V.A.2.f.		

- Status: See cell V.A.2.f.

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps			

V.B. Integrated Treatment Plans

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:

Findings

See sub-cells for findings.

Compliance Status: See sub cells for findings.

V.B.1

where possible, individuals have input into their treatment plans;

Findings

As noted, the IRP policy was revised to incorporate DOJ recommendations and other changes identified through implementation of the new IRP form. Binder V, tab # 1 (IRP policy).

A draft treatment planning manual is available to staff on units. It includes relevant policies, forms, guidelines, audit tools, checklists and tip sheets that are expected to improve individual's input into the IRP. Binder V, tab # 6 (IRP manual). The manual makes clear that assessments are to be completed prior to the IRP conference, and also provides guidelines on involving the individual in the IRP process and engaging him in identifying goals, objectives and interventions. Further, this has been a focus of the IRP training. Binder V, tab # 12 (IRP curricula). The checklist that is part of the manual and the guidelines are expected to assist the facilitator and other team members in ensuring the IRP proceeds in an organized method where the patient's present status, risk, objectives and

interventions are addressed.

In most case, the individual is attending the IRP conference, but the degree of participation still varies. The new IRP process monitoring tool tracks both the participation of family members and community members and the individual. Binder V, tab # 7 (IRP process monitoring tool, indicators 4 and 8). Data shows the individual attended 95% of IRP conferences, and that family attended 10% of conferences, community workers attended 25% and other non Hospital personnel attended 20% of conferences. Binder V, tab # 8 (IRP Process Monitoring results, February, 2009). The IRP review results suggest that individuals are providing some input into certain aspects of the IRP, but that in only 47% of cases did the individual get an opportunity to review options for interventions or chose interventions. Binder V, tab # 8.

These items were also tracked in the prior tool. According to those results, the individual attended in 97% of cases, family in 14% of cases, and 34% of community members were present in those conferences. Binder V, tab # (IRP Process Monitoring results, November 2008). The earlier review also found that family members were invited in about 80% of cases. The prior review rated the quality of individual participation as marginal, as there was little discussion of life goals, strengths treatment objectives or interventions with the individual. These data may serve as a baseline to evaluate the quality of training, but reflect practice pre training.

As previously noted in other requirements, the teams with person centered treatment planning training are performing better at engaging the individual in meaningful treatment and discharge planning, while many other teams still use the conference to obtain information from the individual. Making the treatment planning training available to all units is a key for compliance on this requirement. Improving engagement of individuals is expected to be included as part of the training.

Compliance Status: Some progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectations regarding the process of engagement of individuals in their IRPs.*	***AS; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete treatment plan conference template; finalize treatment plan policy;	6/30/2008	Binder V, Tab # 9 (IRP Manual)	Chief of staff
Complete - Status: Template is being reviewed by consultant and modifications will be made as appropriate. February 2009 Update: IRP conference protocol was revised per recommendations of DOJ report and IRP training consultants.			
2 Create tip sheets for case formulation, engagement of individuals and stages of change to include in treatment plan manual;	9/26/2008	Binder V, tab # 6 (IRP Manual)	Chief of staff
- Status: Tip Sheets created for Stages of Change. Sheet for Engagement of Individuals is being developed.			
3 Purchase person centered treatment planning book for all units;	7/31/2008		COO
- Status: Books have been ordered			

	4 Create treatment planning manual to include policy, conference template, tip sheets, and other key items to assist staff.	8/20/2008	Binder V, Tab # 6 (IRP Manual)	Beth Gouse

Complete - Status: Draft manual being reviewed and changes are expected. 'February 2009 Update: Draft Manual is complete.

1) Apr 2008 — *2 Develop and provide a training module focused on Engagement of Individuals. The purpose is to ensure that the individuals provide substantive input in the formulation and revisions of treatment objectives and interventions.* — ***Medical; BG; Chief Nurse Executive; Discipline directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Enter into contract with vendor to provide treatment planning training that includes engagement of individuals in their treatment plan;	7/16/2008	February Update: Binder V, Tab # 12 (IRP Training outline)	DMH contracts; Chief of Staff

Complete - Status: Contract negotiations underway. Expected to be finalized by August, 2008 and training to begin in August, 2008. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009

2 Monitor patient engagement through treatment plan conference observation	6/30/2008	Binder V, Tab # 7 (IRP process monitor tool, revised); Tab # 8 (IRP process results, Feb, 2009)	QID director

- Status: Tool is being used but ward staff have not been trained, so first is baseline report February 2009 Update: IRP process audits were suspended pending IRP training, but were restarted in February for the five units for which training was completed. Additional units will be added as training is implemented.

1) Apr 2008 — *3 Provide summary outline of the above training including information about instructors, participants and training process and content (didactic and observational).* — ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Once training begins, collect information that reflects content of training, instructor qualifications and participant lists	9/10/2008	Binder V, Tab # 12 (training outline); Tab # 29 (instructors cv)	Chief of staff

- Status: Training was initiated on five units since September 2008 and an additional six units begin training in January 2009. The training includes both didactic and observational opportunities

1) Apr 2008 — *4 Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.* — ***PID; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training database to document competency-based training results for all aspects of training (annual, bi-annual, new employee, and subject specific training recommended by DOJ;	9/15/2008		Training, PID

- Status: Program analyst has been assigned to work with training to create database.

2 Develop and generate summarized training results;	12/31/2008	None at this time	PID, Training

- Status: no steps yet taken.

3 Provide and present aggregate data twice a year .	12/31/2008	None at this time	PID
- Status: no steps yet taken.			
4 See recommendation from V.A.2.D.Recommedation 5		None at this time	
- Status: See recommendation from V.A.2.D.Recommedation 5			

1) Apr 2008 — ***5*** *Implement an IRP process observation monitoring tool with indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies.* — ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate recommendations of DOJ into revised IRP process monitoring tool	6/2/2008	Binder V, tab # 7 (Revised IRP process monitoring tool)	QID Director
Complete - Status: February 2009 Update: Revised tool developed and is being piloted on five units for which training is completed.			
2 Work with consultant to develop operational instructions and indicators and perfect tool	8/13/2008	Binder V, tab #7 (Revised IRP process monitoring tool)	QID Director
- Status: Consultant on board as of June 23, 2008. Will provide comments and recommendations on tool, which will be implemented as appropriate. February 2009 Update: IRP process monitoring tool revised to include DOJ report 2 recommendations and operational instructions, under leadership of PID director			
3 Pilot tool and report results.	6/2/2008	Binder V, Tab # 8 (Results of IRP process monitoring)	
- Status: Tool has been piloted and revised based upon initial feedback. Results of first review are available. February 2009 update: IRP process reviews continued through September using old tool but were discontinued as IRP training had only just begun, and thus review were premature (prior reviews were sufficient to obtain baseline). Reviews restarted in February for the units that have had some training.			

1) Apr 2008 — ***6*** *Present process observation data, to address this requirement based on at least 20% sample (March to August 2008).* — ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify team of reviewers and train same.	6/2/2008		PID,
Complete - Status: Small cadre of staff identified and trained.			
2 Conduct monthly reviews, starting with 20% sample and report on same to Senior staff	6/30/2008	Binder V, Tab # 8 (IRP process monitoring report, july to Sept) Tab # (IRP review report, February, 2009)	QID director
Complete - Status: Reviews ongoing, sample size is 20%. February 2009 Update: IRP process reviews continued through September using old tool but were discontinued as IRP training had only just begun, and thus review were premature (prior reviews were sufficient to obtain baseline). Reviews restarted in February for the units that have had some training.			

2) Dec 2008 — ***1*** *Develop and implement an IRP Policy/Procedure/Manual that includes appropriate expectations and operational guidance regarding the process of engagement of individuals in treatment planning.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in IRP training skill development around engagement of individuals	5/29/2009	Binder V, tab # 12 (IRP training curriculum)	Beth Gouse
- Status: Ongoing			

2 Include in IRP Manual information about engagement of individuals		Binder V, Tab # 6 (IRP Manual)	Beth Gouse

- Status: IRP manual is in draft

2) Dec 2008 ***2*** *Develop and implement a training module focused on Engagement of Individuals. This training must ensure that the individuals provide substantive input in the formulation and review and revisions of treatment objectives and interventions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for V.B.1 (dec 2008 recommendations)			

2) Dec 2008 ***3*** *Provide summary outline of the above training including information about instructors, participants and training process and content (didactic and observational).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide requested information.		See Binder V, Tab # 121 (Training outline); Tab # 29 (trainers cv);	

2) Dec 2008 ***4*** *Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.* ***BG; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Devlelop system to collect results competency based training data.	3/31/2009	None	Beth Gouse, Shelita Snyder

- Status: Present plan is to collect data on competencies through peer review and IRP process monitoring. Work is on-going with training consultants to develop system for evaluating core member competencies.

2) Dec 2008 ***5*** *Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP Process Observation tool to address quality of input into objectives and interventions.	2/26/2009	Binder V, Tab # 7 (IRP process tool, revised)	PID

Complete

2) Dec 2008 ***6*** *Monitor this requirement using process observation data based on at least 20% sample (October 2008 March 2009).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monitor through IRP process observation on 20% sample	2/27/2009	See Binder V, tab # 8 (IRP review results)	PID

- Status: IRP tool was revised, and is being used to monitor those units for which IRP training is complete. Additional units (those that began training in January) will begin being audited by late March, 2009.

2) Dec 2008	*7 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.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide immediate feedback to units observed.			
- Status: Ongoing			
2 Provide summary data to Senior staff and analysis that meets requirements.	4/30/2009		PID
- Status: No progress to report.			

V.B.2

treatment planning provides timely attention to the needs of each individual, in particular:

Findings

Please see sub-cells for findings.

Compliance Status: See sub cells for compliance findings.

V.B.2.a

initial assessments are completed within 24 hours of admission;

Findings

The Hospital's Assessment policy was updated and the timeframes required by the Agreement (as modified by Agreement of the parties, [Comprehensive IRPs to be completed in 7 calendar days]) is incorporated. Binder V, tab # 13 (Assessment policy) New initial assessment forms have been updated for social work, rehabilitation services, psychology and psychiatry but not nursing, which is still being revised. Binder V, See Tab # 31 (Social work initial assessment) , Tab # 32(Rehabilitation Services Initial Assessment), Tab # 24 (Initial Psychological assessment, part A and B), and Tab # 34 (Comprehensive 24 hour Psychiatric Assessment). A psychiatric update form has also been developed. Binder V, tab # 35 (Psychiatric update). The most recent version of the forms were introduced by disciplines and began being used in January, 2009, so in many cases, they are just beginning to be found in the charts and thus the content of assessments is not yet able to be evaluated. Anecdotally, a small sample review suggests that the new assessment forms are improving the quality of assessments, but the results of audits by disciplines will provide more information as they are rolled out.

The revised IRP process tool attempts to evaluate compliance with timely completion of initial assessments for each discipline. However, in many cases, the individual has been a patient for a number of years, and consequently initial assessment information is not particularly relevant to evaluate how the Hospital is doing on this requirement. The tool also reviews completion of assessment updates and progress notes. However data from the most recent IRP process monitoring concerning timeliness of assessments updates were not valid, due to differing interpretations of the question; this will be resolved before the next round of reviews.

In addition, discipline audit tools have been developed by all disciplines (except nursing) for review of initial assessments. Binder V, tab # 36 (Psychiatry initial assessment audit tool and guidelines); tab # 37 (Psychology audit tool and guidelines); tab # 38 (social work audit tool and guidelines); tab # 39 (rehab audit tool and guidelines). These tools also review assessments for timeliness. Tools have only been implemented for social work and rehabilitation services; [Binder V, tab # 15 (SW audit results), tab # 14 (Rehab audit results)]; psychiatry is piloting and still revising the tools so data are not yet available. Data from the psychology self audits should be available by March 2009 visit. Nursing is working to finalize the initial nursing assessment; an audit tool is not available at the present time.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Finalize the draft Policy and Procedure #602-08, Assessments to specify timeliness and content requirements for all initial/admission disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment).*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy to incorporate timeliness and content requirements.	6/15/2008	Binder V, Tab # 13 (Assessment policy (revised))	Director, Policy
Complete - Status: Timeliness and content requirements have been incorporated into Assessment policy document. Consultant A. Adkins is reviewing discipline specific assessment forms and will provide comments. The discipline specific steps set out below may be modified based upon consultant's comments. February 2009 Update: The Assessment policy was modified to incorporate comments from DOJ report 2. Discipline specific assessment forms were modified as needed.			
2 Approval by Exec staff	7/16/2008		CEO
Complete - Status: February Update: Revised policy approved.			

1) Apr 2008	***2*** *Develop self-assessment monitoring tools to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment).*	***CVC; JH; PID; BG; Trg; Chief Nurse Executive; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Social Work will develop a new Social Work Initial Assessment and guidelines for its use.	5/30/2008	Binder V, Tab # 31 (Social Work Initial Assessment and Guidelines, revised) February 2009 Update: Final, approved initial assessment completed. Began being used in January, 2009.	Wilhoit / Richardson
Complete - Status: Assessment completed May 2008. Following DOJ visit in September, Assessment revised and elements recommeded by DOJ Monitor and Chief of Staff added. Final Initial Assessment approved December, 2008. February 2009 Update: Final, approved initial assessment completed. Began being used in January, 2009.			
2 Train social work staff in use of new Social Work Initial Assessment	5/30/2008		Wilhoit / Richardson
Complete - Status: February, 2009 Update: New instrument reviewed with social work staff			
3 Pilot Social Work Initial Assessment on selected civil admission units (RMB 5 & 6) and forensic pre-trial admission units (JHP 6 & 7) for two weeks.	6/16/2008		Wilhoit / Richardson
Complete - Status: Pilot testing completed September 11, 2008. February 2009. New form used beginning January, 2009. No need for pilot based upon modifications.			
4 Based upon results of pilot, revise Social Work Initial Assessment if indicated.	7/30/2008	Final Initial Social Work Assessment approved December 2008	Wilhoit / Richardson
Complete - Status: See V.B.2.a.1			

5	Implement revised Social Work Assessment hospital wide	8/4/2008		Wilhoit / Richardson
Complete - Status: Initial revised social work assessment implemented September 2008. Final, revised, approved assessment implemented December 8, 2008				
6	Develop self-assessment monitoring tool to assess timeliness and quality of Social Work Initial Assessment	5/30/2008	Bidner V, Tab # 38 (Social Work Assessment Peer Review Tool (Revised)).	Wilhoit / Richardson
Complete - Status: February 2009 Update: Monitoring tool revised based upon recommendations DOJ Compliance Officer. Tool submitted to consultant for approval.				
7	Revise self-assessment monitoring tool if indicated	7/30/2008	Binder V, tab # 38 (Social Work Assessment Peer Review Tool)	Wilhoit / Richardson
Complete - Status: February 2009 Update: Monitoring tool revised based upon recommendations DOJ Compliance Officer.				
8	Implement monthly self-assessment monitoring on 20% of all Social Work Initial Assessments	8/4/2008	Binder V, Tab # 15 (Analysis of Social Work Assessment Peer Review)	Wilhoit / Richardson
- Status: not yet initiated. February 2009 Update: Initial set of reviews conducted late January, February, 2009				
9	Rehabilitation Services will develop a new Rehabilitation Services Initial Assessment and guidelines for its use.	3/31/2008	Binder V, Tab # 32 (Rehabilitation Services Initial, Revised and Final Assessments and Guidelines)	Coleman / Robinson
Complete - Status: Revised after two pilot testings, Final approved December 5, 2008				
10	Train Rehabilitation Services staff in use of new Rehabilitation Services Initial Assessment	4/30/2008		Coleman / Robinson
Complete - Status: Staff were trained on revised instrument following each pilot testing. Staff will be trained on final, approved instrument in January 2009, training will be completed by January 31, 2009				
11	Pilot Rehabilitation Services Initial Assessment on selected civil admission units (RMB 5 & 6) and forensic pre-trial admission units (JHP 6, 7 & 9) for a minimum of 12 weeks	8/29/2008	Binder V, Tab # 14 (Data analysis report of second pilot testing completed 10/10/08)	Coleman / Robinson
Complete - Status: Initial Assessment was piloted for 6 weeks as of June 13th. Second pilot completed 8/31/08. February 2009 update. Tool revised one more time and is now ready to be used.				
12	Based upon results of pilot, revise Rehabilitation Services Initial Assessment if indicated.	9/15/2008	Binder V, tab # 32 (Revised Rehabilitation Services Assessment form)	Coleman / Robinson
Complete - Status: Final revision completed and approved by Chief of Staff December 5, 2008.				
13	Implement revised Rehabilitation Services Assessment hospital wide	9/29/2008	None	Coleman / Robinson
- Status: February 2009 Update: To meet CMS requirements, the Civil Program has been using the piloted version since 11/1/08. Due to staffing shortages in the Forensic Program (only 2 certified clinicians), implementation has been postponed pending approval of final version while acitvely recruiting certified clinicians. Final, approved assessment implemented hospital wide February 1, 2009				

14	Develop self-assessment monitoring tool to assess timeliness and quality of Rehabilitation Services Initial Assessment	3/31/2008	Binder V, Tab # (September 2008 revised self-assessment monitoring tool)	Coleman / Robinson
Complete - Status: February 2009 Update: Following pilot testings, self-assessment monitoring tool revised. Will be implemented February 2009				
15	Pilot self-assessment monitoring tool on 50% of assessments conducted in Action Step 11. Revise self-assessment monitoring tool if indicated	9/15/2008	Binder V, Tab # 32 (Report of Rehabilitation Assessment Data Analysis dated 10/10/08).	Coleman / Robinson
Complete - Status: February 2009 Update: Completed for second revised instrument by 9/15/08.				
16	Implement monthly self-assessment monitoring on 20% of all Rehabilitation Services Initial Assessments	9/29/2008	None	Coleman / Robinson
- Status: February 2009 Update: Scheduled to begin February 2009				
17	Revise Initial Nursing Assessment	2/27/2009	Binder V, Tab # 33 (Nursing Assessment Revised)	VPD
- Status: February 2009 Update: Nursing assessment revisions are being made.				
18	Submit revised Nursing Assessment to Dr. Gouse for review	2/27/2009		VPD
Complete				
20	Develop Nursing Assessment guidelines	3/27/2009	Not yet available, expected by March 30, 2009	VPD
Complete - Status: February 2009: New guidelines will be developed to reflect new assessment tool.				
21	Develop Self-auditing Tool	7/15/2008		VPD
- Status: February 2009 Update: No progress				
22	Revise NSP 300-Documentation of Nursing Process	5/15/2009	None	VPD
Complete - Status: February 2009 Update: Will be reviewed and modified as needed to reflect new tool. Expected to be completed by May 15, 2009.				
23	Train Nursing Staff	3/30/2009		VPD
- Status: February 2009 Update: Not yet completed for new assessment form. Target completion date is March 30, 2009				
24	Three month pilot of new assessment tool on Admission Units	8/29/2008		VPD
- Status: February 2009 Update: CNE is considering broader implementation. Will likely use tool across hospital.				
25	Department of Psychology will develop an Initial Psychological Assessment	6/2/2008	Binder V, Tab # 24 (Copy of initial psychology assessment, revised)	R Patterson
Complete - Status: February 2009 Update: Initial Psychological Assessment modifed.				
26	Psychology will obtain the necessary assessment tools for distribution to staff who will pilot the IPA	6/30/2008		R Patterson
Complete - Status: Funds were finally earmarked and order was sent				
27	IPA will be piloted in at least 2 admission areas - for 3 weeks	7/31/2008	Binder V, Tab # 24 (Copy of initial psychology assessment, revised)	R Patterson
Complete - Status: Awaiting arrival of the testing supplies. February 2009 Update: Pilot completed, tool was revised.				

28 Changes made to IPA based on results of pilot, if needed	8/22/2008	Binder V, Tab # 24 (Copy of initial psychology assessment, revised)	R Patterson
- Status: February 2009 Update: Pilot completed, tool was revised.			
29 Psychology Assessment Committee will present an in-service to staff re: proper use of the results of the IPA	8/26/2008	Binder V, Tab # 40 (Minutes from Psychology Meeting)	R Patterson
Complete			
30 Develop guidelines for use of IPA	8/22/2008	Binder V, Tab # 24 (Psychology Guidelines, IPA)	R Patterson
Complete - Status: February 2009 Update: Completed			
31 Develop self-auditing tool for IPA	8/31/2008	Binder V, Tab # 37 (Self-auditing tool for IPA)	R Patterson
Complete - Status: February 2009 Update: Completed			
32 Do a peer review on 20% of IPA completed in September and October	11/15/2008		R Patterson
- Status: Not started. February 2009 Update: Peer review tool was developed but no peer review completed.			
33 Psychiatry to develop revised initial psychiatric assessment	7/16/2008	Binder V, Tab # 36 (New psychiatric initial assessment form)	Mecical Director
Complete - Status: February 2009 Update: Completed			
34 Train psychiatrists in use of new Initial Assessment	8/22/2008		Medical Director
- Status: February 2009 Update: Initial assessment presented			
35 Pilot psychiatry Initial Assessment on selected units	8/29/2008		Medical Director
- Status: February 2009 Update: Form was piloted on admission units beginning December, 2008.			
36 Based upon results of pilot, revise psychiatric comprehensive initial Assessment if indicated.	9/10/2008	Binder V, Tab # 34 (Comprehensive Initial Psychiatric Assessment form)	Medical Director
- Status: February 2009 Update: Form revised slightly			
37 Implement revised psychiatric Assessment hospital wide	9/30/2008	Binder V, tab # 35 (Psychiatric update)	Medical Director
- Status: February 2009: Comprehensive initial assessment form for psychiatric assessments utilized hospital wide. Forms for reassessment/update also developed.			
38 Develop self-assessment monitoring tool to assess timeliness and quality of psychiatric Initial Assessment	10/30/2008	Binder V, tab # 36 (Self audit tool; instructions); Binder V, tab # (Results of self audit)	Medical Director, Manager of Peer review and Standards
- Status: February 2009: Self audit tool developed (Comprehensive initial psychiatric assessment) and piloted			
39 Revise self-assessment monitoring tool if indicated	11/28/2008		Medical Director
- Status: February 2009 Update: Pilot underway			
40 Implement monthly self-assessment monitoring on 20% of all psychiatry Initial Assessments	12/19/2008		Medical Director
- Status: February 2009: Initial audit conducted for one month.			

Not Identified

1) Apr 2008 — ***3*** *Present monitoring data regarding the timeliness and quality of each disciplinary assessment based on at least 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment).* — ***Medical; PID; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.B.2.a.			Discipline chiefs
2 With Office of Monitoring Systems, analyze and report data to senior staff, Medical Staff Executive Committee and discipline chiefs.		See V.B.2.a documents of results of peer review	Discipline chiefs, Director, OMS

- Status: Within 45 days of the reviews. February, 2009 Update: Peer reviews largely just beginning, so OMS had only recently conducting analysis.

1) Apr 2008 — ***4*** *Ensure that the initial treatment plans are completed with an inter-disciplinary input, including, at a minimum, psychiatry, nursing and medicine.* — ***PID; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Treatment Planning policy	6/15/2008	Binder V, tab # 1 (IRP Policy)	J. Taylor
Complete - Status: February 2009 Update: Policy updated.			
2 Final approval of policy	7/16/2008	Binder V, tab # 1 (IRP Policy)	CEO
Complete			
3 Develop revised initial treatment plan form	7/16/2008	Binder V, tab # 2 (Revised initial IRP plan form)	Chief of staff
Complete - Status: February 2009 Update: New form developed that includes input from psychiatry, nursing and medicine.			
4 Work with Consultant to develop audit tool to monitor appropriate content of completion of initial treatment plan.	5/1/2009	Binder V, Tab # 7 (IRP Process monitoring tool)	QID director
- Status: Consultation began June, 2008. Priority list of tools being developed. February Update: Timeliness and completion by all required disciplines is incorporated into the IRP Process Monitoring Tool.			
5 Begin auditing to evaluate whether requirements for initial IRPs is being met; .	12/1/2008	Binder V, tab # 7 (IRP Process monitoring tool)	Medical Director
- Status: Will begin within 45 days of completion of audit tool. February 2009 Update: This will be audited through the			

2) Dec 2008 — ***1*** *Ensure that Policy and Procedure #602-08 includes appropriate timeframes regarding completion of the psychiatric reassessment s (at least weekly during the first 60 days of admission and monthly thereafter).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise assessment policy to ensure appropriate timeframes	2/27/2009	Binder V, Tab # 13 (Assessment policy)	PID
Complete			

2) Dec 2008 ***2*** *Implement revised Policy and Procedure #602.1-08.* ***CVC; JH; Medical; PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement policy.	3/2/2009		
2 Monitor timeliness of discipline assessments through IRP Process Monitoring.	2/27/2009	Binder V, Tab # 7 (IRP Process Monitoring tool)	PID
Complete			
3 Report results of review	3/31/2009	Binder V Tab # 8 (IRP Process Monitoring Results)	PID
- Status: Initial results reported			

2) Dec 2008 ***3*** *Develop self-assessment monitoring tools that include complete indicators and operational instructions to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of the Agreement regarding each disciplinary assessment).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop self assessment monitoring tool to assess timeliness of assessments	2/27/2009	Binder V, Tab # 7 (IRP Process Monitoring Tool)	
Complete			
2 Develop audit tools to look at content of social work, rehabilitation, psychology, psychiatry and nursing assessments	2/27/2009	Binder V, Tab # 36 (Audit tool Psychiatry), Tab # 37 (Audit tool Psychology), Tab # 38 (Audit Tool Social Work), Tab # 39 (Audit Tool Rehab)	
- Status: February 2009: Audit tools for all disciplines completed. Audits completed for social work, psychology and psychiatry, but not for nursing or rehabilitation			

2) Dec 2008 ***4*** *Monitor the timeliness and quality of each disciplinary assessment using the disciplinary assessments monitoring tools based on at least a 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement self assessments for each discipline assessment	2/2/2009	Binder V, tab # 15 (Audit Results Social work); # 16 (Audit results psychiatry), # (Audit results psychology).	Wilhoit?richardson; Parham Dudley; Arons; Patterson; Robinson/Coleman
- Status: February 2009: Self audits began for social work, psychiatry and psychology. Set to begin for Rehab and nursing by March			

2) Dec 2008 ***5*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action step to recommendation #4 above			

2) Dec 2008	***6*** *Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See action step to recommendation # 3 above			

V.B.2.b

initial treatment plans are completed within five days of admission; and

Findings

Since the last report, the IRP policy was revised, and requires that IRPs be held within 24 hours, 7 calendar days, 28 calendar days, day 60 and then every 60 days thereafter. The Hospital is implementing the 60 day requirement.

A new initial IRP form has been developed that integrates the nursing, psychiatric and general medical officer treatment interventions into a single document. See Binder V, Tab # 2 (Initial IRP form); # 3 (IRP Form/Update). The IRP manual has been drafted and is now available to staff. Data shows that of the comprehensive IRP conferences, 89% were scheduled within 7 calendar as required by policy. Binder V, tab # 8 (IRP Process results).

The IRP process observations include a review of the medical record to assess the timeliness of initial assessments and initial treatment plans. Timeliness data is only now available and that eighty one percent (81%) of IRPs were held as scheduled, but only 76% were scheduled in accordance with the Hospital policy. In some cases, delays were by a day or two only. Timeliness data is not available from the prior audit, but cancellation data shows no improvement in the percentage of conference cancelled. Binder V, tab # 8 (IRP Process results).

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectation that the comprehensive IRPs are completed within five days of admission.*			***BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Finalize revisions to treatment plan policy.	7/16/2008	Binder V, Tab # 1 (IRP Policy)	Director, Policy; CEO
	Complete - Status: February 2009 Update: Policy revised			
	2 Develop treatment planning manual.	7/31/2008	Binder V, tab # 6 (IRP manual)	Chief of Staff
	- Status: Consultant is assisting in development of manual. Some aspects are completed, but additional work is needed. This will be provided once the manual is completed. February 2009 Update: IRP manual in draft form			
1) Apr 2008	***2*** *Develop a clinical auditing tool with indicators and operational instructions to monitor the timeliness of the initial and comprehensive IRPs.*			***PID; BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Consultant to review draft clinical chart audit tool for comments and suggestions, and consultant to provide guidance on development of operational instructions	3/31/2009	None	Chief of staff; PID
	- Status: Draft tool is under review by consultant for comment. February 2009 Update: Tool is being reviewed with clinical staff and is expected to be finalized by March 30, 2009			

2 Revise clinical chart auditing tool after consultation with clincial staff to be consistent with policy and to incorporate suggestions as appropriate	3/31/2009		QID director
- Status: Expected to occur in February and March, 2009			
3 Train clinical chart auditors and implement audits	4/30/2009		
- Status: Not yet begun			

1) Apr 2008 ***3*** *Present chart auditing data (March to August 2008) based on at least 20% sample regarding the timeliness of the comprehensive IRPs.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train clinical chart auditors and begin audits by September 30, 2008	9/30/2008		QID, Medical Director, Discipline Directors
- Status: No clinical chart audits have begun. February 2009 Update: Clinical audit tool is being reviewed with clinical staff and is expected to be finalized by March 30, 2009.			

2) Dec 2008 ***1*** *Implement the revised Policy ##602.2-04 regarding this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP policy to incorporate comments	2/26/2009	Binder V, tab # 1 (IRP Policy)	
Complete			

2) Dec 2008 ***2*** *Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions regarding this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise per the recommendation	2/27/2009	See Binder V, Tab # 7 (IRP Process Monitoring Tool)	PID
Complete			

2) Dec 2008 ***3*** *Monitor the timeliness of the comprehensive IRP based on at least 20% sample (October 2008 to March 2008).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement IRP Process monitoring using IRP Process monitoring tool	2/19/2009	Binder V, Tab # 8 (IRP Process results)	PID
- Status: Ongoing (Note, 20% implementation will be phased in on wards as IRP training progresses)			

2) Dec 2008 **4** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement IRP Process monitoring using IRP Process monitoring tool and report results	2/27/2009	Binder V, Tab # 8 (IRP Process results)	PID

- Status: Ongoing (Note, 20% implementation will be phased in on wards as IRP training progresses)

V.B.2.c

treatment plan updates are performed consistent with treatment plan meetings.

Findings

The initial IRP process tool tracked the timeliness of the IRP and also whether there is a person identified with responsibility for scheduling the IRP conference; but the new tool does not track it in the same manner. Instead, it tracks whether the IRP was scheduled appropriately. Binder V Tab # 7 (IRP Process Monitoring Tool). Data shows that in July to September, 2008, in 93% of the cases reviewed, there was clear accountability for the scheduling and coordination of treatment plans; in February, 2009, using the new tool, in 76% of cases, the IRP conference was scheduled within hospital policy timeframes. See Tab # 8 (Results from IRP Observations). The reason for the change is that the clinical administrators are charged with scheduling and coordinating the IRP conference, so there is no reason to track whether someone has been identified to schedule it. However, the Hospital still tracks whether the conference was scheduled timely and whether it was held in a timely manner.

Compliance Status: Some progress is being made toward the June, 2010 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 **1** *Ensure that the self-assessment process observation tool includes an indicator and operational instruction that addresses the identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP process monitoring tool to incorporate DOJ recommendations.	6/2/2008	Binder V, Tab # 7 (IRP Process Monitoring Tool)	QID director

Complete - Status: Tool includes evaluation of whether someone is responsible for scheduling conference

2 Work with consultant to develop operational instructions and indicators that conform to policy.	8/29/2008		QID Director

- Status: Ongoing.

1) Apr 2008 **2** *Monitor this requirement using the process observation tool based on at least 20% sample (March to August 2008).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Requirement monitored for 20% sample of treatment plans scheduled.	6/30/2008	Binder V, Tab # 8 (Results of IRP Process Observations)	QID director

Complete - Status: Monitoring used draft tool. Twenty percent sample completed. February Update: IRP Process tool revised. 20% sample limited to wards with IRP training.

	2 Provide results to senior staff	8/1/2008	See above	

2) Dec 2008 *1 Develop IRP Process Observation Monitoring Form that includes complete indicators and operational instructions that specify the following:*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise and implement IRP Process form to meet recommendations	2/27/2009	Binder V, Tab # 7 (IRP process monitoring tool)	PID

2) Dec 2008 *a. The required frequency of the reviews, e.g. 24 hours (initial), five business days (comprehensive), monthly (for the next 60 days) and 60 days (thereafter).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise and implement IRP Process form to meet recommendations	2/27/2009	Binder V, Tab # 7 (IRP process monitoring tool)	PID

Complete

2) Dec 2008 *b. The identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Revise and implement IRP Process form to meet recommendations	2/27/2009	Binder V, Tab # 7 (IRP process monitoring tool)	PID

Complete

2) Dec 2008 *2 Monitor this requirement using the process observation tool based on at least 20% sample (October 2008 top March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Requirement monitored for 20% sample of treatment plans scheduled.		Binder V, Tab # 9 (Results of IRP Process Observations)	PID

- Status: Ongoing.
February Update: IRP Process tool revised. 20% sample limited to wards with IRP training.

2) Dec 2008 *3 Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement IRP Process monitoring using IRP Process monitoring tool and report results	2/27/2009	Binder V, Tab # 8 (IRP Process results)	PID

- Status: Ongoing (Note, 20% implementation will be phased in on wards as IRP training progresses)

V.B.3

individuals are informed of the purposes and major side effects of medication;

Findings

The Hospital modified its IRP form to specifically include a "consent for treatment." Binder V, Tab # 3 (IRP Form) The intent is that the psychiatrist will obtain informed consent to medications, but that the team will work with the

individual on obtaining informed consent on other interventions. In addition, the Office of Consumer Affairs recently began conducting satisfaction surveys with discharged individuals, which includes a question concerning medication side effects. Binder V, tab # 41 (Discharged consumer satisfaction survey). The survey tool is being piloted in anticipation of a larger, hospital wide satisfaction survey which will include several questions concerning medication. Per the recommendations of DOJ, the Hospital removed the questions about medication and side effects from the IRP process observation tool, and it will be included in the clinical chart audit tool that is being finalized.

The revised comprehensive psychiatric assessment includes a pharmacological plan of care.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Ensure that the clinical chart audit tool contains an indicator and operational instruction regarding this requirement of the Agreement.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Requirement is included in process monitoring tool until clinical chart audit begins..	3/31/2009	None	QID staff
- Status: 20% sample of scheduled treatment plans were reviewed. February 2009 Update: Clincial chart audit tool is not yet in use. PID staff are working with clinical staff to finalize it, which is expected by March, 2009			
2 Report results of whether patients are being informed of medication risks and benefits.	7/16/2008		
- Status: February 2008 Update: No clinical chart audits.			

1) Apr 2008	***2*** *Present clinical chart audit data based on at least 20% sample (March to August 2008) regarding compliance with this requirement.*	***CVC; JH; Medical; PID; Chief Nurse Executive; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize clinical chart audit tool/operational instructions with input from consultant.	8/29/2008		Chief of staff; QID director
- Status: No clinical chart audits have occurred. Consultant is reviewing draft tool. Feb. 2009 Update: No clinical chart audits have occurred.			
2 Train auditors and begin audits at 10% sample size and increasing to 20% sample size by December, 2008.	9/30/2008		Discipline chiefs, Medical director, QID Director
- Status: No progress yet.			
3 Report results of audits	11/10/2008		OMS Director, Discipline chiefs
- Status: Will be provided within 45 days of completion of audit.			

1) Apr 2008 *3 Provide the facility's procedure regarding the process and content of informed consent.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify IRP forms to provide informed consent at time of treatment plan conference and have patient sign IRP form	9/1/2008	Binder V, tab # 2, 3 (IRP Forms)	Chief of staff
- Status: No process is yet in place. February 2009. Informed consent is now part of the IRP process.			
2 Revise treatment plan form to provide for documentation of informed consent	8/27/2008	Binder V, Tab # 2, 3 (IRP form)	Chief of Staff
Complete			

2) Dec 2008 *1 Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID to work with clinical staff to revise clinical audit tool and to develop indicators and operational instructions.	2/27/2009		PID, Medical Director, Discipline chiefs

2) Dec 2008 *2 Monitor this requirement using clinical chart audit based on at least 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Upon completion of clinical audit tool, implement clinical audit reviews using a 20 % sample	5/11/2009		Medical director, Discipline chiefs
- Status: No progress to date			

2) Dec 2008 *3 Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Within 30 days of completion of monthly audits, prepare analysis and submit to senior staff	6/30/2009		PID
- Status: No action taken yet			

2) Dec 2008 *4 Provide the facility's procedure regarding the process and content of informed consent.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate informed consent into IRP process	2/27/2009	Binder V, tab # 2, 3 (IRP Form); Tab # 6 (IRP Manual)	beth Gouse
Complete			

V.B.4 **Findings**

each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;

See V.D.1, V.D. 2 and V.D.3 (goals and objectives); V.D.4 and 4 (interventions)

Compliance Status: See related sub cells.

Recommendations			***Responsible Party***
1) Apr 2008	***1*** *Same as in V.D.1, V.D.2 and V.D.3*		***JH;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same action steps as in V.D.1, V.D.2 and V.D.3 *- Status: Same as in V.D.1, V.D.2 and V.D.3*		Same as in V.D.1, V.D.2 and V.D.3	
1) Apr 2008	***2*** *Same as in V.D.4 and V.D.5*		
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same action steps as in V.D.4 and V.D.5 *- Status: Same as in V.D.4 and V.D.5*		Same as in V.D.4 and V.D.5	
2) Dec 2008	***1*** *Same as in V.D.1, V.D.2 and V.D.3.*		
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.D.1, V.D.2 and V.D.3.			
2) Dec 2008	***2*** *Same as in V.D.4 and V.D.5.*		
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.D.4 and V.D.5.			

V.B.5

the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;

Findings

The Hospital policy titled "Seclusion and Restraint for Behavioral Reasons" requires the Medical Director to review incidents of use of seclusion or restraint that are: 1) for more than 12 hours; 2) more than twice in a 24 hour period; and 3) 3 or more times in a thirty day period. Under current procedures, the Medical Director gets a report of use of seclusion and restraint. Binder V, Tab # 42 (Seclusion and Restraint for Behavioral Reasons policy)

The Performance Improvement Department (PID) reviewed a sample of 24 episodes ofseclusion or restraint. Among the areas reviewed was whether the cases triggered review by Medical Director, and if so, was there evidence of review. The survey showed that in general, while there are cases that should trigger the review by the Medical Director, there is little evidence documented in the records that any review occurs. See Tab # 43 (Restraint and Seclusion Audit Data Analysis) However, the Medical Director reports that he reviews the seclusion and restraint log and identifies high risk cases. The data shows that in none of the cases in which the Medical Director triggers were present was there evidence of consultation or a response documented in the medical record. See Tab # 43 (Restraint and Seclusion Audit Data Analysis).

The Hospital has not developed or implemented a comprehensive system of risk management triggers and thresholds and levels of intervention and review, although it has identified three high risk indicators and additional ones are expected this month after PIC meeting set in March. At that meeting ,the agenda includes decision on the proposed high risk indicators and the setting of performance goals.

Compliance Status: No progress is being made toward the June, 2010 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in XII.E.2.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same action steps as in XII.E.2.	Same as in XII.E.2		
	- Status: Same as in XII.E.2			
2) Dec 2008	***1*** *Same as in XII.E.2.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in XII.E.2.			
2) Dec 2008	***2*** *Develop and implement a mechanism to assess compliance with this requirement.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Review review by Medical Director (or designee) of high risk cases to be measured through S/R audit process and through Involuntary Medication review process	2/27/2009	Binder V Tab # 43 (Seclusion/restraint audit results)	PID,. Office of consumer affairs
	- Status: High risk cases involving s/r are reviewed through S/R audit tool and findings reported.			
2) Dec 2008	***3*** *Provide documentation of the purpose and results of the Medical Director's review of the use of seclusion and/or restraints during the reporting period.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			

V.B.6

mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;

Findings

The Compliance Officer's Status Report in July, 31, 2008 remains accurate, in that Forensic Services implemented its policy of ensuring all post-trial cases are presented to the Forensic Review Board at least once per year. It also modified the template for FRB reports to include at the beginning of each report risk factors leading to initial hospitalization and current risk factors, as well as ensuring these are addressed in the body of the report and in the conclusion. In addition, it has developed a system to document and track the implementation of FRB recommendations.

Chief, Post-trial Services is working with clinical administrators so that the Review Board reports reflect the new template and appropriately address risk. He also conducted a review of records to evaluate the follow up by treatment teams to Review Board recommendations. His review revealed that in 86% of the cases, the feasible Review Board recommendations were implemented; another 6% were in process, and between 6-8 % had not been implemented. Binder V, Tab # 44 (Summary of Responses to Review Board recommendations.)

Compliance Status: Substantial progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop a template for all FRB clinical reports that is more clearly focused on the assessment of risk factors. Identify a section early in the report that describes the risk factors that were responsible for the individual's forensic hospitalization, and any risk factors that have developed while the individual has been hospitalized and*	***JH;***

impact movement to a less restrictive level of care. Treatment while hospitalized can then address progress in managing/ameliorating those risk factors and what interventions have been successful/unsuccessful in that regard. Finally, the individual's current status on each risk factor can then be addressed, as well as treatment strategies for ameliorating current risk.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify Forensic Review Board (FRB) format to identify, in the beginning of report, risk factors responsible for initial hospitalization and risk factors currently present that impact on progression to less restrictive environment. Presence or absence of risk factors to be prominent in body of report with conclusion of report summarizing current status of risk factors, successful and unsuccessful treatments and plans to further reduce risk factors.	5/16/2008		R. Morin
Complete			
2 Revise FRB policy to be consistent with new FRB report format.	6/6/2008		R. Morin / J. Prandoni
Complete			
3 Train Forensic Clinical Administrators to utilize new FRB Report format. Training to include Chief of Post Trial Branch reviewing all FRB reports prior to presentation to FRB and providing feedback to clinical administrators.	8/29/2008		R. Morin

- Status: Feb, 2009 Update: Chief, Post-trial branch continues to work with clinical adminsitrators to ensure that reports reflect the new template and appropriately address risk. Forensic Review Board reports of clinical administrators continue to be reviewed by the Chief of the Post-Trial Branch (chairman of the FRB) and feedback supplied to the clinical administrators in order to improve quality of report, particularly regarding risk factors. In addition, overall length of report is being shortened primarily by reducing the section titled "Hospital Course" by providing historical information in more summary form. Basic format of report remains as outlined in FRB policy to provide complete picture of patient so that the FRB can make appropriate recommendations along multiple dimensions.

1) Apr 2008 **2** *Develop a system for assuring case review/consultation occurs for individuals who fail to make timely progress toward lesser restrictive levels of care, that the recommendations of such consultations and the treatment team's responses to these recommendations are documented in the individual's medical record and that higher levels of review occur if individuals continue not to make progress.* ***JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train Forensic Clinical Administrators to utilize new FRB Report format. Training to include Chief of Post Trial Branch reviewing all FRB reports prior to presentation to FRB and providing feedback to clinical administrators.	4/1/2008		R. Morin
Complete - Status: See Feb 2009 update of V.B.6.1.3			
2 Revise FRB Policy to ensure that FRB recommendations are documented in the medical record and that the treatment team's response to the recommendations is also documented in the medical record.	6/6/2008		R. Morin
Complete			

1) Apr 2008 **3** *Develop a monitoring system to collect, aggregates and analyzes the data necessary to assure that Recommendations 2 and 3 are implemented and reviewed. Make the data from this process available to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement.* ***JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop internal monitoring system to ensure treatment teams respond to FRB recommendations.	5/15/2008		R. Morin
Complete			
2 Incorporate internal monitoring system into FRB Policy.	6/6/2008		R. Morin / J. Prandoni
Complete			
3 Institute quarterly monitoring of all treatment team response to FRB forms (Form SEH 302.02.08B) for those cases in which treatment team has 30+ days to respond to the recommendation.	9/15/2008	Binder V, Tab # 44 (September and December 2008 Report of Responses to Review Board Recommendations.)	R. Morin

- Status: First Quarterly Review to be completed by Target date, Reviews ongoing. February 2009 Update: Quarterly monitoring of all treatment team response to FRB recommendations (Form SEH 302.02.08B) for those cases in which the team has had 30+ days to respond is being done by the Chief of the Post-Trial Branch. The first quarterly review was done in September of 2008 and covered 6/24/08 to 8/31/08. The second report was completed in December of 2008 (9/08 thru 11/08). Feedback was provided by the Chief of the Post-Trial Branch to those clinical administrators having recommendations that needed response. The Chief will also monitor completion of those recommendations.

4	Refer all cases in which an inadequate response to FRB recommendations are found to Forensic Clinical Administrator for corrective action. Corrective actions to be reviewed in subsequent monitoring.	9/19/2008	Binder V, Tab # 44 (September and December 2008 Report of Responses to Review Board Recommendations.	R. Morin

- Status: Feedback from first Quarterly Review to be provided to clinical administrators by target date. February 2009 Update: Feedback was provided by the Chief of the Post-Trial Branch to those clinical administrators having recommendations that needed response. The Chief will also monitor completion of those recommendations.

2) Dec 2008 ***1*** *Continue with all above recommendations*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue with all action steps			

2) Dec 2008 ***2*** *Assure that the Risk Factors section of each FRB submission contains a list of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. These should be presented without commentary, but may be introduced by a sentence or two indicating if the risk factors were determined through the use of particular risk assessment tools. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk factor should again be listed and updated based on the findings in the body of the report. This section is also the appropriate section to report current scores from actuarial risk assessment instruments.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Chief, Post-trial, will continue to work with Clinical Adminstrators as to correct format and increased focus on risk factors.			Chief, Post-tri
	- Status: Onoing			
2	Review Board will enforce policy through requesting revisions to reports that do not address risk factors with sufficient information.			
	- Status: Ongoing			
3	Chief, Postrial will develop instruction sheet for use by clinical administrators in developing reports. It will specifically address risk factors and rationale sections, monthly requirements for presentations, methods of streamlining reports and manner in which reports are presented to Review board.	3/20/2009		
	Not Identified			

V.B.7 **Findings**

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;

See V.E.3, 4 and 5 and Section VIII.

Compliance Status: See related section

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *The review of non-pharmacological treatment interventions is addressed in subsections V.E.3, V.E.4 and V.E.5 and in section VIII (Specific Treatment Services). Please refer to those sections for compliance findings and recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See action steps in V.E.3, 4 and 5 and Section VIII *- Status: See V.E.3, 4 and 5 and Section VIII*	See V.E.3, 4 and 5 and Section VIII		
2) Dec 2008	***1*** *Same as in V.E.3, V.E.4 and V.E.5.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in V.E.3, V.E.4 and V.E.5.			
2) Dec 2008	***2*** *Same as in VIII.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VIII.			

V.B.8

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

Findings

The Hospital revised the Transfer policy to include a requirement that transfer notes address barriers to discharge, review of risk factors and plan of care. See Binder V, Tab # 45 (Transfer of Patients policy). Additionally, the transfer audit tool to track compliance with the policy was revised and instructions were developed. See Binder V, tab # 46 (Inter-unit transfer audit tool with instructions). The tool specifically looks to determine if "barriers to discharge", review of risk factors, and plan of care are addressed in the psychiatric note. An audit was conducted in January, 2009. Results show that 100% of the transfer progress notes for interunit transfers included current diagnosis, review of risk factors and brief hospital course, but 0% addressed barriers to discharge, anticipated benefit of transfer or rationale for the individual's transfer. Binder V, tab # 47 (Transfer Audit results).

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Ensure that Policy #602.1-08, Assessments includes requirements regarding the timeliness of Inter Unit Psychiatric Assessments and their content. The content must address the following:* *a Identifying data;* *b Anticipated benefits of transfer;* *c Brief history;* *d Brief course, including medical;*	***CVC; Medical; PID; Chief Nurse Executive***

e Review of risk factors;
f Current diagnosis;
g Barriers to discharge; and
h Plan of care

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Assessment policy to include requirements for timeliness and obtain approval by Exec staff.	6/15/2008	Binder V, Tab # 13 (Assessment policy)	Director, Policy; CEO
Complete - Status: Timeliness requirements have been incorporated into assessment policy document. Feb 2009 Update: Revise Assessment policy			
2 Develop policy on Patient Transfer to outline content requirements.	7/15/2008	Binder V, Tab # 45 (Transfer Policy)	Director, Policy, CEO
Complete - Status: Policy and transfer summary form has been developed with content requirements.			

1) Apr 2008 ***2 Develop and implement a self-assessment inter-unit transfer tool to ensure timeliness and proper content of these assessments.*** ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft audit tool and submit for review by consultant; obtain assistance with operational instructions development.	7/31/2008	Binder V, tab # 46 (Patient Transfer Audit Tool)	QID director
Complete - Status: Draft audit tool will be forwarded to consultant. She will provide comment and assist in development of operational instructions and indicators. *Feb 2009 Update: Transfer audit tool developed*			
2 Finalize audit tool by incorporating recommendations of consultant			QID director
- Status: Will begin within 30 business days of final tool			
3 Train auditors and begin audits	10/8/2008	Binder V, Tab # 47 (Transfer audit results)	QID director
Complete - Status: Status will begin within 30 business days of final tool.			
4 Analyze data and provide report	11/21/2008	Binder V, Tab # 47 (Transfer audit results)	Director, Monitoring Systems
- Status: Status report within 45 days of audit.			

1) Apr 2008 ***3 Present monitoring data regarding psychiatric inter unit transfer assessments based on at least 20% sample (March to August).*** ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to V.B.8.2.		See action steps to V.B.8.2.	PID,
- Status: See action steps to V.B.8.2.			

2) Dec 2008 ***1*** *Ensure that revised policy regarding inter-unit transfers contains additional documentation requirements that include:*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise transfer policy to include risk factors, plan of care and barriers to discharge in documentation requirements.	2/27/2009	Binder V, tab # 45 (Transfer policy)	PID
Complete			

2) Dec 2008 *a) Review of risk factors;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action step			

2) Dec 2008 *b) Barriers to discharge; and*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 see prior action step			

2) Dec 2008 *c) Plan of care.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 see prior action step			

2) Dec 2008 ***2*** *Monitor this requirement using the inter-unit transfer assessment tool based on at least 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop audit tool that includes these factors	2/2/2009	Binder V, Tab # 46 (Transfer audit tool)	PID
Complete			
2 Implement audit	2/27/2009	Binder v, Tab # 47 (results of transfer audit)	PID
Complete - Status: ongoing			

2) Dec 2008 ***3*** *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			

V.B.9

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

Findings

See findings in V.B.1-8.

The IRP process monitoring tool tracks the existence and timeliness of discipline assessments and progress notes as well as timeliness of the IRPs and participation in the IRP conferences, but it does not evaluate the content of assessments, progress notes or the IRP itself. The tool includes review of leadership of the IRP conferences,

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.

indicators 3 and 10. See Binder V, Tab # 7 (IRP process monitoring tool). For the period of July to September, 2008, assessments or progress notes were completed prior to IRP conference in just over two thirds of the cases for nursing, psychiatry and social work, but less than twenty percent for other treatment providers. Binder V, tab # 8 (IRP process monitoring results, July-Sept, 2008).

Unfortunately, data about timeliness of completion of asssessment updates prior to IRP conferences is not available from the most recent review. The tool asks observers to check on the timeliness of assessment updates, and whether the correct form was used, data collected was not valid due to differing interpretations of the data. Binder V, tab # 8 (IRP Process monitoring results, February, 2009) Some observers credited an assessment update if it was present in the record but on the incorrect form, but others only credited the assessment update if it was in the record and on the correct form.

The quality of notes will be addressed in the clinical chart audits (which have yet to begin) as well as discipline specific audits, which have yet to begin. The audit form is being finalized in March, 2009 after input from clinical staff. IRP conferences were timely held in 76% of cases.

All disciplines except nursing have developed audit tools to review the content of initial assessments. Binder V, tab # 36 (Psychiatric audit tool/instructions); tab # 37 (psychology audit tool/instructions); tab # 39 (rehab services audit tool/guidelines); tab # 38 (social work audit tool/guidelines). Social work also developed audit tools to evaluate content and quality of progress notes and assessment updates, tab # 48 (SW audit tool progress notes), tab # 49 (SW audit tool assessment updates) and rehabilitation services, psychology, and social work conducted initial assessment audits. Binder V Tab # 14 (Results of Rehab Services initial audit); tab # 15 (Results of SW initial audit). Results of Psychology audit will be available by March 30, 2009. Social work audits show that 95% of initial social work assessments are completed within 5 days; for rehabilitation services, 26% were completed within 4 days, 53% completed within 7days, and 16% within 10 days of admission. However, for rehabilitation services, due to staffing, only 46% of new admissions were receiving a rehabilitation assessment.

Other audit tools developed include audit tools for monitoring discharge planning, tab # 50 (Discharge planning audit tool), tardive dyskinesia, tab # 51 (TD audit tool), and high risk medication chart review audit, tab # 52 (Medication chart review audit tool). Audit results are available for discharge planning audits, tab # 27 (Discharge audit results); tab # 53 (High risk medication chart review audit results)

An automated information system which will permit data collection by practitioner across all aspects of care is expected to be rolled out in phases. This system, when fully implemented by Fall, 2009, will provide data on timeliness and comprehensiveness of assessments, updates and progress notes. The Hospital hired crystal report writers that will assist in developing reports that will allow for assessment on timeliness of assessments and treatment plans in an on-going manner.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *See corresponding sections of the Agreement that address items 1 through 8 outlined by this expert consultant above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 See action steps relating to corresponding sections of the Agreement that address items 1 through 8.

- Status: See action steps relating to corresponding sections of the Agreement that address items 1 through 8.

2) Dec 2008 *See corresponding sections of the Agreement that address items 1 through 9 outlined above by this expert consultant.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See corresponding sections of the Agreement that address items 1 through 9 outlined above by expert consultant.			

V.C. Case Formulation

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 individu

Findings

See individual cells for findings.

Compliance Status: See individual cells for findings.

V.C.1

be derived from analyses of the information gathered including diagnosis and differential diagnosis;

Findings

The Hospital has modified its IRP policy and IRP forms to ensure a case formulation occurs, and meets DOJ requirements. Binder V, tab # 1 (IRP Policy). In addition new IPR forms, clinical formulation form and clinical formulation update forms were developed and are to begin being used March 1, 2009. Binder V, tab # 3 (IRP form), tab # 4 (clinical formulation form); tab # 5 (clinical formulation update). The clinical formulation, once implemented, will serve as the case formulation and update. Finally, Indicator 6 in the IRP process monitoring tool, development of a clinical formulation, monitors if a clinical formulation was timely completed but does not evaluate the quality of the formulation. Binder V, tab # 7 (IRP Process monitoring tool). The clinical formulation tool includes historical review and evaluation of the 6 Ps, current clinical data including risk, report of pharmacological interventions and their success, input from the individual being served, and then prompts the author to integrated the historical and current data around goals of hospitalization, how factors identified may influence clinical situation and treatment, and identification of discharge needs and barriers.

Despite the work on the process and development of the framework, case formulations (using the form) are not yet occurring for most IRPs but staff will be completing them beginning March 1, 2009.

IRP training for 5 units is largely completed, five began training in January/February, 2009, and the remaining will begin training by April, 2009. All units will be provided an overview of the training and forms in March, 2009, and following that orientation, mentoring, observations and medical record review will begin. Binder V, tab # 12 (IRP training overview). Training includes support around the clinical formulation.

The IRP manual is in final draft, has been reviewed with treatment teams and is available on the units. The manual includes all relevant policies and forms, audit tools and instructions, "tip sheets" around the 6 Ps, stage of change and other subjects.

The Director, PID, is working with direct care clinical staff to address the issues raised in the report around the content of the clinical audit tool but to date no revised draft is ready. No clinical chart audits have occurred, but the

tool is expected to be finalized by end of March 2009.

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation.*	***AS; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop treatment plan manual and incorporate tip sheet information into the Treatment Planning Manual	8/15/2008	Binder V, Tab # 6 (IRP manual)	CEO; Chief of Staff
Complete - Status: Manual is in draft and case formulation guidance information has been incorporated into draft IRP manual. The manual is under review by the consultant. Changes will be made as appropriate. February 2009: Revised IRP manual to reflect new form and process			
2 Provide copies of person centered treatment book to all units.	8/1/2008		COO
- Status: Books have been ordered.			

1) Apr 2008	***2*** *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning.*	***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with consultant to conduct treatment planning training for 50% of units by December 31, 2008; Remaining units to be trained by March 31, 2009.	7/31/2008		DMH contracts
- Status: Status contract negotiations underway. Possible trainers identified and training is expected to resume in August, 2008. Feb. 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			
2 Begin staff training by August 15, 2008	8/15/2008	Binder V, tab # 12 (IRP training curricula outline)	Chief of staff
- Status: Feb. 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009			
3 Develop schedule that ensures all staff are trained by March 31, 2009	9/19/2008		Chief of staff
- Status: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009			

1) Apr 2008 ***3*** *Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain training outline, summary of qualifications of trainers and list of participants	9/10/2008	Binder V, tab # 12 (training curricula outline), Tab # 29 (CV of all trainers)	Chief of staff
- Status: Will be provided once training begins. Feb 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			

1) Apr 2008 ***4*** *Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.B.1 recommendation 4			

1) Apr 2008 ***5*** *Develop and implement a clinical audit tool that contains complete indicators and operational instructions.* ***PID; BG; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Submit draft clinical chart audit tool to consultant for review and comments; obtain assistance in developing operational instructions and indicators.	6/25/2008		Chief of staff
- Status: Review on-going by consultant; Feb update: Clinical chart audits have not begun. Tool is being reviewed with clinical staff.			
2 Incorporate comments, finalize tool indicators and operational instructions.	8/29/2008		QID director
- Status: Feb update: Status will follow receipt of clinical staff comments.			
3 Train auditors and begin reviews	9/30/2008		QID director, Discipline chiefs, Medical Director
4 Hire Manager of Peer Review and Standards to manage clinical audit and peer review processes	9/30/2008		Medical Director; COO
- Status: PD is under development and expected to be complete by August 15, 2008. Feb. 2009: Position is not filled or advertised.			

1) Apr 2008 ***6*** *Present chart audit data to address compliance with this requirement based on at least 20% sample (March to August 2008).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze results and present data to senior staff	11/27/2008		OMS
- Status: Feb. Update: Reviews have not started			

2) Dec 2008 ***1*** *Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop IRP manual	2/27/2009	Binder V, tab # 6 (IRP Manual)	Beth gouse
Complete - Status: IRP manual drafted			

2) Dec 2008 ***2*** *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop and implement IRP training	2/27/2009	Binder V, tab # 12(Training curricula outline)	beth gouse
- Status: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			

2) Dec 2008 ***3*** *Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action step		Binder V, tab # 12 (training curricula) Tab # 29 (CV of trainers)	

2) Dec 2008 ***4*** *Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 None identified			
- Status: None identified			

2) Dec 2008 ***5*** *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Work with clinical staff to revise clinical chart audit tool	3/31/2009		PID
- Status: Ongoing			
2 Include instructions and indicators in clinical chart audit tool	3/31/2009		Pid
- Status: Not yet completed			
3 Utilize tool and begin chart audits	4/30/2009		medical director, discipline chiefs
- Status: Not yet begun			

4 Provide summary results of audit on ongoing basis	6/10/2009		PID
- Status: Not yet begun			

2) Dec 2008 ***6*** *Monitor this requirement using the clinical chart audit tool based on at least 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See previous action steps			

2) Dec 2008 ***7*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See previous action steps			

V.C.2

include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 same as February, 2008			

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;

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Same as above.

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in February 2008			

V.C.4

consider biochemical and psychosocial factors for each category in Section V.C.2., supra;

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in February 2008			

V.C.5

consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in February 2008			

V.C.6

enable the treatment team to reach determinations about each individual's treatment needs; and

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in February 2008			

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.

Findings

Same as V.C.1

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in February 2008			

V.D. Individualized Factors

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:

Findings

See individual sub-cells for findings.

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;

Findings

The Hospital remains in the early implementation of this requirement, mostly due to the fact that only five units to date have had substantial IRP training and the new assessment forms, which are designed to elicit more individualized data, are only just being used, but performance is better than it was several months ago. The majority of IRPs are not truly individualized and do not reflect individualized needs of patients. Some IRPs continue to have goals that are generic such as "patient will not have any assaults", "patient will be free from delusions", "patient will complete ADLs" or "Patient will accept medications" and are otherwise compliance driven. Three plans that were reviewed from one unit all had the same discharge criteria - - "will be discharged when no longer dangerous to self or others". Many plans do not include enrichment activities. However, there are also records that suggest progress is being made. For example, in one case, the social work assessment highlighted the educational accomplishments of an individual as a strength, and the IRP reflected that in the objective. But truly using the individual strengths in identifying objectives and interventions is still not occurring regularly.

The IRP Process Monitoring review (using the modified tool with indicators and instructions) evaluated some aspects of individual involvement in the development of objectives and interventions. Binder V, tab # 8 (IRP Process Monitoring Results). Observations of IRP conferences found that the treatment teams engaged the individual to obtain substantive input into objectives in 82% of cases and incorporated the individual's cultural preferences in 100% of cases. Areas needing improvement include reviewing the individual's progress in each focus area (53%), modifying the IRP interventions based upon the content of progress notes (6%), providing a

choice of interventions (47%), and reviewing discharge barriers (71%). Teams that have had training are improving in involving the individual in identifying objectives and interventions, although some improvement is still needed. The clinical chart audit will also evaluate this requirement, but the tool has not yet been finalized, so data is not available. The tool is expected to be finalized by the end of March, 2009.

The new IRP forms are designed to ensure more individualized objectives and goal, with more input from the individual. Binder V, tab # 2 (IIRP Form), tab # 3 (IRP). Likewise, training is designed to reinforce this. The forms include clear focus areas of hospitalization, objectives and interventions along 6 domains (Psychiatric/psychological, physical health, forensic/legal, substance abuse, discharge planning and community readiness, and enrichment). Guidelines for completing an IRP and IRP update are set forth in a IRP manual, along with other relevant documents. An outline of the training is attached. See also Binder V, tab # 12 (IRP Training curricula). In addition, the Clincial Administrators will be meeting with the individual prior to the IRP conferences to prepare the individual, which should allow the individual more time to think about his or her goals, objectives and preferred interventions.

Improved assessment tools from all disciplines but nursing are just finalized and implemented and should improve in evaluating the patient's mental status, functional and cognitive capacity, strengths and interests, which in turn should lead to more realistic goals and objectives and more individualized interventions. Binder V, Tab # 34(Comprehensive Psychiatric Assessment form), Tab # 24 (Initial Psychological Assessment form A, B), Tab # 31 (Social Work Initial Assessment form), Tab # 32 (Rehabilitation Assessment Form).

The Hospital is redesigning its treatment mall into three therapeutic learning centers (TLC) that will utilize an evidenced/curriculum based, recovery model. Programming will be based upon anticipated lengths of stay and will be designed to facilitate movement to a lower level of care and community reintegration. TLC I, opening March 16, 2009, is a short term treatment center focusing on community re-entry; it will focus on community living skills based upon the Illness Management and Recovery Model, SAMSHA. TLC II is designed for persons with anticipated lengths of stay of 12 weeks to 2 years. It is for clients who require services around socialization, improving cognition, and acquiring basic living skills; it will utilize the Psychiatric Rehab Model Boston University Psychiatric Rehab Center. The third center will focus on long term patients and provide a comprehensive multi-disciplinary recovery based program, focusing on enrichment, rehabilitation, enjoyment and therapeutic learning. It will also utilize the Psychiatric rehab model. Binder V, tab # 54 (Treatment mall redesign) The plan is to incorporate cognitive remediation therapy in each TLC, and an initial training will be provided by the neuropsychologist in March, 2009.

Finally, the Hospital is evaluating how best to ensure consistent medical care through development of a handbook or other strategy. Additional information will be available during the March, 2009 visit.

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Revise the draft Policy #602-04, Treatment Planning to include the information addressed in this expert consultant's findings above.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1	Incorporate consultant recommendations about treatment plan policy into the Treatment Planning policy document and obtain approval by Exec staff	6/15/2008	Binder V, tab # 1 (IRP Policy)	J Taylor; CEO

Complete - Status: Consultant recommendations have been incorporated. Feb, 2009 Update: IRP policy updated

1) Apr 2008 ***2*** *Provide training modules dedicated to Foci /Objectives/Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning.* ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize contract(s) to ensure that treatment planning training meets requirements of Agreement	7/31/2008	Binder V, Tab # 12 (training curricula outline)	DMH contracts; Chief of Staff

- Status: Vendor identified and negotiations underway.
Feb. 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP7, JHP 9, JHP 12, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.

2	Begin training and continue so that 50% of units are trained in individualized treatment planning by Dec 31, 2008.	12/31/2008		Chief of Staff; Civil and Forensic Directors

- Status: Began on two units but suspended in March; will restart in August. Feb 2009 update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.

3	Complete treatment planning training on all units by March 31, 2009	3/31/2009		

- Status: Feb 2009 update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.

1) Apr 2008 ***3*** *Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).* ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in V.C.1 recommendation 3.		Binder V, Tab # 12 (training curricula outline), tab # 29 (CV of trainers)	

- Status: See in V.C.1 recommendation 3

1) Apr 2008 ***4*** *Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in V.B.1 recommendation 4			

1) Apr 2008 *5 Revise the process observation and clinical chart audit tools to include indicators and operational instructions to address this requirement.* ***Medical; PID; BG; Discipline Directors; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop contract with consultant to provide technical assistance on revising draft clinical audit tool and IRP Process, indicators and operational instructions.	6/30/2008	Binder V, tab # 7 (IRP Process monitoring tool)	Chief of staff
Complete - Status: Consultant on site beginning June 24, 2008. Clinical audit tool under review.. February 2009 Update: IRP Process tool updated and includes indicators and operation instructions. Clinical chart audit tool still in revision process.			
2 Provide tools to consultant for review and comment	7/16/2008		Chief of Staff, QID director
- Status: Process observation and clinical chart audit tools provided June, 2008. Will complete modifications within 15 business days of comments Feb 2009 Update: IRP Process tool updated and includes indicators and operation instructions. Clinical chart audit tool still in revision process.			
3 Finalize tools, indicators and operational instructions, incorporating consultant's comments as appropriate	8/29/2008		Chief of staff

1) Apr 2008 *6 Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).* ***Medical; PID (process); Chief Nurse Executive; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Begin IRP process monitoring using draft tool and instructions.	6/30/2008	Bincer V, tab # 8 (Results of IRP Process monitoring)	QID Director
- Status: Completed 20% sample. Results attached. No clinical audit has occurred. Feb 2009 Update: IRP process monitoring occirred from July to September, but was suspended due to IRP training delays. IRP Process monitoring restarted, with revised IRP process monitoring tool, in February, 2009)			
2 Provide results regularly to senior staff.	8/14/2008		ID Director
- Status: ongoing			

1) Apr 2008 *7 Ensure that individuals diagnosed with cognitive impairments receive appropriate cognitive remediation interventions.* ***CVC; JH; Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise initial psychological assessment to screen for cognitive impairments.	7/31/2008	Binder V, tab # 24 (Copy of initial psychological assessment form, revised)	R Patterson
Complete - Status: Feb 2009 Update: IPA was revised to include a two part assessment at two periods.			
2 Revise treatment mall referral form to incorporate psychology screening assessment recommendations and findings.	10/15/2008	Binder V, tab # 55 (treatment mall referral form)	CVC
Complete - Status: Feb 2008 Update: Treatment mall referral form revise, but does not specifically address cognitive remediation therapies. Treatment mall redesign underway. See VIII for additional information			

3	Using data from patient database around diagnosis, and results of assessments, psychology to work with treatment mall administration to develop appropriate curricula.	12/31/2008	See Binder VIII, tab # 54 (Treatment mall redesign)	CVC; R Patterson
	- Status: Feb, 2009 Update: Treatment mall redesign is underway.			
4	Psychology to provide in house training for nursing and medical staff providing services for cognitive impaired patient population.	11/7/2008		Medical Director
5	Collect data as available (Phase II of AVATAR) to monitor cognitive diagnoses.	2/27/2009	Binder V, tab # 56 (Diagnosis management report)	COO
	- Status: Ongoing			

2) Dec 2008 ***1*** *Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above.* ***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise IRP policy and update IRP manual accordingly	2/27/2009	Binder V Tab # 1 (IRP Policy); Tab # 6 (IRP Manual)	PID, Beth Gouse
	Complete			

2) Dec 2008 ***2*** *Provide training modules dedicated to Foci/Objectives/ Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning.* ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure training curricula includes the specified modules	2/27/2009	Binder V, tab # 12 (Training curricula outline)	Beth Gouse
	Complete			

2) Dec 2008 ***3*** *Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).* ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide request information	2/27/2009	Binder V, Tab # 12 (training curricula outline); Tab # 29 (CV trainers)	B Gouse
	Complete			

2) Dec 2008 ***4*** *Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Collect data			B gouse
	- Status: Not available			

2) Dec 2008 ***5*** *Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP process tool to inlcude indicators and instructions	2/27/2009	Binder V, tab # 7 (IRP Process tool revised)	PID
Complete			
2 Finalize clinical audit tool to include indicators and instructions	3/31/2009		PID

2) Dec 2008 ***6*** *Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least 20% sample (October 2008 to March to 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			

2) Dec 2008 ***7*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			

2) Dec 2008 ***8*** *Provide an outline of the following: a.Cognitive remediation interventions that are currently provided and plans to increase these interventions; b. Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Redesign treatment mall	5/1/2009	Binder V, tab # 54 (Treatment mall redesign documents)	CVC

- Status: Treatment mall is being redesigned to include provision of cognitive remediation interventions for all three divisions of the redesigned mall..

2) Dec 2008

9 *Develop and implement medical care policies and procedures to address the following:*

a *Requirements for preventive health screening of individuals;*

b *Requirements regarding completeness of all sections of initial assessments, including a plan of care that specifies interventions for identified conditions;*

c *Requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format;*

d *Timeliness and documentation requirements regarding period reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks;*

e *Proper physician-nurse communications to ensure the following: Timely and properly documented nursing assessments; Timely and properly documented physician notification; and Physician response within timeframes that reflect the urgency of the condition*

f *Emergency medical response system, including drill practice;*

g *Consultation and laboratory testing to ensure the following: Communications of needed data to consultants;Timely review and filing of consultation and laboratory reports; and Follow-up on consultant's recommendations*

h *Requirements regarding transfer of individuals to outside facilities to ensure the following: Physician to physician communications upon the transfer regarding the reason for the transfer; and Communication of appropriate documents to the outside facility relevant to the reason for the transfer;*

i *Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician: Obtains information from the outside facility that is sufficient for continuity of care; Documents a review and assessment of the individual's status and the care provided at the outside facility; and Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals*

j *Parameters for physician participation in the IRP process to improve integration of medical and mental health care.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop specific procedures governing the listed recommendations and ensure staff are aware of the procedures	4/30/2009		Medical Director

- Status: Some of the procedures are being implemented, but procedures are not yet formalized in any policy.

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);

Findings

Same as V.D. 1.

No systemic method of measuring compliance with the requirement is in place at this time (i.e., no clinical audit is occurring); the Hospital is working with clinical staff to refine the clinical audit tool. It is expected to be finalized by end of March, 2009. However, the new IRP form is designed to ensure the IRP provides objectives around treatment and rehabilitation and therefore it anticipates improvement as the form is rolled out in early March.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations			***Responsible Party***
1) Apr 2008	***1*** *Same as above.*		***AS;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above. *Complete*			
2 Hire 8-10 Avatar user support staff including 2 Crystal Reporters to develop user friendly management reports for tracking active treatment hours. *Complete - Status: In August 2008, five User Support/ Helpdesk Analyst and 1 Crystal Developer were hired. Will begin design of the management report for tracking of active treatment hours in 2/1/ 2009.*	7/11/2008		Lois Branic / Sharmaine Allen
3 Develop reports for treatment mall activities and attendance reports. The Avatar application will be able to track treatment and their attendance after August, 2008. These management reports will be developed in Crystal Reports and will be provided on a weekly basis. Develop Reports for treatment and attendance reports *Complete - Status: A Management Report Development Plan for all Avatar Management reports will be drafted for review and prioritization by the Avatar Steering Committee*	1/31/2009		
4 Treatment Mall reports are on hold until a decision is made as to whether these reports will be manually produced.			
2) Dec 2008	*Same as in February 2008*		
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above			

V.D.3

write the objectives in behavioral and measurable terms;

Findings

Same as V.D.1.

No systemic method of measuring compliance with the requirement is in place at this time, but a review of a small sample of charts by the compliance office suggests that the Hospital is not yet routinely implementing a practice of ensuring IRPs include specific objectives that reflect the functional capacity of the person and will advance the goals of the treatment plan. Objectives are often focused on medication compliance, complying with ward rules or resisting assaultive behavior. In two cases reviewed by the compliance office in February, 2009, the objectives included being free from symptoms, which is not a realistic goal, and in those same cases, the objectives and interventions did not reflect that both individuals had post college educations and successful work histories before the onset of the illness. While return to those careers may not be realistic, objectives and interventions did not

reflect the capacity of the individual if symptoms could be reduced.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1) Apr 2008	***1*** *Same as above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as above.			
2) Dec 2008	*Same as in February 2008*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same action steps as above			

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;

Findings

Same as V.D.1-3.

The Hospital significantly revised the IRP form so that each objective would include a related intervention, and will assign clear responsibility for providing the intervention and the timing of the intervention. However, the form is only just being introduced, so there is no data yet available to determine if the form will have the desired effect.

The IRP Process monitoring process, which for the reviews using the prior tool, provides some data on whether individual is provided options and choices of interventions for identified objectives and whether the person was actively engaged in the IRP process. Data from the February, 2009 reviews, indicates that in 82% of cases, the individual was provided with the opportunity for input into goals and objectives, but in only 47% of cases was the individual provided with choices of interventions, Binder V, tab # 8 (IRP process results, February, 2009). In the earlier review using the prior tool, the IRP observation data indicates poor compliance - - in 13% of cases were persons actively involved in discussions of objectives, and in only 8% of cases were they actively involved in choosing interventions. Binder V, tab 8 (IRP process review, July - September). Similarly the earlier review established that in only 4% of cases did a "problem" have an individualized intervention. On chart reviews, some cases included identification of specific staff and time frames for intervention, but in others, the more generic "nursing staff" or " as needed" was used.

The Hospital is undertaking a major redesign of the treatment mall. See V.D.1 for a description. Under the redesigned TLCs, individuals and their treatment teams will have more selection of groups and interventions than now exists where interventions are limited by the track to which a person is assigned. Stage of change will be utilized in identifying appropriate interventions. Staff will be trained in the various curricula and also about the offerings for each TLC, and will also be trained in group leadership. Binder V, tab # 54 (see Redesign plan). Further, the Hospital is also working to establish minimum treatment hours for each discipline so that nursing and rehabilitation services do not carry an inordinate share of TLC groups.

The Mall progress note was revised and to include a specific reference to the treatment plan objective and to streamline it. See Binder V, tab # 17 (Therapeutic Progress Note)

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

1) Apr 2008 ***2*** *Design and implement a training program for clinical staff (treatment teams and mall providers) in how to properly align mall treatment modalities with the individual's short-term goal as documented in the treatment plan. Ensure that all short-term goals have an accompanying mall treatment intervention, and mall providers are aware of the short-term goal for which the individual has been assigned to that particular mall group so that progress can be appropriately documented and the treatment team can address necessary changes in treatment programs.* ***CVC; AS; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop progress note template that reviews short term goals in conjunction with mall therapies.	6/30/2008	Binder V # 55 (Treatment Mall referral form), Tab # 17 (Therapeutic Progress Note)	Chief of staff
- Status: Draft complete and under review by consultant; Template note is being piloted. February 2009 Update: Treatment mall referral form was modified in September, 2008 to improve alignment of mall therapies with individual's needs. In addiiton, modifications were made to the Mall Progress Note.			
2 Enter in contract with consultant to provide treatment planning training for staff.	8/8/2008	Binder V, Tab # 12 (IRP training curricula outline)	AS
- Status: - Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2 RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			
3 Enhance treatment mall program through development of written curricula based upon clinical profile of patient population.	12/31/2008	Binder V, Tab # 54 (Overview of treatment mall redesign)	CVC; PID
- Status: Patient database that includes diagnosis of patients developed and in use. First report of data complete. Additional reports will follow. The information has not yet been used to inform treatment mall group development or curricula. *February 2009 Update: Treatment mall is being redesigned, into three therapeutic learning centers that will focus on psychiatric rehabilitation and life enrichment and will use a recovery based model. Programming at each center will be based upon anticipated length of stay and is designed to facilitate movement to a lower level of care and reintegration into community. One center is designed for short term stays and will use the Illness Management and Recovery Model, SAMSA to focus on community re-entry through enhancing self esteem, fostering autonomy, community living and emotional skill-building and relapse prevention. The second center is designed for persons with lengths of stay 3 months to 2 years, and will provide services around socialization, improving cognition, and acquiring basic living skills. It will be based upon the Psychiatric Rehab Model, Boston University Psychiatric Rehab Center, The third center will focus on patients with anticipated LOS of greater than 2 years and provides an integrative psychiatric and social learning approach to meet the needs of patients, and is focused on rehabilitation, enrichment, enjoyment and therapeutic learning. The programs will be phased in beginning in March, 2009.*			

1) Apr 2008 ***3*** *Implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: the name of the group/individual treatment, the name of the group/individual treatment provider, the name of the individual patient, the short-term goal for which the individual has been assigned to the modality; the number of attended sessions/number of offered sessions; the quality of the individual's participation; and the individual's progress toward achieving the stated short-term goal.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop mall template note	6/25/2008	Binder V, tab # 17 (Therapeutic Progress Note)	Chief of staff

Complete - Status: Feb. Update: Mall progress note was modified to incorporate DOJ recommendations..

1) Apr 2008 ***4*** *Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Make data available both at the individual level, so that progress toward discharge can be appropriately tracked, and at the aggregate level so that performance improvement can be maintained.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 With technical assistance from consultant, modify chart audit tool to incorporate review of treatment mall notes and therapies. Develop related indicators and operational instructions	3/31/2008		QID; Chief of Staff

- Status: Technical assistance initiated June 24th, 2008. Expect comments from consultant by end of July, 2008. February 2009 Update: Clinical chart audit tool not yet being used. PID is working with direct care clinical staff to modify tool to incorporate recommendations of DOJ. Expected by March 30, 2009

2 Train auditors, conduct audits and report results.	11/17/2008		Medical director, Chief of staff

- Status: Not yet begun. Will be initiated within 45 days of tool finalization.

1) Apr 2008 ***5*** *Train auditors to acceptable levels of reliability.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.D.4 recommendation 4			

- Status: See V.D.4 recommendation 4

1) Apr 2008 ***6*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See actions steps in V.D.4 recommendation 4			

- Status: See V.D.4 recommendation 4

2) Dec 2008 ***1*** *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 ***2*** *Continue with original recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with identified action steps.			

2) Dec 2008 ***3*** *Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify mall progress note template	2/2/2009	Binder V, Tab # 17 (Therapeutic Progress Note).	Beth Gouse
Complete			

2) Dec 2008 ***4*** *Develop a model for treatment planning that assures that individuals are assigned to particular groups on the basis of assessed needs and Stage of Change rather than simply assigning an individual to a specific mall.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify IRP forms to reflect stage of change and that interventions must reflect needs and state of change	2/2/2009	Binder V, Tab # 2 (24 hour IRP form); tab # 3 (Comprehensive IRP form)	Beth Gouse
Complete			
2 Redesign treatment mall so that treatment team, with individual, selects mall groups that meet foci and objectives of IRP.	5/1/2009	Binder V, Tab # 54 (Treatment Mall redesign overview)	CVC

- Status: February 2009 Update: Treatment mall is being redesigned, into three therapeutic learning centers that will focus on psychiatric rehabilitation and life enrichment and will use a recovery based model. Programming at each center will be based upon anticipated length of stay and is designed to facilitate movement to a lower level of care and reintegration into community. One center is designed for short term stays and will use the Illness Management and Recovery Model, SAMSA to focus on community re-entry through enhancing self esteem, fostering autonomy, community living and emotional skill-building and relapse prevention. The second center is designed for persons with lengths of stay 3 months to 2 years, and will provide services around socialization, improving cognition, and acquiring basic living skills. It will be based upon the Psychiatric Rehab Model, Boston University Psychiatric Rehab Center, The third center will focus on patients with anticipated LOS of greater than 2 years and provides an integrative psychiatric and social learning approach to meet the needs of patients, and is focused on rehabilitation, enrichment, enjoyment and therapeutic learning. The programs will be phased in beginning in March, 2009. In the redesigned system, treatment teams, not Mall Administrators, will select appropriate interventions.

V.D.5

design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and

Findings

While not yet using the AVATAR system to track hours of active treatment and attendance, the Hospital is able to produce some data for persons who attend the treatment mall. The data was based upon sign in sheets maintained by treatment mall group leaders for approximately a one month period. The data shows that the weekly average of attendance at the treatment mall was just over 3 hours, and no one attended the requisite 20 hours a week. Groups on the units were not part of this tracking and data are not available for persons who attend ward based groups, therapies or activities at this time. Binder V, tab # 60 (Data from Treatment mall attendance)

The Hospital still must decide how it intends to track active treatment hours. Phase I of AVATAR includes the ability to track hours of treatment scheduled and attended, by client, but it may require modification to be workable for the Hospital. This will give the Hospital an opportunity to better assess the hours provided for each patient at the

mall but there is some concern by staff that data entry is too labor intensive. Phase II of Avatar will include treatment plans and may allow the Hospital to track the scheduled hours of interventions as well as other aspects of clinical care, and will allow the Hospital to track its performance on this requirement. In the meantime, the IRPs are now expected to reflect the length of time as well as frequency of each intervention. A decision on how to track scheduling and attendance is expected by the end of March.

While significant progress has been made in hiring staff, there remain key shortages in rehabilitation services and nursing staff which are impacting the provision of treatment hours; recruitment is underway for 5-7 rehabilitation services staff, and nursing recruitment continues. The Hospital is actively working to set specific standards for each discipline to run groups, which is expected to be finalized by the end of March, 2009.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	*1 Develop and implement a system to track active treatment hours scheduled per week.*	***CVC; AS; Eric Strassman***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Utilize AVATAR scheduling module to schedule and track interventions.	7/22/2008		Sharmaine Allen
Complete - Status: Implemented Phase I of Avatar which included the module to schedule and track interventions. February 2009 Update: Training held on December 5, will begin reporting 2/1/2009 or earlier.			
2 Train users in the AVATAR system.	7/31/2008		Sharmaine Allen Eric Strassman
Complete - Status: Clinical Adminstrators and others have been trained on Treat Mall scheduling and attendance.			
3 Hire crystal report writers and develop necessary Crystal Reports to allow tracking of scheduled and attendance.	9/26/2008		COO
Complete - Status: In August 2008, five User Support/ Helpdesk Analyst and 1 Crystal developer were hired. Five positions are being converted to FTE. The management report will be designed in January 2009 with an expected completion date of 2/1/ 2009.			
4 Obtain technical assistance from A. Adkins to review treatment mall curriculum and make adjustments as recommended.	11/30/2008	Binder V, tab # 54 (Treatment mall redesign documents	Chief of staff
- Status: Some adjustments have been made in Treatment Mall program, but curricula not developed nor has manual been developed. February, 2009 Update: Treatment mall is being redesigned, into three therapeutic learning centers that will focus on psychiatric rehabilitation and life enrichment and will use a recovery based model. Programming at each center will be based upon anticipated length of stay and is designed to facilitate movement to a lower level of care and reintegration into community. One center is designed for short term stays and will use the Illness Management and Recovery Model, SAMSA to focus on community re-entry through enhancing self esteem, fostering autonomy, community living and emotional skill-building and relapse prevention. The second center is designed for persons with lengths of stay 3 months to 2 years, and will provide services around socialization, improving cognition, and acquiring basic living skills. It will be based upon the Psychiatric Rehab Model, Boston University Psychiatric Rehab Center, The third center will focus on patients with anticipated LOS of greater than 2 years and provides an integrative psychiatric and social learning approach to meet the needs of patients, and is focused on rehabilitation, enrichment, enjoyment and therapeutic learning. The programs will be phased in beginning in March, 2009. In the redesigned system, treatment teams, not Mall Administrators, will select appropriate interventions.			

	5 Hire Treatment Mall administrator	8/15/2008		CVC

Complete - Status: A selection certificate was issued to management and interviews are being scheduled.
February, 2009 Update: Treatment Mall Administrator hired 9-15-08.

1) Apr 2008 — ***2*** *Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours.* — ***CVC; AS; Eric Strassman***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement scheduling component of Avatar system (Phase I).	7/22/2008		COO

Complete - Status: Phase I Avatar was implemented on July 22, 2008.

2 Hire 8-10 Avatar user support staff including 2 Crystal Reporters to develop user friendly management reports for tracking active treatment hours.	7/31/2008		COO

Complete - Status: In August 2008, five User Support/ Helpdesk Analyst and 1 Crystal Developer were hired. These positions are being converted to FTE. Will begin drafting management report for tracking of Active treatment hours in 2/1/ 2009
The management report will be designed in January 2009 with an expected completion date of 2/1/ 2009.

3 Develop necessary reports to reflect patient attendance and participation.	10/31/2008		COO

- Status: Feb, 2009 Update: A decision must be made regarding the use of Avatar for tracking attendance. Until such time, all reporting will be manual. 10/2008 Will begin drafting management report for tracking of Active treatment hours in 2/1/ 2009. The management report will be designed in January 2009 with an expected completion date of 2/1/ 2009.

4 Identify staff to record patient attendance at therapies	12/31/2008		CVC

Complete - Status: 12/12/08 meeting with all Clinical Administrators and Avatar to discuss who is to record unit scheduling and who is to record group attendance. The Clinical Administrator of the respective unit or Treatment Mall Program Administrators will be recording unit/Mall schedules and the group facilitators will be required to record attendance of patients in group and record group cancellations and reasons why.

1) Apr 2008 — ***3*** *Provide data regarding the number of active treatment hours per week for all individuals at the facility (March to August 2008).* — ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement Avatar system (Phase I).	7/31/2008		COO

Complete - Status: Phase I AVATAR was implemented on July 22, 2008.

2 Hire 8-10 Avatar user support staff including 2 Crystal Reporters and 1 Reports Manager to develop user friendly management reports for tracking active treatment hours.	7/31/2008		COO

- Status: In August 2008, five User Support/ Helpdesk Analyst and 1 Crystal Developer were hired. These positions are being converted to FTEs.
Crystal report writers were hired, but report has not been developed as system is being evaluated to determine if recording information is feasible
The management report will be designed in January 2009 with an expected completion date of 2/1/ 2009.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Develop reports for treatment scheduling and attendance hours.	9/30/2008		COO
	- Status: See prior action step			

1) Apr 2008 — ***4*** *Identify barriers to individual's attendance at scheduled activities.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Study three wards in each civil and forensic services for 30 days to monitor attendance at treatment activities and track reasons why patient does not attend.	11/21/2008		Director Civil and Forensic Services
	- Status: Not yet begun. *February 2009 Update: Not completed. However, attendance is being evaluated and is a focus of the redesign of treatment mall, so that goal will be to move individuals to treatment mall more quickly and to ensure more individuals attend treatment mall.*			
2	Review data collected and address barriers to attendance at treatment activities.	12/31/2008		Director Civil and Forensic Services

1) Apr 2008 — ***5*** *Develop and implement a Mall alignment monitoring tool, with indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.* — ***CVC; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop tool, with technical assistance from consultant.	12/31/2008	Binder V, tab # 54 (Copy of Strategic Plan for Mall Redesign and other documents)	CVC
	- Status: Consultant on board. Has visited Treatment Mall, but no other steps taken to implement this recommendation. February 2009 Update: Consultant has worked with Director of Civil and Treatment Mall Administrator to complete a Treatment Mall Strategic Plan for Operational Changes and Improvements. Startegic Plan is to be finalized and approved by Executive Staff by January 2009.			
2	Implement Phase II of AVATAR to track treatment interventions and link to treatment plan interventions and active treatment.	2/27/2009		AS
	- Status: Not yet underway. February, 2009. Phase II of Avatar will be rolled out beginning in Spring, 2009, first for assessments and then moving to other areas (ie, IRPs)			
3	Hire 8-10 Avatar user support staff including 2 Crystal Reporters and 1 Reports Manager to develop user friendly management reports for tracking active treatment hours and objectives	2/27/2009		AS
	- Status: Recruitment is underway.			

1) Apr 2008 ***6*** *Provide monitoring data regarding Mall alignment based on at least 20% sample (March to August 2008).* ***CVC; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop instrument, with technical assistance from consultant to allow monitoring of mall alignment.	1/31/2008		Director, Civil Services
- Status: February 2009 Update. Tool has not yet been developed, and no data collection has begun. A decision was made to defer this pending implementation of treatment mall redesign.			
2 Begin monitoring.	2/15/2009		Director, Civil Services
- Status: Not yet begun.			

2) Dec 2008 ***1*** *Develop and implement a system to track active treatment hours scheduled per week.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps		Tab # 60 (Treatment mall attendance hours)	
- Status: Feb 2009 Update: Treatment mall attendance was tracked for one month (January 15- February 15). No patient was meeting the attendance hours.			

2) Dec 2008 ***2*** *Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008 ***3*** *Provide data regarding the number of active treatment hours per week for all individuals at the facility (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified		Tab # 60 (Treatment mall attendance hours); #61 (Ward schedules)	

2) Dec 2008 ***4*** *Identify barriers to individual's attendance at scheduled activities.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Study three wards in each civil and forensic services for 30 days to monitor attendance at treatment activities and track reasons why patient does not attend.	5/1/2009		JH, CVC
2 Review data collected and address barriers to attendance at treatment activities.	6/30/2009		PID

2) Dec 2008	***5*** *Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps at V.D.5, recommendation 5.			

2) Dec 2008	***6*** *Monitor Mall alignment based on at least 20% sample (October 2007 to March 2009).*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Action steps at V.D.5, recommendation 6.			

2) Dec 2008	***7*** *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.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide summary and analysis of aggregated data within 45 days of first audit and each following audit			PID

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.

Findings

Same as in V.D.1 through 5.

Compliance Status: See related sections

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Same as in V.D.1 through V.D.5*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same action steps as in V.D.1 through V.D.5 *- Status: See above.*			

2) Dec 2008	*Same as in V.D.1 through V.D.5.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.D.1 through V.D.5.			

V.E. Treatment Planning Is Outcome-Driven

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

Findings

See sub-cells for findings.

Compliance Status: See related sections

lack thereof. The treatment team shall:

V.E.1

revise the objectives, as appropriate, to reflect the individual's changing needs;

Findings

Using the prior tool, the Hospital conducted IRP process observations for a 20% sample of scheduled treatment plans that provides some information about the team's setting and revising of objectives during treatment plan conferences. Binder V, tab # (IRP Process Monitoring Results July- Sept, 2008). The data from those observations shows that in only 13% of cases were treatment objectives discussed; the data on discussion of life goals and interventions is even more problematic, at 4% and 8% respectively.

The IRP Process tool was revised (indicators and instructions were developed) and and observations were done in February, 2009 using the new tool. The tool includes an indicator around meaningful input and data shows improvement in obtaining input from the individual in discussing objectives (82%), but performance still lags in giving the individual a choice of interventions (47%). There also was improvement around establishing discharge strategies. Despite this, in still many cases, objectives are not realistic and are written in "absolutes" (i.e., refrain from assaultive behavior). The continuation of IRP training is essential to change practice in this area. Binder V, # 12 (IRP training outline)

The new IRP forms and discipline assessment updates also are expected to improve focus on revising objectives and interventions as the person's needs change. Binder V, tab # 3 (IRP Form). The discipline's update now includes an assessment of an interventions' effectiveness, and will be used to help revise the IRP. Binder V, tab # 35 (Psychiatric Update), tab # 49 (SW assessment update). (Nursing update is not available at this time.) Further, the clinical formulation update form prompts consideration of the need to revise objectives and interventions, which should also improve responsiveness to changing needs. Binder V, tab # 5 (clinical formulation update). Finally guidance about the IRP process is now available through the IRP manual.

The clinical audit tool is being finalized with PID and clinical staff.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Revise the draft Policy #602-04, Treatment Planning to specify the requirements regarding reviewing and revising the Foci, Objectives and Interventions..*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the Treatment Planning Policy to incorporate requirements for foci, objectives, and interventions.	6/15/2008	Binder V, Tab # 23 (IRP form)	J Taylor; CEO

Complete - Status: Requirements have been incorporated into Treatment Planning policy document.
Feb 2009 Update: IRP policy revised incorporating comments and changes to IRP form

1) Apr 2008 *2 Ensure that the training modules regarding Foci/Objectives/ Interventions and Stages of Change provide guidance regarding the processes of reviewing and revising the IRPs.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with consultants to provide training to at least 50% of units by December 31, 2008 on treatment planning, and all units by 3/31/09.	7/31/2008		DMH Contracts
Complete - Status: Contract negotiations are underway. February, 2009 Update: Consultants on site to provide training.			
2 Ensure training materials reflect DOJ requirements regarding goals, objectives and interventions and stage of change.	8/29/2008	Binder V, Tab # 12 (Training curricula outline)	Chief of staff
- Status: February 2009 Update: Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.			
3 Train clinical administrators and senior staff on overview of stage of change.	6/2/2008	Binder V, Tab # 12 (Training curricula outline)	Medical Director
- Status: Senior staff provided overview on stage of change. Additional training to be incorporated into treatment planning training. February update: Stage of change training incorporated into IRP training.			

1) Apr 2008 *3 Revise the process observation and clinical chart audit tools to include indicators and operational instructions that address the processes of reviewing and revising the Foci, Objectives and Interventions.* ***PID; BG; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Secure a contract with a vendor to assist the hospital in developing discipline specific tools and revising existing tools.	6/25/2008		COO; Chief of Staff
Complete - Status: February Update: New Director of PID hired. He will lead development of audit tools			
2 Modify IRP process tool and begin utilization as pilot. Incorporate consultants comments upon receipt.	6/2/2008	Binder V, Tab # 7 (IRP Process Monitoring tool, revised)	QID director
Complete - Status: Feb 2009 Update: IRP process tool revised and includes indicators and instructions.			
3 Review clinical chart audit tool and modify per consultant's recommendations	3/31/2009		QID Director; Chief of Staff
- Status: Clinical chart audit tool has been provided to consultant for TA. Feb 2009 Update: Clincial chart audit tool not yet finalized. PID staff are working with clinical staff to revise tool. Expected to be complete in March, 2009.			

1) Apr 2008 ***4*** *Monitor the requirements in V.E.1 through V.E.5 using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).* ***Medical; PID; BG; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Pilot process monitor tool for 20% sample, and report results	7/24/2008	Binder V, Tab # 8 (IRP process monitoring results)	QID director
- Status: Initial observations complete. Results attached. Feb 2009 Update: IRP Process Tool utilized beginning Feb, 2009. Prior audits were completed through September, but were suspended until IRP training could be implemented.			
2 Modify draft clinical audit tool and begin audit.	10/24/2008		PID, Medical Director, Discipline chiefs, QID director
- Status: Clinical chart audit tool under review by consultant. February 2009 Update: Clinical audits have not occurred. Tool is still being developed			

2) Dec 2008 ***1*** *Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IPR Policy	2/2/2009	Binder V, tab # 1 (IRP policy revised)	PID
Complete			
2 Finalize IRP manual	2/27/2009	Binder V, Tab # 6 (IRP Manual)	Beth Gouse
Complete			

2) Dec 2008 ***2*** *Ensure that the training modules regarding Foci /Objectives/Interventions and Stages of Change provide operational guidance regarding the processes of reviewing and revising the IRPs.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate foci/interventions/objectives and stage of change into IRP Training		Binder V, Tab # 12 (IRP training curricula outline)	Beth Gouse
Complete			

2) Dec 2008 ***3*** *Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, V.E.1 recommendation 3.			

2) Dec 2008 ***4*** *Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps V.E.1 recommendation 4.			

2) Dec 2008 *5 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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide analysis of the the results fo IRP process monitoring and clincial chart audits.	5/1/2009	Binder V, Tab # 8 (IRP process monitoring results)	PID

- Status: IPR process monitoring audits results available for 5 units. Clinicial chart audits have not begun

V.E.2

monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;

Findings

The IRP Policy was revised to require IRP conferences every 60 days (after the first 60 days) and each month, disciplines must complete a progress note that should address the effectiveness/accuracy of goals, objectives and interventions. Binder V Tab # 1 (IRP Policy); Tab # 57 (Medical records policy), tab # 17 (Therapeutic progress note). The notes/updates for the disciplines (except nursing note which is still pending) have also been updated to prompt an evaluation of objectives and effectiveness of treatment, but the notes have only been used since late January, so it is too early to assess the quality and effectiveness. Binder V, tab # 35 (Psychiatric Update); tab # 49 (Social Work Assessment Update). By reviewing the objectives and goals monthly, it is expected IRP updates will occur as needed.

There is some data on the completion of monthly notes, but does not address the content or quality. The IRP process observations completed in July-September, 2008 shows that progress notes were completed before the treatment plan in 76% of cases for psychiatry and nursing, and 67% for social work. Binder V, tab # 8 (IRP Process results, July- Sept 2008). Data from the February 2009 reviews around discipline assessment updates and progress notes is not available due to discrepancies in how observers understood the question. There is data around completion of the therapeutic monthly note - about 28% of cases included one from psychology or rehab services.

The clinical audit and discipline audit tools will include a provision to address whether the content of the notes reflect ongoing monitoring of effectiveness of treatment and the person's condition. There is no data yet that addresses whether the notes meet the quality and content expectations of the policies and the SA.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify Treatment Planning policy and obtain Executive Staff approval.	6/15/2008	Binder V, Tab # 1(IRP Policy revised)	J Taylor

Complete - Status: Requirements have been incorporated into the Treatment Planning policy.
Feb 2009 Update: IRP policy revised

1) Apr 2008 ***2*** *Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008).* ***CVC; JH; Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to V.E.1 recommendation 4			
- Status: See V.E.1 recommendation 4. Feb 2009 Update: No clinical chart audits have occurred. Tool is not yet finalized.			

2) Dec 2008 ***1*** *Same as in V.E.1*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.E.1.			

2) Dec 2008 ***2*** *Implement the schedule of IRP reviews as specified in the revised policy.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP Policy	2/11/2009	Binder V, Tab # 1 (IRP Policy, revised)	PID
Complete			
2 Utilize process monitoring tool to evaluate timeliness of IRPs		Binder V, Tab # 8 (IRP porcess monitoring results, July- Sept) Tab # 8 (IRP process results, February), Tab # 27 (Discharge record review results)	PID
- Status: Ongoing for 5 units. Additional 6 units will be added in March. Remaining units added after 2 months of IRP training. Also evaluated in discharge record reviews.			

2) Dec 2008 ***3*** *Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure disciplines complete monthly notes as required by policy			
- Status: Ongoing			
2 Conduct monthly notes audits by disciplines			

2) Dec 2008 ***4*** *Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

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;

Findings

See V.E.2.

Chart reviews reveal that use of restraint and seclusion still does not generally trigger updates to the IRP. A review of 24 episodes of use of restraint or seclusion was completed in February, 2009. See Binder V, tab # 58 (R/S audit tool). The review indicated that in the majority of cases, there were no changes to the IRP after use of restraint or seclusion, even when the intervention was used on more than one occasion. Data shows documentation of a treatment team debriefing the day following restraint or seclusion in 5% of cases, and that in only 0% of cases was

there documentation of interventions in the IRP that were targeted to avoid future use of restraints or seclusion. Binder V, tab # 43 (Restraint and seclusion audit results). If objectives or interventions are modified due to use of seclusion or restraint, it is not clear from the record.

The newly developed psychiatric update, Binder V, tab # 35 (psychiatric update), requires the reporting and evaluation of use of restraint or seclusion, and thus their use should be considered in the development of updated objectives or interventions. Binder V, tab # 6 (IRP Manual)

The Hospital revised its Advanced Instruction/Comfort plan.

Compliance Status: See V.E.2

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate requirements into the Treatment Planning policy.	6/15/2008	Binder V, Tab # 1 (IRP Policy revised)	J Taylor

Complete - Status: Requirements have been incorporated into the Treatment Planning policy. Feb 2009 Update: IRP Policy revised

1) Apr 2008	***2*** *Ensure that the training module regarding Foci /Objectives/Interventions provide guidance to correct the deficiencies outlined by this expert consultant above.*	***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.E.1 recommendation 2.			

- Status: See V.E.1 recommendation 2.

1) Apr 2008	***3*** *Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008).*	***PID; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.E. 1 and V.E. 2.			

- Status: See V.E. 1 and V.E. 2.

2) Dec 2008	*Same as in V.E.1.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.E.1.			

V.E.4

provide that the review process includes an assessment of progress related to discharge; and

Findings

Changes to the IRP form and to the manner in which planning is to occur should improve the focus on progress toward discharge. The IRP has six domains/areas of focus (psychiatric/psychological; physical; legal/forensic; substance abuse discharge planning and community readiness and enrichment). In addition to a dedicated domain, factors bearing on discharge are to be considered in each domain and the manual provides some guidance on formulating individualized discharge criteria. Binder V, tab # 3 (IRP Form), tab # 6 (IRP manual). Training on IRP planning is essential to improvement in performance; 5 units are completing training, 5 are in the beginning stages of training, and the remaining 8 units will begin training by April, 2009. Because training has not

been completed, many IRPs still include generic discharge criteria (i.e. will not be dangerous to self or others"; or "Patient to be discharged when stable and medication compliant").

Some data is available around discharge planning in the IRP conferences. The IRP observations in July to September, evaluated whether there was a facilitated discussion during the IRP on the person's role in discharge, progress toward discharge, discharge readiness, discussion of discussion barriers, and roles of the disciplines in effecting discharge. Data show that less than 20% of cases involved effective discussion around discharge during the IRPs held in July to September, 2008. See Binder V, tab # 8 (IRP Results, July - September, 2008, #27-31). The revised IRP Process Monitoring Tool was used to conduct IRP observations in February, 2009. Two indicators, 6 and 8 address discharge planning. Binder V, tab # 8 (IRP Process results, Feb, 2009). The IRP conference observation data shows that in 71% of cases, discharge barriers were addressed in the conference, and in 89% of observed conferences, the individual had an opportunity to be an active participant in the discharge planning discussion.

Additional training is needed in formulating discharge criteria and in building on patient's strengths.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge.*	***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include training on discharge planning in treatment planning training contract.	7/31/2008	Binder V, Tab # 12 (IRP Training curricula outline)	DMH

- Status: Contract with Mary Thornton in final stages of negotiations. Expect it to be signed August, 2008.
Feb 2009 Update: Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009. Training includes training around discharge planning and formation of individualized discharge criteria.

1) Apr 2008	***2*** *Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).*	***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Collect data from trainers and provide to DOJ.	9/30/2008	Binder V, tab # 12 (Training curricula) Tab # 29 (CV for trainers)	Chief of Staff

- Status: Will be provided as training occurs.
Feb 2009 Update: Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2,. RMB 3, RMB 7, and RMB 8 will begin training in April 2009.

1) Apr 2008 ***3*** *Provide aggregated data regarding results of competency-based training of all core members of the treatment team.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Institute training database to audit all training activities.	9/30/2008		PID
- Status: A program analyst from OMS has begun working with Office of Training to develop data base that captures training classes and dates as well as competency determinations. Feb 2009 Update: Training data base completed.			
2 Enter data relating to staff and training courses.	10/31/2008		Training
- Status: Will begin upon establishment of data base. Feb, 2009 Update: Business process around data entry finalized, but only minimal data entered.			
3 Review the competency based training data and analyze them for assessing compliance	11/15/2008		Training
- Status: No update			
4 Work with trainers to ensure training is competency based, and that results are maintained on all core staff.	10/31/2008		Training; Chief of staff
- Status: Feb 2009 Update: New Director of Training was hired in January, 2009, and in October, 2008, nurse educators were moved from training department to office of Chief Nurse Executive to improve competency based training. However, no assessment yet has been made to determine if training is more competency based.			

1) Apr 2008 ***4*** *Revise current process observation and clinical chart audit tools to address requirements of this agreement regarding discharge planning.* ***PID; BG; PID with consultant trainers***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP process tool to capture required information.	6/27/2008	Binder V, tab # 7 (IRP process tool revised)	QID director
- Status: Tools under review by consultant. Feb 2009 Update: IRP Process tool updated.			
2 Work with consultant to perfect both tools to adequately assess discharge planning	9/30/2008		QID Director
- Status: Tools under review by consultant. Feb 2009 Update: IRP Process tool updated, but revisions to clinical chart audit tool have not yet been completed			
3 Provide results of discharge record review and discharge planning sections of IRP Process observations	7/31/2008	Binder V, Tab # 27(Discharge record review audit results) Results from IRP process monitoring tool relating to discharge planning, Tab # 8	OMS
Complete			

1) Apr 2008 *5 Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).* ***Medical; PID; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct IRP process assessment utilizing 20% sample of scheduled treatment plans and report results.	7/31/2008	Binder V, tab # 7 (IRP Process results July- Sept); tab # (IRP Process results, Feb) Results of IRP Observations, Tab # 7	QID director
Complete - Status: Tool is under review by consultant. *Feb 2009 Update: IRP process reviews using old tool conducted from July to Sept, 2008, but were suspended because units had not been trained on new IPR model, and enough data had been collected for baseline. IRP process tool was modified in Jan, 2009, and process monitoring re-initiated for 5 units that had substantial training. Additional units will be added in March.*			
2 Within 45 days of finalizing clinical chart audit tool, train reviewers and begin audits	10/31/2008		Med Director, Discipline Chiefs
- Status: Clinical chart audit tool not completed.			
3 Hire Manager of Peer Review and Standards to manage clinical chart audits and peer review.	9/30/2008		Medical Director
- Status: Position description is under development. *Feb Update: Position not yet advertised.*			

2) Dec 2008 *1 Ensure that the treatment planning policy and/or manual provide operational specifics regarding the formulation of discharge criteria and documentation of the present status of individuals in terms of progress towards discharge.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, V.E.4. recommendations 1 and 2.			

2) Dec 2008 *2 Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, V.E.4. recommendations 1 and 2.			

2) Dec 2008 *3 Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, V.E.4. recommendation 2.			

2) Dec 2008 *4 Provide aggregated data regarding results of competency-based training of all core members of the treatment team.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, V.E.4. recommendation 3.			

2) Dec 2008 ***5*** *Revise current IRP Process Observation and Clinical Chart Monitoring forms include complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps V.E.4.			
2 Modify IRP Process Tool to include indicators around discharge planning.	2/12/2009	Binder V, tab # 7(IRP Process Monitoring tool)	PID
Complete			
3 Modify clinical chart audit tool	3/31/2009		PID
- Status: PID staff are working with clinical staff to modify tool and ensure indicators and instructions are developed.			

2) Dec 2008 ***6*** *Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Restart IRP process monitoring,phasing in units as they begin training in IRP development	2/19/2009	Binder V, Tab # 8 (IRP process results)	PID
- Status: ongoing			
2 Finalize clinical chart audit tool	3/31/2009		PID
3 Begin clinical chart audits	5/1/2009		Medical director

2) Dec 2008 ***7*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Present summary data of IPR process results	2/19/2009	Binder V, Tab # 8 (IRP process results)	PID
- Status: Ongoing, but phasing in based upon units receiving IRP training.			
2 Provide summary data of clinical chart audit results within 45 days of audits and ongoing thereafter	6/17/2009		PID
- Status: No audits yet conducted			

V.E.5

base progress reviews and revision recommendations on clinical observations and data collected.

Findings

See findings in Sections V.

The previously developed Progress note for mall groups has been modified to include the specific treatment objective as well as the intervention. Binder V, tab # 17 (Therapeutic monthly progress note). A review of records review that the notes are being completed by treatment providers. The IRP process review specifically addressed the presence of the therapeutic progress note (Indicator 2). Binder V, tab # 7 (IRP Process Monitoring tool) Unfortunately, raters interpreted the questions differently and thus the data is not valid. This will be corrected for the next set of audits.

Further, psychiatry and social work have developed and begun using assessment updates that focus the clinician on evaluation the individual's progress or lack thereof. A nursing assessment update will be developed following completion of the initial nursing assessment form. These assessment updates will be used as a basis of the clinical formulation update that will be completed before each IRP. Further, training and guidelines for the IRP conference are targeting the focus of IRP reviews to the individual's current symptoms, behaviors and functional abilities.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in Section V.A.1 to V.A.1.5*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See action steps in Section V.A.1 to V.A. 5			
	- Status: See in Section V.A.1 to V.A. 5			
1) Apr 2008	***2*** *Same as V.E.4*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same action steps as V.E.4.			
1) Apr 2008	***3*** *Develop and implement a mechanism for review by the treatment teams of progress notes developed by Mall facilitators that specify the individual's progress in Mall interventions.*			***CVC; JH; AS;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Implement the Avatar application (Phase II).	12/31/2008		Eric Strassman, Mark Larkins
	- Status: Feb, 2009 Update:The kick-off meeting for Phase II was held on 11/19/20089. There will be staggered implementation beginning 1/2009 through summer 2009.			
	2 Develop progress note template.	6/13/2008	Binder V, Tab # 17 (Therapeutic Progress Note)	Beth Gouse
	Complete - Status: Is being piloted, and is under review by consultant to obtain comments. Feb 2009 Udpate: Progress note template modified.			
	3 Develop system to ensure mall progress notes are filed in clinical record in timely manner.	7/31/2008	Binder V, Tab # 6 (IRP Manual)	CVC
	Complete - Status: Feb 2009 Update: System was developed and is being implemented. IRP manual being developed includes a treatment planning conference protocol which cues treatment team to review progress notes from treatment mall. Progress note template was revised.			
	4 Include non ward based treatment mall staff in treatment plan training	8/8/2008	Binder V, Tab # 6 (IRP Manual)	CVC; JH; Chief of staff
	- Status: Treatment plan schedules are on the global shared drive so that treatment providers are aware of the schedule. In addition, the IRP conference protocol cues the treatment team leader to gather information from additional members unable to be present for the scheduled meeting.			

5	Develop Draft Treatment Mall Strategic Plan for Operational Changes and Improvements. This plan discusses improvement in patient assessments, treatment planning, mall referrals, staffing, resources, education, training and space allocation.	1/30/2009	Binder V, tab # 54(Treatment Mall Strategic Plan for Operational Changes and Improvements), Tab # 54 (Tx mall redesign)	CVC

Complete - Status: Mall redesign well underway. Implementation of Phase is set for late Feb, early March and full implementation of all three TLCs by Mid April.

2) Dec 2008 ***1*** *Same as in Section V.A.1 to V.A.1.5.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Same as in Section V.A.1 to V.A.1.5.			

2) Dec 2008 ***2*** *Same as in V.B.1.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Same as in V.B.1.			

2) Dec 2008 ***3*** *Same as V.E.4.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as V.E.4.			

2) Dec 2008 ***4*** *Fully implement the new template for the Monthly Therapy Progress Note.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement new progress note template	2/12/2009		Beth Gouse

Complete - Status: New template is on intranet. Implementation ongoing

VI. Mental Health Assessments

Summary of Progress

1. The Hospital revised the previously provided Assessment policy to meet the standards of the DOJ Agreement. The Policy sets out clear content standards for assessments as well as timeframes for assessments and updates. The Medical records policy also specifies the time frames for completion of assessments and assessment updates.

2. The Hospital modified the discipline initial assessment forms for psychiatry, psychology, social work, and rehabilitation services (nursing's is pending finalization) to incorporate Policy changes and the recommendations from the two DOJ reports and to link the Assessments more closely to the IRP forms.

3. The Comprehensive Initial Psychiatric Assessment includes a mental status examination, a risk assessment as well as a substance abuse screening. The Initial Psychological Assessment includes a risk screening, a behavioral screen and a cognitive functioning screen. The results are utilized in developing the clinical formulation and clinical formulation updates which is completed prior to the IRP conference.

4. The Hospital continues to monitor and report on the timeliness of discipline assessments through a revised IRP process monitoring tool, which includes indicators and operational instructions. An audit was conducted in February 2009 focusing generally on units with some IRP training. Results show that nursing, psychiatry and social worker were completing assessments timely in about 80% of cases. Results were not as good for psychology, rehabilitation services or general medical services.

5. Social work, Rehabilitation Services and Psychology have completed at least one audit of the discipline initial assessments. Results are available for social work and rehabilitation, and psychology results should be available by March 30, 2009. Psychiatry has developed a tool and instructions, and will initiate audits in March, 2009.

6. The Hospital has not begun clinical chart audits that will evaluate the quality of assessments. A draft tool is complete, but it needs additional work, and the Hospital's PID director is working with clinical staff to refine the instrument. It should be completed by March 30, 2009.

6. IRP training has been ongoing on 5 units since September, 2008, and began on five more units in January, 2009. The remaining nine units will begin training by April 2009. The training involves substantial hours of direct observations, mentoring and coaching and review of records. The revised IRP Forms will be utilized beginning March 3, 2009.

7. Psychologists are now expected to complete admission assessments on all newly admitted patients that includes a risk assessment component and a cognitive functioning screening. This information will assist in identifying appropriate treatment interventions.

8. Psychiatric, psychological and nursing staffing have all significantly improved since the Baseline visit. Eleven units meet caseload requirements, and another will also meet requirements as a new psychiatrist begins the end of February. There are currently 16 psychologists (non supervisory, non-clinical administrators) in the psychology department.

VI. Mental Health Assessments.

By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after

Findings

See sub cells below.

Compliance Status: See sub cells below.

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.

VI.A. Psychiatric Assessments and Diagnoses

Findings

See sub-cells below

Compliance Status: See sub cells below.

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;

Findings

The Hospital revised its Assessment policy to incorporate the most recent recommendations of DOJ. Binder VI, Tab # 1(Assessment Policy). In addition, the disciplines, except nursing, all revised their assessment forms and began using them in January/ February, 2009. Binder VI, Tab #2 (Comprehensive Psych Assessment form), tab # 3 (Psychiatric Update), Tab # 5 (Initial Social Work Assessment form), Tab # 6 (Social work assessment update), Tab # 7 (Initial Psychological Assessment form Part A and B), Tab # 8 (Initial Rehabilitation Services Assessment form). The new discipline assessment forms work together to provide a whole picture of the individual and also parallel the IRP form, so that the information obtained during the assessments can be used to form the basis of the IRP.

The Assessment Policy sets out specific requirements for the content of assessments/reassessments as well as the time frames in which assessments/reassessments must be completed. The comprehensive psychiatric assessment form includes a pharmacological plan of care. The policy also specifies that a risk assessment must be completed within the first 24 hours. The Hospital also created a clinical formulation form and a clinical formulation update form. Binder VI, tab # 9 (Clinical case formulation/update forms). The Medical records policy requires weekly psychiatric notes for the first 60 days and monthly thereafter. Binder VI, tab # 10 (Medical Records policy)

Some data is available around completion of psychiatric and other discipline assessment. The IRP observations in July to September looked at completion of initial psychiatric assessments within 24 hours, and data shows that they were completed in 86% of cases. The data should be taken with some caution however, as the sample include persons who were admitted at any point in time (the sample was based upon who had an IRP scheduled, not who was admitted) and thus may not reflect current practice. See Binder VI, tab # 11 (IRP Results, July - September, 2008, #27-31).

The revised IRP Process Monitoring Tool utilized for the February 2009 reviews, also evaluated the timely completion of initial assessments, but the same cohort issues exist. (IRP Process results, Feb, 2009) A sample review of 8 charts of admissions in January, 2009 by the compliance office showed 100% compliance with the 24 hour requirement. In addition, this also will be monitored through the audit of the Comprehensive Psychiatric

Assessment; the tool is in pilot phase but should be used beginning in March. Binder VI, tab # 12 (Psychiatric audit tool). An audit tool has not yet been developed for the psychiatric assessment update form.

There is some data available about rehabilitation services and social work assessments which shows high rates of timely assessments for social work (95%), but much lower for rehabilitation services, likely due to staffing shortages. Binder VI, tab # 13 (Results of Rehab services assessment audit, Feb, 2009); tab # 14 (Social work assessment audit, Feb 2009). Other than these two audits, there is no additional information about the quality of content of the Assessments as the clinical chart audit process has not yet begun.

Compliance Status: Some progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Revise and finalize the current policy and procedure regarding Assessments to address this expert consultant's findings above.*	***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop and incorporate recommendations into Assessment policy document and obtain Exec staff approval.	6/15/2008	Binder VI, tab # 1 (Assessment policy, revised)	J Taylor: CEO
	Complete - Status: Recommendations have been incorporated into Assessment policy draft document. Feb 2009 Update: Assessment policy revised			
2	Format all discipline assessments in easily usable format and in way to allow data collection.	6/30/2008	Binder VI, Tab # 2 (Comp 24 Psychiatric assessment); Tab # 3 (Psychiatric Assessment Update); Tab # 5 (Initial social work assessment); Tab # 7 (Initial Psychology Assessment); Tab # 8 (Rehab assessment form)	PID
	Complete - Status: Feb 2009 Update: All assessments have been reformatted.			

1) Apr 2008	***2*** *Develop and implement self-monitoring tools, including indicators and operational instructions, that address the timeliness and content requirements for the initial psychiatric assessment (24 hours), admission psychiatric assessment (by fourth day) and psychiatric reassessments.*	***Medical; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include timeliness of assessments in IRP process tool.	6/27/2008	Binder VI Tab # 15 (IRP process tool)	QID director
	Complete - Status: Timelines of assessments is included in IRP process tool, which is under review by consultant. Tool was piloted and results pending. Feb Update: IRP process tool monitors this requirement.			
2	Upon finalization of assessment policy, and with assistance from consultant modify draft clinical audit tool to address discipline content requirements.	8/29/2008	Binder VI, Tab # 6 (psychiatry self audit tool), Tab # 17 (social work self audit tool); Tab # 18 (rehab self audit tool); Tab # 19(psychology self audit tool)	Chief of Staff; QID director
	- Status: Consultant is reviewing IRP process and clinical tools, as well as discipline specific assessment forms. Feb udpate: IN addition to monitoring this through IRP process tool, timeliness is reviewed through discipline self audit tools			

3 Train and begin auditing for IRP process.	6/27/2008	Binder VI, Tab # 15 (IRP Process Monitoring tool revised) IRP process results report, Tab #11	QID director

Complete - Status: Initial training occurred; additional training will be provided once tools finalized. Feb Update: Revised tool developed

4 Train and begin audits for content.	10/15/2008	Binder VI, tab # 13 (Audit results, Rehab) Tab # 14 (Audit results social work),	Medical Director, Discipline Chiefs

- Status: Rehab services has begun audit and has initial report.
Feb 2009 Update: In addition to IPR process audit, initial set of audits are available for social work, and rehab services.

1) Apr 2008 ***3*** *Provide monitoring data regarding psychiatric assessments and reassessments based on at least 20% sample (March to August).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete revision of assessment policy.	7/16/2008	Revised Assessment policy, Tab # 1	PID/CEO

Complete

2 See action steps in section VI.A.1 recommendation 2.			

- Status: See updates, action steps in section VI.A.1 recommendation 2

2) Dec 2008 ***1*** *Revise and implement Policy #602.1-08 including appropriate timeframes for the completion of the psychiatric reassessments, templates for the comprehensive psychiatric assessment and the psychiatric reassessments and guidelines for the completion of the assessments/reassessments.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy	2/5/2009	Binder VI, Tab # 1 (Assessment policy)	PID

Complete

2) Dec 2008 ***2*** *Ensure that the template for the initial psychiatric assessment includes a plan of care that addresses medications (regular and PRN) and precautions to ensure safety of the individual and others pending completion of the comprehensive assessment.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise initial plan of care form	2/5/2009	Binder VI, tab # 22 (Initial IRP)	Beth Gouse

Complete

2 Train psychiatric staff and implement use of form	2/27/2009		Medical director

- Status: Medical staff trained on form on February 5, 2009. Form will be utilized beginning February 15, 2009.

2) Dec 2008 ***3*** *Develop and implement self-monitoring tools, including indicators and operational instructions, that address the timeliness and content requirements for the initial psychiatric assessment (24 hours),admission psychiatric assessment (by fourth day) and psychiatric reassessments.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See actions steps in VI.A.1 recommendation 2			

2) Dec 2008 ***4*** *Provide monitoring data regarding psychiatric assessments and reassessments based on at least 20% sample (March to August).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			Medical director

- Status: Audit tool for initial psych assessment was developed and tested. Audits expected to begin in March, 2009.

2) Dec 2008 ***5*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See previous action step.			

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;

Findings

The initial psychiatric assessment form has been revised to include a more specific risk screening within the first 24 hours. Binder VI, See Tab # 2 (Comprehensive Initial Psychiatric Assessment form). Risk also is screened in the first 3 business days through a psychological risk screen. Binder VI, Tab # 7 (Initial Psychological Assessment forms, Part A and B). Both forms are now in use hospital wide (since January for psychiatric assessments, since December for psychological assessments). Further, consideration of risk factors has been incorporated into the clinical formulation and clinical formulation update, theinitial interdisciplinary recovery plan (IIRP) and the IRP. Binder VI, tab # 22 (IIRP); tab # 24 (IRP), tab # 9 (clinical formulation), tab # 9 (Clinical formulation update). The new IRP forms and clinical formulation are being rolled out to all units in March, 2009.

A small sample review of the comprehensive initial psychiatric assessments by the compliance office (8 charts of admission since January 1, 2009) show that in all cases, the new assessment form was utilized and that the risk assessment portion was partially completed in all. However, the review also indicated that the mitigating factors and necessary precautions sections were not completed in the majority of assessments. In contrast, in 7 of 8 charts, an initial psychological assessment was completed, and all aspects of the IPA were completed. In two cases reviewed, day room restriction precautions were identified, ordered, and were implemented.

Psychology has developed an audit tool reviewing the completion of the initial psychological assessment and conducted an initial audit. Binder VI, tab # 16 (Psychology audit tool/instructions). . Psychiatry also developed an audit tool and instructions, which was tested in February, 2009 and modified. The tool and instructions address risk assessment and will be utilized for a full audit in March, 2009. Binder VI, tab # 12 (Psychiatry audit tool/instructions).

Compliance Status: Progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as IV.A.1*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

	1 Same action steps as IV.A.1.			

- Status: Phase II prep sessions with Vendor began in October 2008; the kick-off was 11/19/20089. There will be staggered implementation beginning in 1/2009. The management report will be designed in January 2009 with an expected completion date of 2/1/ 2009.

1) Apr 2008

2 *Develop and implement a mechanism for risk assessment within the first 24 hours of admission. At a minimum, the assessment must provide information regarding:* ***Medical; BG;***

a The type of risk (e.g. suicide, homicide, physical aggression, sexual aggression, self-injury, fire setting, elopement, etc);

b Timeframes for risk factors;

c Description of severity of risk and its relevance to dangerousness; and

d A review of the circumstances surrounding the risk events, including mitigating factors

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise initial psychiatric assessment form to address risk assessment.	6/30/2008	Binder VI,Tab # 2 (Comprehensive 24 Hour Psychiatric Assessment)	Medical Director

Complete - Status: Feb Update: Form was updated and revised.

1) Apr 2008

3 *Revise the current format of the admission psychiatric assessment to ensure that the mental status examination provides specific information regarding dangerousness.* ***Medical; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise psychiatric assessment form.	6/30/2008	Binder VI, Tab # 2 (Comprehensive 24 Hour Psychiatric Assessment)	Medical Director

Complete - Status: Feb 2009 Update: Form was revised.

1) Apr 2008

4 *Ensure that the monitoring tool regarding the initial psychiatric assessment includes indicators and operational instructions to address risk assessment.* ***Medical; PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Secure a contract with a vendor to assist the hospital in developing discipline specific monitoring tools and revising existing tools.	6/25/2008		Medical Director

- Status: Director, PID hired and will lead development of tools, indicators and instructions

2 With technical assistance from consultant, develop monitoring tool, indicators and instructions to permit assessment of quality of discipline assessments.	8/31/2008	Binder VI, Tab # 16 (Audit Tool, initial psych assess and operational instructions)	Medical Director

- Status: Timeline prioritizing tool development is under development.
Feb 2009 Update: Audit tool for initia psych assessment and instructions developed and piloted

1) Apr 2008 ***5*** *Provide data regarding risk assessment as part of the initial psychiatric assessment monitoring data, based on at least 20% sample (March to August 2008).* ***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID will analyze data and consult as appropriate with the risk manager.	10/31/2008	Binder VI, Tab # 16 (Audit Tool, initial psych assess and operational instructions)	PID, Risk Mgr
- Status: Feb 2009 Update: Risk assessment is part of audit tool			
2 Ensure monitoring instrument includes indicators and criteria to evaluate quality and timeliness of risk assessment. Consider including it in initial chart audit; TA from consultant.	8/29/2008	Binder VI, Tab # 16 (Audit Tool, initial psych assess and operational instructions)	Chief of staff
- Status: No action to report. *Feb 2009 Update: Audit tool includes operational instructions*			
3 Implement audit as part of clinical audit tool.	10/31/2008	Binder VI, Tab # 16 (Audit Tool, initial psych assess and operational instructions)	Medical director
- Status: No action to report. *Feb 2009 Update: First audit was conducted for January Admissions.*			
4 Hire Manager of Peer Review and Standards to manage clinical audit.	9/30/2008		Medical Director
- Status: PD under development. *Feb 2009 Update: Position has not yet been filled.*			

2) Dec 2008 ***1*** *Same as VI.A.1.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as VI.A.1.			

2) Dec 2008 ***2*** *Implement an admission risk assessment that integrates the information in the initial psychiatric assessment and psychological screening tools.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise comprehensive 24 hour psychiatric assessment	2/6/2009	Binder VI, Tab # 2 (Comprehensive initial psych assessment)	Beth Gouse
Complete			
2 Revise initial psychological assessment.	2/18/2009	Binder VI, Tab # 7 (Initial Psychological assessment)	Beth Gouse
Complete			
3 Revise IRP form to address results of risk assessment	2/12/2009	Binder VI, Tab # 24 (Comprehensive IRP form)	Beth Gouse
Complete			

4 Complete training on all units on addressing risk in IRP	6/30/2009		Beth Gouse

- Status: Ongoing. Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP 2, JHP7, JHP 9, JHP 12, RMB 2, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.

2) Dec 2008 ***3*** *Ensure that the monitoring tool regarding the initial psychiatric assessment includes complete indicators and operational instructions to address risk assessment.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, VI.A.2 recommendation 4.			

2) Dec 2008 ***4*** *Monitor risk assessment as part of the initial psychiatric assessment m, based on at least 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.A.2, recommendation 4 and 5.			

2) Dec 2008 ***5*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action step			

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;

Findings

The Hospital uses the DSM-IV as its diagnostic manual.

Psychiatry also developed an audit tool and instructions, which was tested in February, 2009 and modified. The tool and instructions address diagnostic accuracy and will be utilized for a full audit in March, 2009. Binder VI, tab # 12 (Psychiatry audit tool/instructions).

There is now available a management report from AVATAR that provides diagnostic information on each individual, which managers can use to review for some diagnostic issues. However, the system does not appear to have the capacity to run a report of diagnosis for certain periods of time (i.e., list of persons with R/O diagnosis for longer than 90 days) without some modification or change in business processes, which is being evaluated. Thus, until the Hospital can resolve these issues, the clinical chart audits and the psychiatric assessment update audits will need to include this as an indicator in order for the Hospital to be able to monitor this aspect of diagnosis. It is also expected that diagnostic issues will have a greater focus on the IRP process.

The new Comprehensive Initial Psychiatric Assessment form, Binder VI, tab # 2, includes an assessment of cognitive impairments, as does the Initial Psychological Assessment Form, Binder VI, tab # 7.

Compliance Status: Partial

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in VI.A.1 and VI.A.6.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same action steps as in VI.A.1 and VI.A.6.			
1) Apr 2008	***2*** *Ensure that the monitoring tools regarding psychiatric assessments and reassessments include indicators and operational instructions that address diagnostic accuracy, including that the diagnoses are consistent with the individuals' history and current presentation.*			***Medical; PID; BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 With technical assistance from consultant, develop monitoring tools for review of psychiatric assessments and reassessments	10/31/2008	Binder Vi, Tab # 12 (Self audit tool/operational instructions for psych assessment)	Medical Director; QID; chief of staff
	- Status: Revised psychiatric assessment form has been developed. Being reviewed by consultant. Clinical chart audit tool is in draft but will need revision and is being reviewed by consultant.			
	Feb 2009 Update: Monitoring tool and instructions developed for initial psych assessment, but a tool is not yet finalized for reassessment.			
1) Apr 2008	***3*** *Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (March to August 2008).*			***Medical; PID;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See action steps under VI.A.3 recommendation.	11/27/2008		Medical Director, QID
	2 Summarize and report data monthly subsequent to audits.	11/28/2008		OMS
	- Status: None available			
	3 Create patient database to serve as interim measure pending AVATAR implementation.	6/2/2008	Clinical profile of inpatient population, Tab # 55	OMS
	Complete - Status: Database complete, and provides some information about diagnoses. It does note provide capacity to assess if patient is properly diagnosed, but does give information about r/o and other differential diagnoses. *Feb Update: Diagnostic information is now available in Avatar, and management reports that are able to track some indicators (ie, persons with r/o dx longer that 60 days) are in development. Those reports, with the self audit results, will help improve diagnostic accuracy.*			
2) Dec 2008	***1*** *Same as in VI.A.1 and VI.A.6.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.1 and VI.A.6.			

2) Dec 2008 ***2*** *Develop and implement monitoring tools regarding psychiatric assessments and reassessments, including complete indicators and operational instructions that address diagnostic accuracy.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop self audit tool for initial psych assessments that include assessment of diagnostic accuracy.	2/2/2009	Binder VI, Tab # 16 (Self audit tool, psychiatry)	Medical director
Complete			
2 Develop self audit tool for psych reassessments that include assessment of diagnostic accuracy.	3/18/2009		Medical director
3 Conduct self audits for initial and psych reassesments	2/26/2009		Med Director
- Status: Audits began in Feb. 2009 for initial psych assessments. Tool not yet finalized for psych reassessment audits, but expected to be finalized in March.			

2) Dec 2008 ***3*** *Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (October 2008 to March 2009).* ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide self audit results for initial psych assessments			Med Director
- Status: Ongoing			
Provide self audit results for initial psych reassessments	5/1/2009		Med Director
- Status: Self audit tool not yet developed. Expected March, 2009 and audits to begin in April, 2009. Results within 45 days of audit			

2) Dec 2008 ***4*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.A.3 rec #3.			

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;

Findings

Same as above

Compliance Status: Progress has been made toward the December 2008 compliance date.

Recommendations	*Responsible Party*
1) Apr 2008 ***1*** *Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in February 2008			

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;

Findings

Same as above.

The Hospital is largely completing psychiatric assessments within 24 hours of admission, although the quality of the assessments has not yet been evaluated as psychiatric peer review and clinical chart audits are not yet occurring.

IRP training includes training around identifying the individual's strengths, Binder VI, tab # 26 (IRP Training outline), and new assessment instruments developed by the disciplines other than nursing are expected to impact positively this deficiency. Tab # 2 (Comprehensive Initial Psych Assessment form), Tab # 5 (Initial Social Work Assessment form), Tab # 8 (Initial Rehabilitation Services form). In addition, identification of the individual's strengths and development of objectives and interventions off the strengths are key components of the clinical formulation, IRP process and form. Binder VI, tab # 9(Clinical formulation and update); tab # 24 (IRP form).

There is some data available about strength identification from IRP process monitoring and social work initial assessment audits but none is yet available about the psychiatric assessment's formulation of the individual's strengths.

Other than Rehabilitation Services which has developed a tool that is being piloted, the Hospital has yet to develop peer review materials for disciplines that will capture this requirement, but is working with a consultant to develop an appropriate monitoring tool. A review of a small sample of charts suggest that this will need to be a focus of the treatment planning training, as in some cases strengths were overlooked (i.e., in one chart, the patient had some college education and work history, but neither was noted as a strength).

The IRP process tool briefly assesses the recognition of patient strengths as part of treatment planning, but that tool does not provide the appropriate venue to assess the quality of the assessment of patient strengths.

Compliance Status:

Partial compliance.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.1 and VI.A.2.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1 and VI.A.2.			

2) Dec 2008 *Same as in February 2008*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in February 2008			

VI.A.6

By 12 months from the Effective Date hereof, SEH shall ensure that:

Findings

See sub cells

Compliance Status: See sub cells.

VI.A.6.a

clinically supported, and current assessments and diagnoses are provided for each individual;

Findings

Same as VI A 1, A 3 and A 6.

Compliance Status: Partial.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.1, VI.A.3 and VI.A.6.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1, VI.A.3 and VI.A.6.			

2) Dec 2008 *Same as in VI.A.1, VI.A.3 and VI.A.6.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.1, VI.A.3 and VI.A.6.			

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;

Findings

The revised Assessment policy and protocols from the Psychiatry Training Department require that psychiatrists write a note, rather than merely countersign trainee notes. Binder VI, Tab # 1 (Assessment Policy). However, it is still too common a practice for attending doctors to merely countersign notes. In a small sample of charts reviewed by the compliance office that used the new Comprehensive Initial Psychiatric Assessment, three of 8 did not include a signature of an attending psychiatrist and none included a separate note by the attending psychiatrist. The Hospital will monitor this requirement through the psychiatric audit tool.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Provide the facility's procedure that ensures adequate supervision of trainees and appropriate communications between the trainees and attending physicians.* ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate requirement into assessment policy.	7/15/2008	Assessment Policy, Tab # 1	CEO
2 Train psychiatrists on this requirement.	8/22/2008		Medical Director

1) Apr 2008 *2 Provide self-assessment data regarding implementation of this requirement.* ***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in clinical audit tool.	8/31/2008	Binder VI, Tab # 12 (Audit tool and instructions, comprehensive 24 hour psych assessment)	Chief of Staff
Complete - Status: Feb 2009 Update: Clinical audit tool is not yet finalized. This requirement is included in instructions to audit tool for initial psych assessments.			
2 Obtain TA from consultant.	7/24/2008		Chief of staff
- Status: Consultant is reviewing draft. Feb 2009 Update: No longer using consultation, but will be led by PID director			
3 Revise tool as needed.	8/29/2008		QID
- Status: Feb 2009 Update: Clinical audit tool is not yet finalized. This requirement is included in instructions to audit tool for initial psych assessments.			
4 Begin audits using revised tool.	9/30/2008	Binder VI, Tab # 12 (Audit tool and instructions, comprehensive 24 hour psych assessment)	Medical Director
- Status: Feb 2009 Update: First Audit for comprehensive 24 hour psych assessment complete.			

2) Dec 2008 *1 Provide self-assessment data regarding implementation of this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps			

2) Dec 2008 *2 Ensure that all trainees are properly oriented to the facility's procedures regarding identification and reporting of abuse/neglect.* ***Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train all staff on obligations to report suspected abuse and neglect.	2/27/2009	Binder VI, tab # 29 (Training curricula), Binder VI Tab # 30 (Training data)	
- Status: February 2009: Over 700 staff trained			

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 diagno

Findings

See VI.A.3 concerning NOS and R/O diagnosis.

Training is scheduled for Spring, 2009 for psychiatry around cognitive remediation. The neuropsychologist is developing a set of standards to guide all caregivers in the hospital related to level of Cognitive Function (as determined by the IPA). These standards will address what can be realistically expected from patients with Cognitive Compromise and how best to approach these patients while providing care and treatment. We will likely focus on categorizing patients as having low, moderate or high cognitive functions. They will also address the need for individualized care as well.

Training on cognitive impairment is also part of the training for the TLC programs at the treatment mall.

Compliance Status: Partial.

Recommendations	*Responsible Party*
1) Apr 2008 *1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.*	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.			

1) Apr 2008 *2 Provide CME training to psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders.* ***Medical;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Develop capacity for CME training for psychiatry staff.	12/31/2008		Farooq Mohyuddin
	- Status: CME application is being submitted in August 2008 and approval is expected in October 2008. Feb 2009 Update: The process of getting CME accreditation takes about one year, but application is pending. In the interim, the Hospital applied for and was granted interim Joint Accreditation from MedChi.			
	2 As approval process is pending, begin development of training schedule.	10/8/2008		Farooq Mohyuddin

1) Apr 2008 *3 Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.* ***Medical;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Will provide once application is approved and speaker is scheduled.			

1) Apr 2008 *4 Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS* ***Medical; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Develop patient database to collect diagnosis information	6/2/2008	Binder VI Tab # 31 (Management report around diagnosis)	OMS
	Complete - Status: Data base created and all doctors completed training February 2009 Update: Developing management reports around diagnosis that includes ability to track length of time persons remain with NOS and/or r/o dx			
	2 Bi-monthly report clinical profile data.	7/31/2008		OMS
	Complete - Status: Feb Update: Previously, this information was not easily available, but through AVATAR there is now a management report on this. It will be included in trend analysis			
	3 Medical Director and Director of Psychology review results and address diagnosis issues with treating doctors.	8/15/2008	Binder VI Tab # 31 (Management report around diagnosis)	Medical Director
	- Status: Ongoing			
	4 Train doctors on r/o and NOS diagnosis.	10/1/2008		Medical Director
	- Status: No update is available.			

2) Dec 2008 *1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.			

2) Dec 2008 ***2*** *Provide CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain CME certification.	11/28/2008		Medical Director
Complete - Status: The process of getting CME accreditation takes about one year, but application is pending. In the interim, the Hospital applied for and was granted interim Joint Accreditation from MedChi.			
2 Provide training in cognitive and neuropsychiatric disorders	9/30/2009		Medical director
- Status: Initial training was providing on "Seasonality in suicide" and "Recovering Psychiatry". The planned lectures for this year include "Cognitive Remediation", "Update in Hepatitis C treatment"; Update in Dementia treatment; and Evidence based treatment of schizophrenia and Bipolar Disorder.			

2) Dec 2008 ***3*** *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Documentation of the cognitive remediation training will be provide once it occurs			

2) Dec 2008 ***4*** *Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

VI.A.6.d

each individual's psychiatric assessments, diagnoses, and medications are clinically justified.

Findings

Same as VI.A.1 through VI. A.6.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.1 through VI.A.6.a and VI.6.c.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1 through VI.A.6.a and VI.6.c.			

2) Dec 2008 *Same as in VI.A.1 through VI.A.6.a and VI.6.c.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.1 through VI.A.6.a and VI.6.c.			

VI.A.7

By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.

Findings

The Hospital modified its Assessment policy to provide more specific guidance about the content of psychiatric reassessments. Binder VI, Tab # 1 (Assessment Policy). A new psychiatric assessment update form has been developed, Binder VI, tab # 35 (Psychiatric Update Form). The forms is designed to address the deficiencies noted in DOJ report #2. It is more focused on clinical course since last update; identifying residual or target symptoms, use of PRNs, seclusion or restraint and adverse reactions to medications; updating risk assessment and diagnosis; and describing medication changes or failure to change medications and relevant risks/benefits. The form was

introduces for use in late February, 2009.

Clinical chart reviews have not yet begun so there is not data to measure the quality of reassessments. An audit tool for the Psychiatric Update is still being developed.

The IRP process observations are a source of some data around the timely completion of psychiatric updates. The IRP process review for the period of July to September, 2008 indicate that psychiatric progress notes preceding the treatment plan conference were timely completed in 76% of cases reviewed. Binder VI, tab # (IRP Process Results, July - Sept, 2008). Data from the latest round of IRP observations around timeliness of psychiatric updates is not available due to rater reliability issues. The issues with the tool will be revised for the March, 2009 audits.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in VI.A.1.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.1.			
1) Apr 2008	***2*** *Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above.*			***Medical; BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Finalize revised assessment policy.	7/15/2008	zBinder VI tab # 1 (Assessment policy, revised)	J Taylor
	Complete - Status: Policy revised.			
	2 Update new psychiatric reassessment form that is consistent with policy.	7/31/2008	Binder VI, Tab # 3 (Psych Reassessment/update form)	Chief of staff
	Complete - Status: Feb Update: New format developed for psychiatric reassessment effective end of February, 2009.			
	3 Evaluate appropriateness of developing form for reassessments and develop as needed.	10/31/2008		Medical Director
	Complete			
2) Dec 2008	***1*** *Same as in VI.A.1.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as in VI.A.1.			
2) Dec 2008	***2*** *Develop and implement a standardized format for psychiatric reassessments that addresses and corrects the deficiencies identified above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Update new psychiatric reassessment form that is consistent with policy.		Binder VI, Tab # 3 (Psych Reassessment/update form)	
	- Status: Feb Update: New format developed for psychiatric reassessment effective end of February, 2009.			

VI.B. Psychological Assessments **Findings**

See findings in specific sub-cells

Compliance Status: See specific findings.

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.

Findings

The Psychology Department includes 16 staff psychologists, a neuropsychologist (20 hours per week) with 6 externs, Director of Psychology and a Director of Psychology Training. These numbers do not include the 5 clinical administrators who are also psychologists by training.

The Director of Psychology is developing protocols for reports addressing various types of referrals that will establish time frames for completion of the assessments. Templates for risk assessment, the IPA and a general psychological evaluation are complete. Binder VI, tab # 32 (Template, risk assessment), tab # 7 (Template IPA, part A and B); tab # 33 (Template, psychological evaluation). It maintains a referral log. Binder VI, tab # 34 (referral log). Referrals are made on the Hospital's standard Form 660. Binder VI, tab # 35 (Form 660)

Psychology also developed and conducted a initial audit of the IPA. Binder VI, tab # 19 (IPA Audit tool with instructions) The Audit tool includes monitoring the timeliness of the IPA. As of the writing of this report, data is not available, but should be available during the March, 2009 visit.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	*1 Develop and implement a policy governing the appropriate timelines for the completion of referrals for all psychological assessments. Since the monitoring of all psychological assessments falls within the purview of the Psychology Department, the hospital should consider reorganization so that the neuropsychologist reports through the Chief of Psychology.*	***Medical; Psychology Director (Patterson)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Time frames are reflected in the data base which tracks referrals and status of the referrals.	7/31/2008	Binder VI, Tab # 1 (Assessment policy revised);	Director Psychology
Complete - Status: Referral database is completed; Assessment policy established time frames. February 2009 Update: Assessment policy and Psychology department manual include parameters for appropriate time frames for completion of assessments. Manual is not yet complete but expected by March 30, 2009			
2 Medical Director will evaluate reporting structure for neuropsychology.	7/31/2008		Medical Director
- Status: February 2009 Update Neuropsychologist reports to Director of Psychology			

1) Apr 2008

2 *Develop and implement a tracking system to determine when all referrals for any type of psychological assessment are made and track these assessments to completion. This process will help the Psychology Department and the hospital better understand its need for psychological services, so that an adequate number of psychologists can be hired.*

Medical; PID; Psychology Director (Patterson)

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop psychology referral tracking system on Global Share drive.	6/30/2008	Binder VI, Tab # 34 (Referral Log)	Director of Psychology
Complete - Status: Feb 2009 Update: Due to technical difficulties, referral log is no longer on global shared drive, but referrals are being tracked. Until such time as AVATAR goes live, psychologists keep a loose leaf with all copies of referrals			
2 Not Identified			
Complete			

1) Apr 2008

3 *Develop standard templates for all psychological screening and assessment reports that mirror the requirements of the DOJ agreement. At a minimum, address:*

Medical; R Patterson

- *a The individual's identifying information*
- *b Precipitants to hospitalization*
- *c The reason for the referral*
- *d Relevant social, educational, employment and legal history*
- *e History of head or brain injury*
- *f Past mental health and substance abuse history*
- *g Risk for harm factors where relevant*
- *h The dates and results of previous psychological assessment*
- *i The psychological tools and measures employed in the assessment process*
- *j The results of all psychological tools and measures*
- *k Conclusions that directly address the referral question and draw a connection between testing results and other current and accurate data*
- *l Recommendations that flow logically from the conclusions or that provide clarification for the referral question*
- *m Any recommendations for further assessment*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a Department of Psychology manual; initial section will be the standard formats for psychological assessments.	2/1/2009		R. Patterson
- Status: Expected to be completed by March 30, 2009.			
2 Establish policies and procedures to the recommended areas.	8/30/2008		R Patterson
Complete			

3 In-service will be provided for the department staff on new policies and formats.	8/26/2008		R Patterson
Complete			
4 Templates will be implemented.	9/1/2008		R Patterson
Complete - Status: Feb 2008 Update: Templates were implemented following a pilot period.			

1) Apr 2008 — ***Medical; R. Patterson***

4 *Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools) that address the psychological assessment process. At a minimum, monitor:*

- *a All of the items indicated in the template outlined in Recommendation 3 above;*
- *b Timeliness of the assessment process as per yet to be established policy guidelines*
- *c The quality of each section of the evaluation*
- *d The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record*
- *e The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop monitoring tools that track established format for each kind of psychological assessment.	10/31/2008	Binder VI, Tab # 19 (psychology self audit tool and instructions for initial psychological assessment);	R Patterson
Complete - Status: New Initial psychology assessment self audit form has been developed, and piloted. Results are available			
2 Develop audit tools and instructiosn for all types of assessments	4/30/2009		R. Patterson
3 Implement self audits.	5/29/2009		R. Patterson

1) Apr 2008 — ***PID; Rose Patterson***

5 *The auditing/monitoring data can be used as part of the peer review process for individual psychologists. Aggregate and trend as part of an ongoing performance improvement process that will help determine where needed intervention, training or supervision is best directed within the department.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop policy and procedures for a peer review process based on the standard templates and timelines established for Psychological Reports.	8/30/2008	Binder VI, Tab # 19 (psychology self audit tool and instructions for initial psychological assessment);	R Patterson, QID
- Status: New Initial psychology assessment self audit form only has been developed, and piloted. Results expected by March 30, 2009			
2 Conduct Peer review using the auditing tools.	2/15/2009		R Patterson
- Status: Only peer review conducted is for initial psychological assessments. Tools for other types in development.			
3 Publish results of the review and recommend corrective measures.	2/28/2009	Binder VI, Tab # 19 (psychology self audit tool and instructions for initial psychological assessment)	R. Patterson; OMS
- Status: New Initial psychology assessment self audit form only has been developed, and piloted. Results are expected by March 30, 2009.			

1) Apr 2008 *6 Train auditors to acceptable levels of reliability.* ***Medical; R Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct in-service for psychology staff prior to peer review.	2/10/2009		R Patterson

- Status: Staff has reviewed draft form; pilot underway; 1st formal review in February

1) Apr 2008 *7 Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***Medical; Psychology Director (Patterson)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Utilize consultant for technical assistance to Psychology Dept to develop operational instructions and indicators.	3/16/2009	Binder VI, Tab # 19(Psychology self audit tool and instructions for initial psychological assessment)	Director of Psychology

- Status: February 2009 update: Consultation not utilized for this, but department developed its operational instructions, after initial pilot resulted in changes to tool; Instructions reflect new tool

2) Dec 2008 *1 Continue all above recommendations in February 2008.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all above action steps from recommendations in February 2008.			

2) Dec 2008 *2 Develop policy and practice guidelines that assure that reading level is reported as a grade level in all psychological evaluations/IPAs.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop psychology department procedure that requires reading level to be reported as grade level in all psychological assessments	2/27/2009		R. Patterson

- Status: Manual expected to be completed by March 31, 2009

2) Dec 2008 *3 Complete the Psychology Department Manual to assure that guidelines are given for how to meet each relevant item of the agreement as it concerns psychology assessments.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft psychology manual	2/6/2009		R patterson

- Status: A draft manual is expected to be completed by March 30, 2009.

2) Dec 2008 *4 Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

VI.B.2 **Findings**

By 24 months from the Effective Date hereof, all psychological assessments shall:

See sub-cells for findings.

Compliance Status: See sub cells.

VI.B.2.a

expressly state the purpose(s) for which they are performed;

Findings

The current practice continues to be to include in assessments the reason for the assessment.

Compliance Status: Substantial

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Continue current practice with Risk Assessments and Neuropsychological Assessments.*	***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice.			
- Status: Current practice is continuing. Samples will be provided prior to September 22 visit.			

1) Apr 2008	***2*** *See cell VI.B.1, Recommendation 4. An important item to monitor is that all psychological assessments clearly state the referral question, and that the referral question is directly answered in the assessment's conclusion section.*	***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train psychologists to develop concise referral question(s) and assist the treatment team.	8/26/2008		R Patterson
Complete - Status: Training is complete. Informal monitoring ongoing.			
2 Include assesment of referral question in the monitoring process for psychological assessments.	2/15/2009		R Patterson
- Status: Audit for iniital psychological assessment completed in February, 2009, results pending			

1) Apr 2008	***3*** *Have psychologists work with treatment teams informally or provide teams formal training in assisting them in how to structure appropriate referral questions.*	***Medical; R Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure psychology staff discuss the referral process with any referring source to refine the questions prior to initiating assessment.	6/25/2008		Director, Psychology
Complete - Status: This is ongoing.			
2 Train to Senior Staff on August 19, 2008 , in part, on how to make a referral and state reason for referral.	8/19/2008		Director, Psychology
Complete - Status: Completed during department presentation.			

2) Dec 2008	***1*** *Continue present practices.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue present practices.			

2) Dec 2008 ***2*** *Assure and document that all psychology department members have received training in how to work with teams on structuring the referral questions for psychological assessments/evaluations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Director, Psychology Department, will work with psychologists in assisting teams on how to structure psychology referral questions			R Patterson
- Status: Ongoing			
2 Link individual psychologists to treatment teams to provide expertise to treatment teams on developing referral questions		Binder VI, Tab # 36 (Ward assignments)	R Patterson
Complete			

VI.B.2.b

be based on current and accurate data;

Findings

Assessments/evaluations continue to be based upon current and accurate data.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*

1) Apr 2008 ***1*** *Continue to use current and accurate data in arriving at their conclusions, as was evident in the great majority of reviewed assessments.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice.			
- Status: Practice continues			

1) Apr 2008 ***2*** *See cell VI.B.1, Recommendations 4, 6 and 7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VI.B.1, Recommendations 4, 6 and 7.			

2) Dec 2008 *Continue all past recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps to related recommendations			

VI.B.2.c

provide current assessment of risk for harm factors, if requested;

Findings

Prior practice continues.

Compliance Status: Substantial

Recommendations	*Responsible Party*

1) Apr 2008 ***1*** *Maintain current level of practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Continue current practice.

- *Status: Current level of practice is maintained*

1) Apr 2008 *2 See cell VI.B.1, Recommendations 4, 6 and 7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VI.B.1, Recommendations 4, 6 and 7.			
- *Status: See cell VI.B.1, Recommendations 4, 6 and 7*			

2) Dec 2008 *Continue to implement all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue to implement all past action steps related to prior recommendations.			

VI.B.2.d

include determinations specifically addressing the purpose(s) of the assessment; and

Findings

Prior practice around risk assessment continues. A risk assessment report template has been developed and now is being utilized.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1) Apr 2008 *1 Develop clear guidelines for the Conclusions and Recommendations sections of all psychological assessments and screenings.*	***Medical; Psychology Director (Patterson)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a department manual; the 1st section to be completed will include templates for psychological evaluation formats and guidelines regarding what to address in each section.	1/15/2009		R Patterson
- *Status: Manual development, standardization of forms with guidelines complete, though changes may be made as all are implemented. Manual draft expected to be available during March, 2009 visit.*			

1) Apr 2008 *2 Provide directions on how the psychological assessment is to directly answer the referral question and make appropriate recommendations based on that answer.*	***Medical; Psychology Director (Patterson)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to VI.B.2.a recommendation 2.			
- *Status: See response to VI.B.2.a recommendation 2.*			

1) Apr 2008 *3 Auditing tools for monitoring the psychological assessment process must include items relevant to determining ongoing compliance with this element of the DOJ agreement. See cell VI.B.1, Recommendation 4.*	***Medical; PID; Psychology Director;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VI.B.1. Recommendation 4 and 5.			
- *Status: See VI.B.1. Recommendation 4 and 5.*			

1) Apr 2008 ***4*** *See cell VI.B.1, Recommendation 7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VI.B.1, Recommendation 7.			
- Status: See cell VI.B.1, Recommendation 7.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with all prior action steps.			

VI.B.2.e

include a summary of the empirical basis for all conclusions, where possible.

Findings

See cell VI.B.2.d

Psychologists have access to current research.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See cell VI.B.2.d, Recommendation 1.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in cell VI.B.2.d, Recommendation 1.			
- Status: See cell VI.B.2.d, Recommendation 1.			

1) Apr 2008 ***2*** *Provide directions on how the empirical basis for all conclusions is to be addressed in the assessment report.* ***Medical; R Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Provide access to Psychology staff to current research; Policies under development will include direction to access this information for assessments and therapy	1/15/2009		R Patterson
Complete - Status: Psychology Department Manual expected to be completed by March 30, 2009.			

1) Apr 2008 ***3*** *See cell VI.B.2.d, Recommendations 3 and 4.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in cell VI.B.2.d, Recommendations 3 and 4.			
- Status: See cell VI.B.2.d, Recommendations 3 and 4.			

2) Dec 2008 *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with all prior action steps			

VI.B.3

Findings

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.

Ward based psychologists are evaluating the individuals on the unit, reviewing old psychological examinations, and will refer those in need of an updated assessment.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and implement a timeline for the completion of this item of the agreement.*	***BG; R Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify individuals currently in Hospital who had psychological assessment in past through review of available logs.	6/30/2009		Rose Patterson
- Status: Ward based psychologists are working with teams to identify persons in need of psychological assessments; review of prior assessments will be part of that assessment process			
2 Ward based psychologist shall review previous assessment to assess if additional assessment is required.			Rose Patterson
Complete - Status: This process has proceeded on admission and pre-trial wards during IPA and in JHP for all risk assessments			
3 A tracking log of the review of each person prior assessment, and recommendation as to whether a reassessment is needed, will be maintained in Psychology department.	5/13/2009		Rose Patterson
- Status: A formal log has not been initiated, but is under development			
4 Where needed, reassessment will be completed; if not needed, psychologist shall complete note in medical record.	8/31/2009		Rose Patterson
- Status: No update.			

1) Apr 2008	***2*** *Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment (see Cell VI.B.1).*	***Medical; Psychology Director (Patterson)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VI.B.3 recommendation #2.	11/28/2008		
- Status: See VI.B.3 recommendation #2.			

2) Dec 2008	*Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

VI.B.4 **Findings**

By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.

The Hospital's revised Assessment policy is complete and provides content requirements for psychological assessments. Binder VI, tab # 1 (Assessment policy) The policy provides for psychology screens on all newly admitted patients, that includes a risk screen as well as a cognitive impairment screen. A new psychological initial assessment form was drafted, piloted, and revised. Binder VI, tab # 7 (Initial Psychological Screening form). Each admission unit has a psychologist assigned to complete initial assessments.

In addition, the Psychology Department has the capacity to complete risk assessments, neuropsychology assessments, dementia evaluations, general psychological evaluations, and behavioral guidelines and plans.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Finalize and implement the draft policy.*	***Medical; PID; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate psychology assessment requirements into the Assessment policy.	6/15/2008	Binder VI tab # 1 (Assessment policy revised)	J Taylor
Complete - Status: Psychology assessment requirements have been incorporated into the Assessment policy. *Feb Update: Assessment policy has been updated*			
2 Develop procedures and train staff on when a referral to psychology is appropriate.	8/29/2008		Rose Patterson
Complete - Status: This issue will be supported by the psychologist that is assigned to each unit, who will support the identification of patients who are in need of psychological assessments or testing. See also VI.B.2.a. *Feb 2009 Udpate: Ongoing.*			

1) Apr 2008	***2*** *Give careful consideration to requiring that all new admissions receive at a minimum a cognitive screening in addition to the required risk assessment. Both chart reviews and discussion with psychology staff suggest that a high percentage of those individuals admitted to St. Elizabeths Hospital have some measure of cognitive impairment that will be an important determinant in providing adequate treatment and rehabilitation, as well as a prominent issue in discharge planning.*	***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete an Initial Psychological Assessment form that assesses cognitive functioning and risk assessment on all new admissions. .	7/31/2008	Binder VI, Tab # 7 (IPA forms, Part A and Part B) Initial Psychological Assessment form)	Rose Patterson
Complete - Status: New assessment form complete and assessment will begin in July. *Feb Update: Assessment policy updated, and IPA forms have been modified to reflect results of pilot and new forms.*			

2) Dec 2008	***1*** *Continue with all past recommendations*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps.			

2) Dec 2008 ***2*** *Assure that reading levels reported in the IPA use grade level equivalencies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Iniital Psychological Assessment (IPA)	2/6/2009	Binder VI Tab # 7 (IPA parts A and B)	R Patterson
Complete			

VI.B.5

By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.

Findings

Several steps were taken to address this requirement. Each unit now has a psychologist assigned to it to provide support which will increase communication. Binder VI, Tab # 30 (Ward staffing in Forensic and Civil Services). Second, the Assessment policy specifically requires that psychologists communicate and interpret results for treatment teams along with the implications of the results. See Binder VI, Tabs 1 (Assessment policy) and Tab # 7 (Initial Psychological Assessment, A and B). The IPA specifically provides for signatures of the psychologist as well as other members of the treatment team. Additionally, the Psychological Evaluation template includes a provision for treatment teams to respond to the recommendations through the IRP meeting. Binder VI, tab # 33 (Psychological evaluation form). No information is yet collected to evaluate whether recommendations are followed, or if not, if there is a note in the record addressing a decision not to follow the recommendations.

In addition, the Hospital is monitoring the attendance of psychologists at IRP meetings, which is a strategy designed to improve the integration of psychiatric and psychological assessments and treatments. There has been noted improvement since monitoring has begun. For the period of July to September, 2008, IRP observations found that psychologists attended only 45 % of IRP conferences. Binder VI, tab # 4 (IRP Process results, July-Sept, 2008). February 2009 observations show that 60% of IRP conferences were now attended by psychologists. Binder VI, tab # 11 (IRP Process results, February, 2009)

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Develop policies and procedures that address the process by which psychological assessment results are directly communicated to the treatment team and such communication is noted in the individual's medical record.* ***Medical; PID; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in the Initial Psychological Assessment Form the date that the results were discussed with the treatment team and signature from the team leader.	7/31/2008	Initial Psychological Assessment form, Tab # 7	Rose Patterson
Complete - Status: This will begin to be utilized in July, 2008.			
2 Utilize above procedure with all Psychological Assessments.	8/30/2008		R. Patterson

1) Apr 2008 ***2*** *Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations.* ***CVC; JH; Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate in written procedure in Psychology expectation that staff members discuss issues with the treatment team; documentation requirements will be developed.	2/15/2009	Binder VI tab # 7 (IPA part A and B form); Tab # 25 (Psychological Evaluation Form)	R Patterson

- Status: IPA requires signature of unit administrator after results are discussed with team.

1) Apr 2008 ***3*** *Monitor through chart auditing tools for fidelity to these processes.* ***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.B.2.D.			

- Status: See action steps VI.B.2.D

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with identified action steps.			

VI.C. Rehabilitation Assessments

Findings

See sub-cells below.

Compliance Status: See sub cells below.

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.

Findings

The Hospital's Assessment Policy provides for a Rehabilitation Assessment for every newly admitted patient. Binder VI, tab # 1 (Assessment Policy). Throughout the fall, 2008, Rehabilitation Services has been refining its assessment instrument through a series of pilots and has recently finalized the assessment form. See Binder VI, tab # 8 (Rehab Assessment Forms A, B and C) Unfortunately, lack of staffing in rehabilitation services continues to affect the ability of rehabilitation services to complete rehabilitation assessments on all newly admitted patients as is required (both with respect to time frame and completing them on all admissions) and is impacting service delivery as well. There are currently seven vacancies in rehabilitation services (1 Art therapist, 2 music therapists, 1 supervisory recreational therapist, 1 occupational therapist, and 1 vocational rehabilitation therapist), with a particular acute problem in forensic services. Selections for some of the positions have been made and staff will join in March. At that time, the Hospital will reassess the staffing in rehabilitation services to ascertain if staffing is sufficient.

Civil Services have completed initial rehabilitation assessments on 21 individuals in September, 2 in October, 24 in November, 41 in December, 40 in January, 2009 and 8 by the middle of February. Due to staffing shortages (there are just two certified rehab services staff for forensic services), forensic has not been able to complete admission assessments during this period. Rehabilitation services staff are key treatment providers, leading numerous groups and activities throughout the Hospital and this impacts on the ability to complete assessments.

Audit tools with instructions have been developed for auditing the assessment as well as the progress note. See Binder VI, tab # 18 (rehab assessment audit tool/instructions), tab # 37 (rehab services therapeutic progress note

audit tool/instructions). There are three sets of data available around audits of rehabilitation assessments. The first reflects the period of April to June, 2008 and covers 34 patients. Binder VI, Tab # 13 (Results of Rehab Services self-audit, April - June 2008); the second covers July to August, 2008, tab # 13 (Results of Rehab Self audit, July-August, 2008). Finally, an audit was conducted for January, 2009 Rehab assessments, tab # 13 (Results of Rehab self audit, Jan., 2009). The audit (sample size 21% of assessments completed, not 21% of admissions) shows that 79% of the assessments were completed within 7 days and that 95% were completed within 10 days. The audits provide useful information about the types of therapies that interest patients as well as functional levels of the patient population. For this audit, the raters exchanged a sample of records to check inter-rater reliability. The ratings differed in two categories - instructions will be modified to ensure consistent ratings.

Audits of the quality of therapeutic progress notes have not yet begun; but the recent IRP Process monitoring audits look for the presence of a monthly therapeutic progress note.

In this last audit of rehabilitation assessments, reviewers also selected 10 records which both reviewed to evaluate inter-rater reliability. Results show that the raters were consistent in all but two areas, where one rater gave credit for partially completed sections and the other did not. Instructions are being updated to ensure consistency, and to require raters only credit where the sections are completed in their entirety. Tab # 13 (Results of inter rater reliability, rehab services).

Compliance Status: Progress is being made toward the June, 2009 compliance date, but lack of staffing remains a significant barrier to achieving compliance.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Implement the newly revised Initial RT Assessment across all admission units. The newly designed assessment provides important material for the functional assessment of individuals that is critical to determining their level of care while in the hospital and upon discharge.*	***CVC; JH; Rehab Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete a new diagnostic Rehab assessment tool with guidelines.	6/2/2008	Binder VI, Tab # 18 (Rehabilitation Services Diagnostic Tool and guidelines, revised)	Coleman, Robinson

Complete - Status: Training on the use of the tool provided to staff by April. Piloted tool on the Civil Admissions wards 5 & 6 in late April until early June. As of May 13, 2008 seventeen assessments were completed on the admissions wards for the civil side. As of June 13, 2008, 21 assessments were completed on the Forensic pre-trial admission units.
February 2009 Update: The rehab assessment form has been refined based upon the results of the pilot. It has not yet been utilized in forensic due to staff shortages, but was recently introduced there. It has been used on the civil side, but again staff shortages are affecting the timeliness of assessments. Since September, 2008, 136 rehabilitation asesssments have been completed on the civil side.

1) Apr 2008	***2*** *Develop and implement an auditing tool that monitors the medical record for the presence, timeliness and quality of the Initial RT Assessment.*	***JH; PID; Rehab Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Audit tool for rehab assessments.	6/2/2008	Binder VI, Tab # 18 (Rehabilitation Services Assessment Audit Tool and guidelines)	Robinson, Coleman

Complete - Status: Draft audit tool is completed and will be reviewed by consultant.
Feb 2009 Update: Tool was revised to reflect revisions to the Assessment form.

2	Conduct Initial Audits and provide results.	6/27/2008	Binder VI, Tab # 13(Audit results, July/August) tab # 13 (Audit results)	Robinson, Coleman

Complete - Status: Initial audits were conducted in May and June 2008. Results previously provided

3	Conduct monthly audits of progress note documentation by reviewing five (5) records of patients each clinician is treating.	3/2/2009		Robinson. Coleman

- Status: Feb 2009 Update: Audits were suspended as tool was revised. Auditing of February notes scheduled to begin March 2, 2009.

1) Apr 2008 ***3*** *Auditors must be trained to reliability.* ***Rehab directors***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train auditors using guidelines.	6/26/2008	Binder VI, tab # 13 (Results of inter-rated reliability)	Robinson, Coleman

Complete - Status: Feb 2009 Update: Auditors will be trained on new guidelines. Direcctors of Civil and Forensic Rehab Services reviewed same set of records, and reliability was assessed.

2	Work with consultant to review audit tools and guidelines, update tools as needed and retrain staff as needed	8/29/2008		Chief of staff; Coleman and Robinson

- Status: Consultant is reviewing tools.
Feb Update: Consultant is no longer reviewing tool, but new PID director is providing technical assistance. Tool is in use

1) Apr 2008 ***4*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***CVC; JH; Rehab directors***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps VI.C.1 recommendation 3.			

- Status: See VI.C.1 recommendation 3

2) Dec 2008 ***1*** *Continue with all past recommendations.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Continue with identified action steps.			

2) Dec 2008 ***2*** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.* ***Rehab directors.***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify additional positions for Rehab staff.	1/2/2009		HR, COO

- Status: February 2009 Update: Recruitment for seven additional staff underway, inlcuding 2 music therapists, and 1 each art, recreation supervisor, recreation therapist, occupational and vocational rehab therapist.

2	HR to Work with Rehab directors to develop strategies to target hirign of Rehab staff.	3/31/2009		HR, COO; Rehab Directors

2) Dec 2008 ***3*** *Develop policies so that all clinical disciplines are providing a required number of mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Plan and implement redesign of treatment mall.		Binder VI, Tab # 38 (Treatment mall redesign overview)	CVC
- Status: Redesign plan has been developed and implementation begun.			
2 As part of redesign, develop discipline specific criteria for mall treatment groups.			CVC; Medical Director; Discipline Directors, CNE
- Status: Discussion underway to identify by discipline group hours expectations			

VI.C.2

By 24 months from the Effective Date hereof, all rehabilitation assessments shall:

Findings

Please see findings and sub cells.

Compliance Status: See findings and sub cells.

VI.C.2.a

be accurate as to the individual's functional abilities;

Findings

The newly designed rehabilitation assessment form is implemented but not all admissions are yet getting assessments due to staffing shortages. See VI.C.1.

Audit tools with instructions have been developed for auditing the assessment as well as the progress note. See Binder VI, tab # 18 (rehab assessment audit tool/instructions), tab # 37(rehab services therapeutic progress note audit tool/instructions). There are three sets of data available around audits of rehabilitation assessments. The first reflects the period of April to June, 2008, the second, from July to August, 2008 and covers 50 patients. Binder VI, Tab # 13 (results of rehab services self-audit, April - June, 2008), See tab # 13 (results of rehab audit, July-August). A third audit was conducted in January, 2009, and this audit also included an evaluation of inter-rater reliability, when the directors of rehabilitation services in forensic and civil services evaluated the same set of assessments.

Results show rates gave identical ratings in all but two categories, where one rater gave credit for partially completed sections. Binder VI, tab # 13 (Interrater reliability results). The raters have met and decided that sections must be completed in their entirety in order to be rated as completed; instructions are being modified accordingly.

Results of the July - September pilot audit show improvement in the timeliness of rehabilitation assessments (48% of initial audits were completed within 4 days of admission, and 76% completed within 10 days) over the initial April to June audit period. Patient involvement is also improving. Binder VI, tab # 13 (Rehab Services data analysis for period July-August, 2008). In January's audit, Rehabilitation assessments were timely completed in 79% of cases where they were done, but only 46% of admissions were assessed. This is likely due to staffing issues.

Rehabilitation services also has implemented rehabilitation rounds which are designed to inform treatment planning. All rehab staff that are serving an individual meet prior to the IRP conference. A rehabilitation services liaison assesses the individual, reviews chart data and presents the information in rehab rounds. Other rehab staff who are involved in the individuals treatment provide additional information, and a report is prepared for the treatment team; The report is provided to the clinical administrator. See Binder VI, tab # 39 (Rehab rounds

conference guidelines and report form)

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1) Apr 2008	***1*** *Same as above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as above. *- Status: same as above*			
2) Dec 2008	***1*** *Continue with all past recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Continue with prior action steps			
2) Dec 2008	***2*** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	See VI.C.1 recommendation #2			
2) Dec 2008	***3*** *Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	See VI.C.1 recommendation 3			

VI.C.2.b

identify the individual's life skills prior to, and over the course of, the mental illness or disorder;

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessment due to staffing shortages. See VI.C.2.a.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1) Apr 2008	***1*** *Same as above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as above. *- Status: Same as above*			
2) Dec 2008	***1*** *Continue with all past recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Continue with prior action steps			

2) Dec 2008 ***2*** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation #2			

2) Dec 2008 ***3*** *Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend treatment planning conferences.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation 3			

VI.C.2.c

identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessments due to shortage of rehabilitation services staff. See VI.C.2.a

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above. - *Status: Same as above*			

2) Dec 2008 ***1*** *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

2) Dec 2008 ***2*** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation #2			

2) Dec 2008 ***3*** *Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all clinicians to attend treatment planning conferences.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation 3			

VI.C.2.d

provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessments due to staffing shortages. See VI.C.1.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above			

2) Dec 2008	*1 Continue with all past recommendations.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

2) Dec 2008	*2 Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation #2			

2) Dec 2008	*3 Develop policies so that all clinical disciplines are providing mall groups and so that treatment planning is scheduled at times that permit all clinicians to attend treatment planning conferences.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VI.C.1 recommendation #3			

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.

Findings

Rehabilitation services has not yet begun to address this requirement, and thus no progress is being made. With the current level of staffing, this requirement will not likely be met. Recruitment is underway for seven additional staff.

To date, only a limited number of forensic patients (18) attend the treatment mall. As the treatment mall redesign is implemented, (see below), additional forensic patients will likely participate, but no data is yet available.

Compliance Status: No progress is being made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Develop and implement a plan to address this issue.*	***CVC; JH; Rehab Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assign a rehab specialist to each unit.	6/27/2008	Binder VI, Tab # 40 (Current staffing of civil and forensic units), Tab # 41 (Job Vacancy Announcements)	Coleman, Robinson
Complete - Status: Each unit has a specialist assigned, but due to shortages, some specialists are covering multiple units. Recruitment for additional specialists is underway.			
Feb 2009 Update: Civil has successfully hired a registered dance therapist. The hospital has announcements posted for an additional five certified/licensed clinicians. A selection certificate with three names has been developed, but there are not adequate number of applicants to fill all vacancies.			

2	Rehab. Specialists will review prior assessments and update as needed.	12/31/2008		Coleman, Robinson
	- Status: Review of assessments conducted using final, approved instrument will begin February 23, 2009			
3	Fill all rehab specialist positions and identify additional positions for recruitment	8/29/2008		COO, Chief of staff
	- Status: See status in action step 1			

1) Apr 2008 ***2*** *Utilize some version of the audit tool referenced in cells VI.C.2.a through VI.C.2.d for use in this review process.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in VI.C.2.a through C.2.d.			
	- Status: See VI.C.2.a through C.2.d.			

1) Apr 2008 ***3*** *Develop and implement a plan for the provision of treatment mall services to all forensic individuals.* ***CVC; JH; Chief Nurse Exective***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Recruit and hire nursing staff to fill vacancies in Forensic Services.	8/15/2008	Binder VI, tab # 42 (HR Report, Nursing positions)	CNE D.J. and J.H.
	Complete - Status: Forensic Services has hired 43 nursing staff and promoted 6 staff as of July 14, 2008.			
2	Recruit and hire Rehabilitation Services staff to fill vacant and new positions (Education Specialist, Music Therapist, and Vocational Rehabilitation Specialist). Positions based upon patient treatment needs in Forensic Services.	8/29/2008		C.R J.Gallo
	- Status: February 2009 Update: The Hospital has announcements posted for an additional five certified/licensed clinicians. A selection certificate with three names has been developed, but there are not adequate number of applicants to fill all vacancies.			
3	Expand the variety of therapeutic activities available to forensic patients, their frequency, and times treatment activities are available to forensic patients in John Howard Pavilion.	8/29/2008		D.J., C.R, J.H.
	- Status: Nursing staff have received orientation to group work. New nursing staff members paired with experienced forensic nursing staff members. Nursing currently offering 153 active treatment groups on forensic inpatient units on weekdays between 8:00AM and 8:00PM. A limited number of weekend groups also are being conducted. Other services available include the gardening program, stamp program and pens and lens. Approximately 15 forensic patients attend the treatment mall, and that number is expected to increase with the redesigned treatment mall.			

2) Dec 2008 *Continue with all past recommendations.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue with all prior action steps.			

VI.D. Social History Assessments

By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally

Findings

Social work is implementing a social work initial assessment. It was further revised and additional comments from the DOJ report were incorporated. The assessment provides for more narrative assessments rather than a checklist, and there is an expectation social workers will review for and resolve factual disparities in histories.

accepted professional standards of care. This includes identifying factual inconsistencies among sources,

Guidelines were also modified based upon changes to the form and provide adequate guidance for social work staff in completing the assessment. See Binder VI, tab # 5 (Social Work Initial Assessment and guidelines). Social work also modified its monthly note and assessment update to reflect the new more narrative style of assessment. The most recent draft of the SWIA was finalized and began being used in January, 2009.

While social work staff were trained on the instrument, no substantive training around discharge planning or assessment has yet been provided, though these areas are expected to be covered in the IRP training. It is expected that this training will also strengthen the discharge planning parts of the IRP process. The IRP form has been revised and discharge and community supports is a specific new focus area for IRP planning. Binder VI, tab # 22 (IRP form). The IRP form as revised began being used by the 10 units that have started/completed training effective March 1, 2009; other units may also start using it in March as well.

Social work also has developed audit tools for each type of assessment/update. Binder VI, tab # 17 (Audit tool for SWIA); tab # 43 (Audit tool for progress note); tab # 44 (Audit tool for assessment update). Per DOJ recommendations, the audit tool was modified to include "Adequate", "Inadequate" and "Not present" as the rating scale. To date, only the SWIA has been audited. The audit completed in February, 2009, reviewed social work initial assessments for 23 of 71 (32%) admissions over a five week period. In only 1 record was an assessment not found, and on average, all of the 22 completed assessments were done within 5 days. Several areas were identified as in need of improvement, including discussion of patient's goals and whether they were realistic or achievable, patients feelings about placement and their level of cooperation with discharge planning and individualized interventions. There were notable differences in civil versus forensic around discharge planning. Binder VI, tab # 14 (SWIA audit results, Feb, 2009)

The compliance office reviewed a small sample of records of persons admitted after January 1, 2009, where the revised SWIA should have used. In all seven cases, the correct form was used, and the quality of assessment was improved when compared to prior assessments, although they were not still meeting all aspects of the Social work requirements in the Agreement. Efforts were made to identify discrepancies, although in two cases there were no notes following up on identified discrepancies. It is possible that efforts were ongoing, as in both cases, the individuals had been at the Hospital for less than 30 days, but it was not clear from the record.

Compliance Status: Partial compliance.

Recommendations		***Responsible Party***
1) Apr 2008	*1 Revise the SWIA to include a narrative section following the section on Social History that indicates what attempts were made to reconcile conflicting information and the outcome of those attempts, as well as further plans to reconcile information if appropriate.*	***CVC; JH; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Social Work initial assessment tool with guidelines. Train staff	6/2/2008	(Binder VI, Tab # 5 (Social Work Initial Assessment and Guidelines)	Wilhoit / Richardson

Complete - Status: The tool was piloted on the Civil admissions units 5 & 6 in early June 2008. The tool was piloted on the Forensic pre-trial admission units 6 and 7 in early June 2008. February 2009 Update: Tool was refined several times in the Fall, and finalized.

2	Develop a standard set of data that should be made available within 48 hours of patient's admission to hospital and provide same to community providers.	4/16/2008	CVC

Complete - Status: Hospital staff met with CSA program managers about need for more information upon admission, but information is still not routinely being provided upon a patient's admission. February, 2009. No improvement on access to prior history.

3	Meet with community, providers to announce information that will be needed by Hospital upon .	4/10/2008	CVC

Complete

4	Work with MHA Division of Integrated Care and Division of Adult services to improve access to social history available in community records.	5/20/2009	CVC

- Status: Ongoing

1) Apr 2008 ***2 Develop written guidelines for the SWIA that clearly articulate how individual social workers are to document their sources for conflicting data in the Social History section of the assessment. Simply providing check boxes for all sources of information does nothing to resolve conflicting information, and may in fact, increase confusion, for when multiple sources are checked, it could imply that conflicts were resolved.*** ***CVC; JH; SW directors***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Redesign the Social Work Assessment Tool with a section on resolution of discrepancies in social history.	7/1/2008	Binder VI, Tab # 5 (SWI Assessment)	Wilhoit / Richardson

Complete - Status: SWIA is being reviewed by consultant for comments. Modifications will be made as needed. February 2009 Update: Final, approved SWIA includes recommended section.

2	Redesign Social Work Peer Review Document which is also used as a Monitoring Tool used by Supervisors to assess performance.	7/1/2008	Binder VI, tab # 17 (SW Peer review tool)	Wilhoit / Richardson

Complete - Status: February 2009 Update: Social Work peer review document pending DOJ final approval.

3	Pilot peer review monitoring tool.	7/31/2008	Binder VI, Tab # 14 (Results of SWIA audit)	SWIA is being reviewed by consultant for comments. Modifications will be made as needed.

- Status: Pilot initiated last week of July. Feb 2009 Update: Tool revised following September 2008 DOJ visit. Tool used in reviews conducted late January and early Feb.

1) Apr 2008 ***3*** *Develop and implement an auditing tool to monitor the presence, timeliness and quality of this and all sections of the SWIA.* ***CVC; JH; SW directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Social Work Peer Review Document and Supervisory Monitoring Tool.	6/25/2008	Binder VI, tab # 17 (SW Peer review Tool)	Wilhoit / Richardson
Complete - Status: Tool drafted and under review by consultant. February 2009 Update: See VI.D.2			
2 Submit SWIA and peer review forms to consultant Adkins for comment and advice.	7/31/2008		Chief of staff
Complete - Status: Peer review form recently utilized.			
3 Pilot tool by reviewing SWIA.	8/29/2008	Binder VI, Tab # 14 (Results of SWIA audit)	Wilhoit / Richardson
- Status: February 2009 Update: See V.B.2.a.4			

1) Apr 2008 ***4*** *Train auditors to acceptable levels of reliability.* ***CVC; JH; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain assistance from consultant to strengthen training and ensure inter relater reliability	9/30/2008		Wilhoit; chief of staff
- Status: Contractor identified and consultation underway, but too early to begin training.			
2 Discipline chiefs for forensic and civil services will review and score same set of records and compare results. Guidelines will be modified as needed.	2/27/2009	Binder VI, Tab # 14 (Results of SWIA audit)	Wilhoit
- Status: Ongoing			

1) Apr 2008 ***5*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***CVC; JH; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.D recommendation 4			
- Status: See VI.D recommendation 4			

2) Dec 2008 ***1*** *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

2) Dec 2008 ***2*** *Revise the audit tool so that it only contains 2 or at most 3 rating categories: "Not present" and "Adequate" with the possible addition of "Present, but Poor Quality"*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 revise audit tool to reflect recommendations	12/31/2008	Binder VI,, Tab # 17(SWIA audit tool)	Wilhoit
Complete			

2) Dec 2008

3 *The social work chiefs need to develop reliability around the scoring of Questions 13, 14, 15 and 17 according to the following methodology:*

- *a* *Each of the SW chiefs will select 5 charts from their division for a total of 10 charts.*
- *b* *Both SW chiefs will audit the 10 chosen charts with careful attention to Questions 13, 14, 15 and 17.*
- *c* *Each of the audits will be compared for consistency/inconsistency in scoring and the SW chiefs will discuss discrepant findings until there is agreement between them on how to reliably score all questions.*
- *d* *The results of this discussion should lead to the development of operational definitions for all questions on the auditing tool.*
- *e* *Based on the operational definitions, revise as necessary the Social Work Initial Assessment (now Comprehensive Assessment) Guidelines to assure that all staff have an adequate understanding of the appropriate way to fill out all sections of the CSWA.*
- *f* *This reviewer will use the newly designed tool and the operational definitions to review CWSA during the next monitoring visit.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 revise audit tool to reflect recommendations. *Complete*			
2 Audits conducted to reflect directions in recommendations. *Complete*	2/27/2009		

VII. Discharge Planning and Community Integration

Summary of Progress

1. The Hospital implemented its "Discharge Planning and Community Integration" policy.

2. The Hospital maintains a database in which it is tracking issues that are delaying/preventing discharge of persons ready for discharge. DMH and the Hospital have instituted weekly meetings to review status of newly admitted individuals as well as those who are ready for discharge but not yet discharged. Individuals are tracked by issue preventing discharge, with a special focus on housing needs and those who are resistive to discharge.

3. DMH has created a special division, the Division of Integrated Care, to focus on high risk individuals, providing oversight in an effort to improve the likelihood of successful community placement. The Division is actively involved in discharge planning with the Hospital, and also monitors post discharge services. In addition, DMH is about to award an integrated care contract to serve 30 Hospital patients who are resistive to discharge or who have histories of multiple hospitalizations.

4. The new Social work initial assessment includes an increased focus on discharge planning. While still in the initial phase of use, early indications are that the form does result in improved identification of discharge needs as well as individual's strengths. Social work has completed just one audit cycle of the SWIA, so it is too early to draw specific conclusions however.

5. The Hospital continues to review 20% of closed records through a Discharge Record review although the old assessment tool was used during this period. Reviews have been conducted from May to December, 2008. Data indicates that improvement is needed in identification of strengths, individualizing assessments and in individualizing interventions.

6. The Hospital is monitoring patient participation in discharge planning in part through the IRP process monitoring tool. See Tab # 6 (IRP Process monitoring tool). See also Tab # 7 (Results of IRP process monitoring)

7. The Hospital is significantly restructuring the treatment mall, into 3 therapeutic centers where individuals are assigned based upon anticipated lengths of stay. Each center will have a full menu of groups and activities, including expanded substance abuse services and services targeted for those with cognitive impairments. TLC I will target those with expected short term stays, and will focus on community reentry needs/programs. All centers will offer an evidenced based written curricula. TLC I will open March 16, 2009.

VII. Discharge Planning and Community Integration.

Taking into account the limitations of court-imposed confinement and public safety, SEH, 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.

Findings

See sub-cells below

Compliance Status: See sub cells for findings.

VII.A.

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:

Findings

Meaningful discharge planning beginning at admission is improving, although is still not consistent across cases or across disciplines and does not yet meet Settlement Agreement requirements. Disciplines assessment forms, primarily the Social Work Initial Assessment, were refined to improve the focus on discharge planning, although they have only been in use for about a month. The new IRP form and process should also result in better discharge planning beginning upon admission, but again that form was only introduced to some wards in late February, 2009, so results cannot be reported. The IRP form includes discharge planning as a specific foci of hospitalization, and discharge planning is also a part of the other foci. Binder VII, tab # 1 (Social Work Initial Assessment and guidelines), tab # 2 (Initial IRP); tab # 3 (IRP Form); tab # 4 (Clinical Formulation), tab # 5 (Clinical Formulation Update).

In Fall, 2008, DMH formed a new division at the MHA, the Division of Integrated Care, that monitors community support for the high risk discharged population; this Division developed processes that are designed to improve community case management involvement from the very first day of admission by requiring more involvement of the community case manager in discharge planning from the time of the individual's hospitalization through actual discharge. Binder VII, tab # 6 (Division of Integrated Care Table of Organization), tab # 7 (Protocol for Initiation of Discharge Planning and Continuity of Care when Consumers are admitted to SEH). The Division is now fully staffed.

The Hospital continues to review records of discharged individuals to evaluate discharge planning. The Hospital reviewed a 20% sample of discharges for the period of May, 2008 through December 2008. Binder VII, tab # 8 (Discharge record review tool May to August review); tab # 9 (Discharge Record Review, September -December, 2008). Data shows that additional work is needed in order to strengthen discharge planning but there is some improvement from past reviews. [It should be noted that for most of the review period, the new SWIA was not yet being used across the hospital (it was still in pilot phase), and for none of the period were the new IRP forms being used.] The discharge record review shows a decrease in the "Not met" ratings around effective discharge planning beginning at admission (from 26% in the first quarter to only 11% in the third quarter) although the rating of "met" was essentially the same in all three quarters. There is also improvement around discharge planning as a component of the IRP (from 33% in the first quarter to 41% in the third quarter). Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009). Another area in which a significant improvement was noted included providing the individual with a copy of the discharge instruction sheet (from just 59% in the first quarter to 83% in the third quarter) and presence of a current IRP (from 67% to 81%). However, meaningful patient participation actually decreased from the first to third quarters and provision of active psychosocial rehabilitation services to permit discharge was also rated poor, with only 3% of records showing the standards were being met. Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009) The results of the reviews overall show some improvement, but also that in key areas, the Hospital is not performing as required.

As noted, MHA created a Division of Integrated Care which targets high risk individuals. Binder VII, tab # 6 (TO for Division of Integrated Care). The Division serves as a monitor and quality check on the services provided by core service agencies. The Division has just reached full staffing, but developed protocols that focus on discharge planning from the time of admission for those persons. Binder VII, tab # 7 (Protocol for Discharge Planning). In addition, the Hospital maintains a database to collect key data on patients ready for discharge but for whom discharge could not be effected, and is now actively engaged with the MHA to focus on discharge planning for this targeted group. The ready for discharge list tracks the barriers, including housing, discharge resistance, need for DD services, need for benefits, and other issues. Binder VII, tab # 10 (Ready for discharge list and summary). In January, 2009, the Hospital social work staff began meeting weekly with staff from MHA's Division of Adult Services

and Division of Integrated Care to review cases of persons admitted the prior week as well as those on the "ready for discharge list". Staff are prepared to adjust the protocol as needed to improve discharge planning and results. Data included on discharge instructions provided to individuals is entered into DMH's Ecura system for easier tracking of community services.

The Compliance Office also reviewed a small sample (7) of charts of persons admitted after January, 2009, when the new SWIA form began being used. The review showed improvement in identifying preferences and goals, as these sections of the form were completed in all reviewed cases. Some improvement was also noted in the identification of individual strengths (i.e.. Work history), although in several cases reviewed the individual had completed college, but educational achievement was not noted as a strength. There still were instances where discharge criteria in IRPs were not individualized - i.e., 4 of 7 IRPs had as the discharge criteria "no longer dangerous to self or others" and in some cases included unrealistic objectives (patient will be free of all hallucinations or will not be delusional). However, in two cases discharge goals were more realistic, such as "increased awareness of symptoms" and "improved understanding of why medication is important."

Compliance Status: Partial compliance.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Provide guidelines for how appropriately individualize the Discharge Plan of the SWIA to accurately reflect the relevant discharge needs of all newly admitted individuals. At a minimum indicate the likely discharge placement and the necessary community based supports and services that will be necessary to optimize community tenure.*	***CVC; JH; SW Directors***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify SWIA to include assessment of relevant discharge needs, and obtain technical assistance review by consultant.	7/31/2008	SWIA, Binder VII, Tab #1.	Wilhoit / Richardson; Chief of staff
	Complete - Status: February 2009 Update: Final, approved SWIA includes recommended section.			
2	Include individualized discharge planning and assessment in treatment planning training.	6/30/2009	Treatment planning curricula, Binder VII, Tab #11.	Beth Gouse
	- Status: February 2009 Update: Treatment planning training includes curricula on discharge planning and assessment. To date, five Units (RMB 1, 2 and 5, JHP 3and 6) have completed the treatment planning training; mentoring is still available to those units. Five additional units began training in January, 2009, and the remaining 8 units will begin the training by March, 2009.			

1) Apr 2008 *2 Provide guidelines on how to integrate the above information from SWIA into the case formulation and long term goals of the individual's initial IRP. Utilize later treatment planning conferences to incorporate goals and objectives consistent with the development of a written Wellness and Recovery Action Plan that at a minimum addresses: the individual's strengths and acquired skills, warning signs for relapse regarding any and all aspects of the individual's diagnoses or risk factors; strategies to put in place when warning signs are encountered; supports and services which the individual will be provided upon discharge.* ***CVC; JH; BG; Trg; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train social work staff on treatment planning including focus on case formulation and long term goals. 5O% of civil and forensic social workers will be trained by 12/31 and remaining staff by March 31, 2009.	12/31/2008	Treatment planning curricula, Binder VII, Tab #11.	Gouse/Wilhoit / Richardson; Chief of staff
- Status: February 2009 Update: Treatment planning training includes curricula on discharge planning and assessment. To date, five Units (RMB 1, 2 and 5, JHP 3 and 6) have completed the treatment planning training; mentoring is still available to those units. Five additional units began training in January, 2009, and the remaining 8 units will begin the training by March, 2009.			
2 Implement revised IRP form hospital wide.	4/15/2009	IRP Form, Binder VII, Tab #3	Gouse
- Status: February 2009 Update: The new IRP form is being implemented as treatment planning training begins. Five units began using the form in February, 2009, six more in February, 2009, and the remaining units will begin using the form with the onset of training.			
3 Implement self-auditing tool for SWIA, analyze results and modify training as needed.	2/27/2009	Self Audit tool, Binder VII, Tab #12, Analysis, Binder VII, Tab #13	Wilhoit/Rischardson
- Status: Self-audits began in January.			

2) Dec 2008 *Continue with past recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above action steps.			Gouse/Wilhoit/Richardson

VII.A.1

those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;

Findings

The Social Work Initial Assessment was revised and comments from the DOJ report were incorporated; in addition, the assessment was modified based upon feedback received during the pilot phase. The assessment provides for more narrative assessments rather than a checklist, and is accompanied by guidelines, which were modified to incorporate DOJ recommendations. See Binder VII, tab # 1 (Social Worker Initial Assessment and guidelines). While social work staff were trained on the instrument, no targeted substantive training around discharge planning or assessment has occurred; these areas are generally covered in the IRP training, which has been essentially completed in only 5 of 19 units.

Social work peer review/clinical chart audits of the new SWIA are underway, using a modified audit tool. See Binder VII, tab # 12 (SWIA audit tool). Results show that in 22 of 23 SWIAs reviewed, all but one was timely completed. Three areas were scored as adequate in 100% of cases reviewed. In two areas, ratings were scored as "inappropriate" in over half the cases, and in three other areas, ratings were scored "inappropriate" in over 10% of cases. Binder VII, tab #13 (Results of Social Work Audit).

The Compliance Office also reviewed a small sample (7) of charts of persons admitted after January, 2009, when the new SWIA form began being used. The review showed improvement in identifying preferences and goals, as these sections of the form were completed in all reviewed cases. Some improvement was also noted in the identification of individual strengths (i.e.. Work history), although in several cases reviewed the individual had completed college, but educational achievement was not noted as a strength.

Compliance Status: Partial

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Revise the SWIA to include an analysis of individual strengths that are relevant to the individual's chosen discharge setting.*			***CVC; JH; BG; SW Directors***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Redesign Social Work Assessment to include individual strengths.		SWIA, Binder VII, Tab #1	Wilhoit / Richardson
	Complete			
1) Apr 2008	***2*** *Develop this section of the Assessment so that it is a narrative block rather than a check-off form.*			***CVC; JH; BG; SW Directors***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Redesign Social Work Assessment.		SWIA, Binder VII, Tab #1	Wilhoit / Richardson
	Complete - Status: See VII.A.1			
1) Apr 2008	***3*** *Develop and implement an auditing tool that monitors for the presence, timeliness and quality of this and all sections of the SWIA.*			***CVC; JH; SW Directors***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Revise previously developed self-audit tool to provide for three ratings, and clarifiy guidelines	12/31/2008	See Self Audit tool, Binder VII, Tab # 12;	Wilhoit / Richardson
	Complete			
	2 Conduct peer review of 20% of cases.	1/30/2009	Self Audit tool, Binder VII, Tab #12;	Wilhoit / Richardson
	- Status: February, 2009 Update: Implementing peer review and interrater reliability checks..			
	3 Provide raw data to OMS for analysis and discipline chiefs to report on same	10/31/2008	Analysis, Binder VII, Tab #13.	Wilhoit / Richardson, OMS
	- Status: See VI.D. February 2009 Update: Implementing peer review.			
1) Apr 2008	***4*** *Train auditors to acceptable levels of reliability.*			***CVC; JH; SW Directors***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 SW chiefs will review same random sample of cases and then cross check ratings.	2/27/2009	Analysis, Binder VII, Tab #13.	Wilhoit/Richardson
	- Status: First set of reviews completed. Data on reliability is not yet available			

1) Apr 2008	*5 Provide operational definitions of all terms in a written format to aid in data reliability and validity.*	***CVC; JH; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI D recommendation 5.			

2) Dec 2008	*1 Continue all past recommendations.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with identified action steps			Gouse/Wilhoit/Richardson

2) Dec 2008	*2 See recommendations from VI. D above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps from VI D. above			

VII.A.2

the individual's symptoms of mental illness or psychiatric distress;

Findings

See sub-cell VII.A and VII.A.1. The guidelines to the SWIA were modified to incorporate information about how to complete the section of the SWIA addressing psychiatric goals. See Binder VII, tab # 1 (Social Worker Initial Assessment and guidelines). In addition, modifications to each of the discipline assessment forms and to the IRP increase the focus on the psychiatric symptoms as well as how it affects the person, so implementation of those forms is expected to improve compliance with this requirement.

A small sample of records for admissions after January 1, 2009, was reviewed by the compliance office in February 2009, with a specific focus on the implementation of the revised SWIA and the Comprehensive initial psychiatric assessments. (The office did not review records prior to January, 2009 as it was assessing the use of the new forms and whether they made a difference on discharge planning.) Of the 7 records reviewed, the new comprehensive initial psychiatric assessment and social work assessment forms were used in all cases. All seven records showed improvement in describing symptoms experienced by the individual, providing specific information about the type and content of hallucinations or paranoia.

Social work assessments largely contained general and not patient specific statements around discharge: "patient will be discharge when stable" and "patient will be discharged when no longer a danger to self or others." There is no real focus on the symptoms or behavior that led to hospitalization or will need to be addressed to effect outplacement.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	*1 Revise the SWIA to address specifically the individual's symptoms of mental illness or psychiatric distress as it directly impacts on anticipated placement.*	***CVC; JH; BG; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Redesign Social Work Assessment.	6/4/2008	SWIA, Binder VII, Tab #1	Wilhoit / Richardson
Complete - Status: SWIA revised and comments incorporated			

1) Apr 2008 ***2*** *See cell VII.A.1, Recommendations 3 through 5.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in cell VII.A.1, Recommendations 3 through 5.			

2) Dec 2008 ***1*** *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conintue implementing previously developed action steps.			

2) Dec 2008 ***2*** *See recommendations in VI. D above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VI D above			

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

Findings

See sub-cells VII.A and VII.A.1

The Social Work Initial Assessment form now includes a section on barriers to discharge, and the guidelines provide instructions on completion of the assessment in this aspect. See Binder VII, tab # 1 (Social Worker Initial Assessment and guidelines). The small review by the compliance office of recent admissions revealed some progress here as well, largely due to improved focus due to the new form. Barriers identified now go beyond housing, also evaluating financial, community support and well as need for productive day activities. However, the assessments still do not include rationales for some conclusions, (i.e., why the individual needs a CRF as opposed to a lower level of care). Further, none of the assessments addressed what specific issues arose in the prior housing that would need to be resolved to improve the likelihood of a successful discharge.

The social work initial assessment audit conducted in February assessed 5 different areas around discharge planning. The audit showed good performance around identification of skills needed for discharge but marginal performance around interventions and discharge outplacement activities. Binder VI, tab # 13 (SWIA audit results, Feb, 2009)

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Revise the SWIA must to address those 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. Provide integrative analysis of this issue in the SWIA.* ***CVC; JH; BG; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise SWIA to identify known barriers to discharge.	6/4/2008	SWIA, Binder VII, Tab #1	Wilhoit / Richardson

Complete - Status: February 2009 Update: Final, approved SWIA identifies known barriers to discharge.

2 Create database that tracks relevant discharge information including issues preventing discharge and provide summary reports to Hospital management and authority.	6/2/2008	Binder VII, Tab # 10 (Ready for discharge information)	OMS

Complete

1) Apr 2008 ***2*** *See cell VII.A.1, Recommendations 3 through 5.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VII.A.1, Recommendations 3 through 5.			

2) Dec 2008 ***1*** *Continue all past recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue all prior action steps			

2) Dec 2008 ***2*** *Include auditing of this item in development of auditor reliability and delineation of operational definitions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in self audit tool and instructions, and test through the inter-rater reliability evaluation.	3/31/2009	Self Audit tool, Binder VII, Tab #12; Analysis, Tab #513	Wilhoit/Richardson

- Status: Ongoing

VII.A.4

the skills necessary to live in a setting in which the individual may be placed.

Findings

See sub cells VII.A and VII.A.1. The revised social work initial assessment form reflects this requirement. See Binder VII, tab # 1 (Social Worker Initial Assessment and guidelines).

The review of 7 records of admission since January 2009 shows only slight improvement in identifying the needs for community living. Descriptions were largely in broad categories - such as housing, benefits, but were not further specified. More detail information is available in such places as the ready for discharge list, but that only focuses on persons who have been identified as ready for discharge, and is not kept from the time of hospitalization. Further, there were no specifics about what "failed" in the past that would have to be addressed (i.e. did the person object to living in a group home but might be successful in a independent setting with supports).

The Discharge Monitoring review found improvement in ensuring IRPs included measurable interventions that focus on building skills needed for community placement; in the first quarter, 33% of charts reviewed met this requirement, but it was up to 41% by the third quarter. Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009). However, the reviews also indicated only 3% of cases had documentation of 20 hours of treatment per week. Full implementation of the new assessment and IRP forms and expansion of the IRP training and redesign of the treatment mall should improve performance in this category as well.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Revise the SWIA to provide a mechanism whereby individual social workers can discuss the skills necessary for the anticipated discharge placement.*	***CVC; JH; PID; BG; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Redesign Social work Assessment to include Discharge Criteria/identified community needs/support services required for sustained community living.	6/4/2008	SWIA, Binder VII, Tab #1	Wilhoit / Richardson
Complete - Status: February 2009 Update: Final, approved SWIA includes discharge criteria/identified community needs/support services required for sustained community living.			
2 Use results from ITP process monitoring observations and discharge record chart reviews as well as self audits to inform social work supervisors on skills needed to be developed.	7/31/2008	ITP Process Observation Monitoring Results, Binder VII, Tab # 14 ; Dishcarge Record Quarterly Assessments Results, Binder VII, Tab # 8, 9	Hartley/Wilhoit/Richardson
Complete - Status: Ongoing			

1) Apr 2008 *2 See cell VII.A.1, Recommendations 3 through 5.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VII.A.1, Recommendations 3 through 5.			

2) Dec 2008 *1 Continue all past recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue implementing all prior action steps			

2) Dec 2008 *2 Include auditing of this item in development of auditor reliability and delineation of operational definitions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in self audit instrument	2/27/2009	Self Audit instrument, Binder VII, Tab # 12 ; Analysis of Self Audit, Binder VII, Tab # 13 .	Wilhoit/Richardson
Complete - Status: Modified self audit instrument to include; will be part of inter-rater reliability assessment			

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.

Findings

Individuals routinely attend IRP conferences, but the level of meaningful participation varies. The IRP process monitoring tool assess this through an indicator, and the most recent data suggests 95% of individuals attend the conferences and, in 89% of observed conferences, the team gave the individual the opportunity to participate in discharge planning although it was not clear the individual's preferences were alwasys respected. Further, the IRP conferences still did not include review of discharge barriers for each focus area. Binder VII, tab # 14 (IRP Observation results). The discharge monitoring review showed the individual participated in discharge planning to be deficient, with 21% of the cases meeting expectations and 59% partially meeting expectations (i.e., individual attended). While the percentage of "partially met" improved, the percentage of "met" actually decreased. Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009).

The Hospital developed a draft IRP manual which provides guidance to treatment teams about the role of individuals in treatment and discharge planning. See Binder VII, Tab # 14 (IRP Manual). As noted previously, training in treatment planning, the Hospital's key strategy in reforming practice, was interrupted from March until September, 2008. To date, 5 of 18 treatment teams have largely completed IRP training, five are in training, and the remaining will begin training by April, 2009. The interruption adversely affected the pace of progress in all

aspects of treatment and discharge planning.

Compliance Status: Partial.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Provide hospital staff with training in how to effectively engage individuals in their own treatment and discharge planning.*			***BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Include engagement of individuals in discharge planning in treatment planning training and train 50% of units by 12/31/08; remaining teams to be trained by March 31, 2009.	12/31/2008	Treatment planning curricula, Binder VII, tab # 11	Chief of Staff, DMH contracts
	- Status: Engagement of individuals in discharge planning is part of treatment planning training. To date, 5 units have completed training (ongoing mentoring available), six units began training in late January, 2009,			
	2 Include discussion of patient participation on Patient Advisory Board meeting agendas for patient input.	9/2/2008		CVC, JH
1) Apr 2008	***2*** *Provide hospital staff with training in how to run effective and organized treatment planning conferences. See Cell V.A.2.a for further information.*			***CVC; JH; BG;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Contract with trainers to provide treatment planning training to 50% of units by 12.31.08 and remaining staff by March 31, 2009.	7/31/2008		DMH contract office, chief of staff
	- Status: Planning meeting to develop training plan and contract discussions held July 25, 2008. Contract and initial training expected in August, 2008.			
	2 Begin training in August, 2008.			
2) Dec 2008	*Continue with all past recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Implement past action steps.			

VII.C.

By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:

Findings

The Hospital recently modified its Initial IRP form and the Comprehensive IRP form to increase the focus on discharge planning. Binder VII, tab # 2 (Initial IRP form); tab # 3 (IRP form). In addition to addressing discharge in each focus area of the IRP, the IRP form includes a specific focus area around discharge and community readiness; it also addresses strengths related to discharge, psychosocial factors related to discharge, person's stage of change and interventions to support this IRP focus. The SWIA form has a significant focus on discharge needs and barriers. A new discharge instruction sheet also was developed and is being used. Binder VII, tab # 16 (discharge instruction sheet). Training in IRP planning has proceeded, with 5 units largely completed training, five units just beginning training, and the remaining units scheduled to begin training by April.

The Hospital continues to conduct a review of a 20% sample of discharged patient records. The inclusion of a meaningful discharge planning as component of the IRP improved from 33% of cases in the first quarter to 41% in the third quarter, and partially met in 38% of cases by the third quarter.. See Binder VII, tab # 8, 9 (Discharge

Quality Assessment Reports, dated November 5, 2008 and February 11, 2009).

The Discharge Monitoring review found improvement in ensuring IRPs included measurable interventions that focus on building skills needed for community placement; in the first quarter, 33% of charts reviewed met this requirement, but it was up to 41% by the third quarter. Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009). However, the reviews also indicated only 3% of cases had documentation of 20 hours of treatment per week. Full implementation of the new assessment and IRP forms and expansion of the IRP training and redesign of the treatment mall should improve performance in this category as well. There is improvement in identifying specific individuals (as opposed to disciplines) in providing interventions, and also some improvement in specificity around the duration and frequency of interventions.

Compliance Status: Partial compliance.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop policies and procedures that assure that all treatment plan documents include the anticipated place of discharge or level of necessary care, integral community-based services and supports, and current barriers to discharge to that setting, measurable interventions related to these barriers, the person responsible for delivering the intervention, and the timeframe for completion of the intervention.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP policy and obtain approval by Exec staff	7/16/2008	Binder VII, Tab #s 2, 3,4,5. Revised IRP forms Tabs # 2, 3	J Taylor; Beth Gouse
Complete - Status: Feb. Update -IRP policy was updated to incorporate DOJ recommedations from latest report			
2 Update IRP form	2/2/2009	IRP form, Binder VII, Tab # 2, 3	Beth Gouse
Complete			
3 Update SWIA	2/2/2009	SWIA, Binder VII, Tab #1	Wilhoit/Richardson
Complete			
4 Develop IRP Manual	2/18/2009	Draft IRP Manual, Binder V, Tab # 15	Beth Gouse

1) Apr 2008	***2*** *Provide training in developing this portion of the treatment plan in conjunction with in the hospital-wide treatment plan training recommended in cell V.A.2.a. Provide additional and more focused and specific training in this process to all social workers.*	***CVC; JH; BG; SW Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in V.A.2.a.		See IRP training outline, Binder VII, Tab # 11	beth Gouse
Not Identified			

2) Dec 2008	***1*** *Continue with all past recommendations.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement all prior action steps			

2) Dec 2008 *2 Revise IRP to include a section specifically on Discharge Criteria.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP tool to include section specifically on discharge criteria	2/27/2009	IRP Form, Binder VII, Tab # 2, 3, 4, 5	Beth Gouse

Complete

VII.C.1

measurable interventions regarding his or her particular discharge considerations;

Findings

See VII. C.

The Discharge Monitoring review reported improvement in ensuring IRPs included measurable interventions that focus on building skills needed for community placement; in the first quarter, 33% of charts reviewed met this requirement, but it was up to 41% by the third quarter. Binder VII, tab # 8, 9 (Discharge Quality Assessment Reports, dated November 5, 2008 and February 11, 2009). However, the reviews also indicated only 3% of cases had documentation of 20 hours of treatment per week. Full implementation of the new assessment and IRP forms and expansion of the IRP training and redesign of the treatment mall should improve performance in this category as well.

Compliance Status: Partial compliance

Recommendations ***Responsible Party***

1) Apr 2008 *1 Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior action steps			

VII.C.2

the persons responsible for accomplishing the interventions; and

Findings

See VII. C.

The new IRP form includes a target date for meeting the objectives around discharge planning and community readiness and also requires the identification of a specific staff to provide the intervention. The IRP form was introduced to staff in February, 2008, so at the time of the writing of this report, it is too early to determine its effectiveness in addressing this requirement. Binder VII, tab # 2-5 (IRP Form) The social work audit generally scored the establishment of objectives and interventions related to discharge in the marginal category hospital-wide, except the identification of skills needed for discharge was rated in the green zone. Binder VI, tab # 13 (Social work assessment audit results, Feb 2009)

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 *1 Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Same as above.

- Status: Same as above.

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior recommendations			

VII.C.3

the time frames for completion of the interventions.

Findings

See VII. C.

The new IRP form includes a target date for meeting the objectives around discharge planning and community readiness and also requires the identification of a specific staff to provide the intervention. The IRP form was introduced to staff in February, 2008, so at the time of the writing of this report, it is too early to determine its effectiveness in addressing this requirement. Binder VII, tab # 3 (IRP Form) The social work audit generally scored the establishment of objectives and interventions related to discharge in the marginal category hospital-wide, except the identification of skills needed for discharge was rated in the green zone. Binder VI, tab # 13 (Social work assessment audit results, Feb 2009)

Compliance Status: See VII.C.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior recommendations			

VII.D.

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

Findings

The Hospital continues its community reentry program, Pathways to Independence, that targets discharge resistant individuals or persons that need to develop skills. Binder VII, tab # 17 (Description of Community Reentry Program and participation). The program is held 3 days a week and includes community trips as well as activities at the Hospital. To date, the program has included 4 cohorts. Of the 18 who have completed the program, 7 have been successfully discharged, two refuse to leave the hospital, and the remaining are awaiting various types of housing. There are currently 4 patients in cohort # 4 with three additional persons expected to start this month. The program will likely be modifed as part of the treatment mall redesign, but specific information is not available at this time.

Both Forensic and Civil Services have persons who attend day treatment in the community. See Tab 18 for list of persons attending community programs.

The Hospital is working with the Department of Mental Health to assess needs of discharged patients and effectiveness of services. The Department has created a new Division of Integrated Care that is dedicated to

reducing inpatient census and admissions to SEH by identifying individuals who need a comprehensive array of services and supports to allow them to remain in the community. The Division provides discharge planning support from the time a person is admitted to SEH and for those who are currently there and for whom discharge planning has not been effective. For those admitted, within one week of admission, MHA and Hospital staff will review their needs to identify those who may need additional supports to sustain community living. See Binder VII, tab # 7 (Continuity of Care Form). The Division also provides post discharge supports ensuring community staff are actively involved in discharge planning, and by following persons after their discharge from the Hospital to ensure services identified are provided. See Binder VII, Tab # 16 (Protocols for Division of Integrated Care) This Division has only been in existence since November, however, so it is too early to be able to report outcomes. In the meantime, the MHA is now doing specific follow up of post discharge services provided to high risk individuals. Binder VII, Tab # 19 (Seen within 7 Days of discharge data). Further, the Division now reports data about the follow up and transitions services provided to discharged individuals. Binder VII, tab # 19 (Follow up data on services post discharge). A contract for integrated care to focus on discharge of 30 of the most resistant to discharge or hard to place persons should be awarded in March, 2009.

The joint meetings described above are to be reflected in the medical record of individual's as the case is presented, but that policy was put in place only in late January, 2009, so most conferences have yet to be noted in the record as of the writing of this report. Of the small sample of charts reviewed by the compliance office, none had a notation in the record of the staffing and none had updated IPRs, although there were efforts noted in the records relating to effecting discharge (i.e., showing person housing options).

Finally, a major initiative is underway to reform the treatment mall, a key to providing transition services to hospitalized individuals. The treatment mall is being redesigned through the creation of three Therapeutic Learning Centers that focus on psychiatric rehabilitation and enrichment, based upon a recovery model and evidence based curricula. The programming will be based upon length of stay so that it can provide focused facilitation of movement to lower level of care and reintegration into the community. Binder VII, Tab # 20 (Summary of Treatment Mall Redesign). It is expected that this will improve as the cases are staffed.

Compliance Status: Partial.

Recommendations		***Responsible Party***
1) Apr 2008	*1 Provide an assessment of the discharge placements to which the hospital refers individuals to determine the specific skills that will be necessary for successful community living in those placements.*	***CVC; JH; MHA***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop inventory of housing and community support services.	10/31/2008	Binder VII, tab # 21 (housing and support services inventory	DMH Authority Alvin Hinkle
Complete			
2 Implement and continue review of cases with three or more hospitalizations within a year to identify trends or themes. Based upon assessment, modify contracts as needed.	6/27/2008	See Tab # 18 (Analysis of data of cases involving 3 or more hospitalizations in a year)	DMH Authority
- Status: Project is ongoing			

3	Train hospital social work staff on levels of care of various housing and services	3/31/2008		Authority
Complete - Status: Social workers trained on levels of care				
4	Review contract language concerning services to be provided patients upon release from hospital	12/31/2008		Authority
- Status: February Update: no action to report				

1) Apr 2008 ***2*** *Provide an adequate number of mall groups that teach these skills with manual based curriculum.* ***CVC;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Collect data on patient diagnoses and provide data to give baseline information on patients' clinical profiles.	7/31/2008		OMS
- Status: Ongoing				
2	Hire Treatment Mall administrator	8/29/2008	PD and Resume for Tx mall Administrator, Binder VII, tab # 29	CVC
Complete - Status: February, 2009 Update: Treatment Mall Administrator hired 9-15-08				
3	Obtain consultation on assessment of treatment needs based upon clinical profile of patient population and adjust groups accordingly.	12/31/2008	Treatment Mall Redesign documents (Binder VII, Tab # 20	CVC
Complete - Status: February 2009 Update: Development of the Draft Treatment Mall Strategic Plan with input from consultant for Operational Changes and Improvements. This plan discusses improvement in patient assessments, treatment planning, mall referrals, staffing, resources, education, training and space allocation.				
4	Develop manual based mall curriculum.	3/31/2009	Treatment Mall Redesign documents (Binder VII, Tab # 20)	CVC
- Status: February 2009 Update: Curricula for the three mall programs identified and purchase underway				
5	Train group leaders on new curriculum and assess qualifications to lead interventions.	6/1/2009	(Binder VII, Tab # 20	CVC, Office of training.
- Status: Not yet begun, though curricula identified.				

1) Apr 2008 ***3*** *Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions.* ***CVC; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop priority list of auditing tools required by DOJ	8/15/2008	Binder VII, tab # 22 (List of monitoring tools)	Chief of staff
- Status: Comprehensive Auditing tool list/management report list in draft. Will be revised pending redesign of treatment mall				
2	Work with consultant to develop tool that monitors treatment mall groups.	5/1/2009	Binder VII, tab # 20 (Treatment Mall Redesign)	CVC
- Status: Strategic plan for redesign of treatment mall includes tool development				

1) Apr 2008 ***4*** *Train auditors to acceptable levels of reliability.* ***CVC; PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop capacity to train auditors, working with consultant	11/28/2008		Chief of staff, Training dept.
- Status: No progress to report			
2 Begin process of training auditors in order reflected in priority list of auditing tools.	12/31/2008		PID. CVC
- Status: No progress to report			

1) Apr 2008 ***5*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop operational instructions/definitions and create as needed.	11/28/2008		Chief of staff
- Status: Consultant has begun but redesign of mall not yet completed, so tools/instructions not completed			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement prior action steps			

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

Findings

Discharge record monitoring found that 39% of records reviewed included information about specific services and supports appropriate to the person's condition that will be effective at the time of discharge, compared with only 25% in the prior review. Binder VII, tab # 8, 9 ((Discharge Record Review Analysis). Instructions sheets of follow up were provided to patients in 83% of records reviewed, a marked improvement over the 44% in the first quarter review.

The Hospital revised its Discharge Instruction sheet to provide substantially more information to the individual and about the individual. Binder VII, tab # 16 (Hospital discharge instruction sheet) The information on the discharge instruction sheet is now entered into the community provider network information system for provider and MHA use. It is then used as a basis of the initial care management review by the Division of Integrated Care and should improve continuity of care and follow up. See Binder VII, tab # 7 (Protocols, Division of Integrated Care)

The Hospital developed separate forms for discharge, transfer and death summaries, all of which are now approved and in use. Binder VII, Tab # 23 (Transfer Summary form), Tab # 24 (Discharge Summary Form), Tab # 25 (Death Summary form).

See also Sections VII. C and VII D for additional information.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop separate forms for Transfer, Discharge and Death summaries.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop separate forms for transfers, discharges and deaths.	6/15/2008	See Binder VII, Tab # 23, 24, 25 (Transfer, Discharge and Death Summary forms)	J Taylor

Complete - Status: Developed three separate forms for Transfer, Discharge, and Death Summaries. Transfer form attached to Transfer Policy. Remaining forms not yet approved.

1) Apr 2008 ***2*** *Clarify policies and procedures to assure that the Discharge Summary is to include documentation that the information about the discharge treatment needs of the individual has been communicated to the outpatient providers.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise current patient discharge policy.	9/15/2008		J Taylor

Complete - Status: Policy approved. No update February, 2009

1) Apr 2008 ***3*** *Develop and implement an auditing tool to monitor each section of the Discharge Summary for compliance with the DOJ agreement.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Discharged record review instrument.	7/30/2008	Binder VII, Tab # 26 (Discharge quality checklist, revised) Results of Discharge record audit, Tab # 8, 9	QI director

Complete - Status: February 2009 - Instrument has been modified fo reflect additional comments.

2 Review tool upon completion of revised discharge policy and modify as needed.	10/15/2008	Binder VII, Tab # 26 (Discharge quality checklist, revised) Results of Discharge record audit, Tab #8,9	QI director

Complete - Status: February 2009 - Instrument has been modified fo reflect additional comments.

3 Provide report summarizing results	7/31/2008	See Binder VII, Tab # 8,9 (Discharge record review audit report)	QI Director

Complete

1) Apr 2008 ***4*** *Auditors must be trained to reliability.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training protocol that ensures inter-rated reliability.	8/29/2008		QID

- Status: A small cohort of reviewers were trained on the Protocol, and the protocol was piloted. Some adjustments were made based upon feedback from the reviewers. Additional training will be provided once the tool is finalized, indicators and operational instructions are finalized.

2 Work with consultant to assess rater reliability.	9/30/2008		Chief of staff, PID

- Status: Instructions were clarified, and auditors meet to review audit questions and results.

1) Apr 2008 ***5*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide discharge record tool and guidelines to consultant for comment.	7/15/2008	See Binder VII, tab # 26 (Discharge record review audit tool)	Chief of staff

Complete - Status: Tool modified to include instructions

2 Work with consultant to develop operational instructions.	10/31/2008	See Binder VII, tab # 26 (Discharge record review audit tool)	Chief of Staff, QID
- Status: Tool modified to include instructions			

2) Dec 2008 ***1*** *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps.			

2) Dec 2008 ***2*** *The Hospital must develop a clinical review system that tracks individuals who are ready for but resisting discharge. The recommendations from high level case review meetings must be documented in the individual's medical record, and specific objectives and interventions related to those recommendations must be added to the individual's IRP. Follow up must then take place to determine if these interventions have been successful in helping the individual move closer to discharge, and if not, what changes have been made. This must be part of an ongoing clinical review process for these individuals. Data must be aggregated and trended so that those objectives/interventions that prove to be the most effective can be readily implemented in similar cases.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop tracking system.	10/31/2008	Binder VII, Tab # 10 (Ready for Discharge List)	CVC; Wilhoit, Richardson
Complete			
2 Develop process with MHA to work with discharge resistive patients around discharge, including documentation of meetings.	2/11/2009	Binder VII, Tab # 28 (Integrated Care Team Meetings)	MHA; Wilhoit; Richardson
Complete			
3 Conduct a quality review to determine if results of consultation are included in patient's medical record.	3/13/2009		Wilhoit/Richardson

VII.F.

By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:

Findings

The Authority monitors discharge process and aftercare services in two ways. First, it is has an on-going review of cases in which a person is hospitalized three or more times in a year. In addition, it collects data on whether persons are seen within 7 days, 30 days or not all post hospitalization. See Binder VII, Tab # 19 (Seen post discharge data from DMH). That information is shared with executive staff of the Department.

Major efforts are underway at the DMH Authority office to address quality assessments post discharge. The Division of Integrated Care was created and staffed to focus on high risk persons currently at SEH and those who have been discharged but remain high risk. See VII C and D for more description. This Division will specifically follow up and assess whether core service agencies are providing the services and supports targeted at discharge and initial data is available. See Binder VII, Tab # 7 (Protocols for Division of Integrated Care). Four new staff have been hired and trained. See Binder VII, tab # 27 (Training for Division of Integrated Care). The Hospital also

revised its Discharge Instruction sheet to provide substantially more information to the individual and about the individual. Binder VII, Tab # 16(Hospital discharge instruction sheet) The information on the discharge instruction sheet is now entered into the community provider network information system for provider and MHA use. It is then used as a basis of the initial care management review by the Division of Integrated Care. See Binder VII, tab # 17 (SOP, Division of Integrated Care)

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and implement policies and procedures that specify which staff members are responsible for this aspect of community placement follow up, the timeliness by which data is to be collected and aggregated and an auditing tool that monitors compliance.*	***MHA***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review continuity of care guidelines and modify as needed.	9/30/2008		DMH
	- Status: February, 2009 update: Review of guidelines is underway but not yet completed. Sections relating to continuity of care are being modified and a new protocol to support changing the current process to see consumers face to face on ward after admission will be implemented March 1, 2009. Other related processes are in review by SEH and community providers with expected completion date of April 1, 2009. New target date for implmentationis April 30, 2009			
2	Review contracts of providers to ensure appropriate community follow up of all services is required.	11/28/2008		DMH
3	Develop capacity to monitor compliance with contractual community service requirements.	11/28/2008		DMH
	- Status: February, 2009 Update: New office within MHA (Division of Integrated Care) was created and staffed with 4 people, who will monitor compliance with community service contracts. This office targets the high risk individuals. In addition, the Adult Services Division is developing a system to evaluate providers.			
4	Conduct monthly reviews of 20% of all discharged patients in prior month to assess if patient was seen and if services identified by Hospital as needed have been provided and report results.	12/31/2008	Binder VII, tab # 7(MHA Division of Integrated Care SOPs); Tab # 19 (Results of initial care post discharge reviews)	DMH
	- Status: February, 2009 Update: MHA is monitoring discharged patients whether they are seen post discharge. Other monitoring is being phased in over the next three months. During the first reporting period, 35 individuals were discharged from SEH; 12 have had case reviews, exceeding the 20 % target			

1) Apr 2008	***2*** *Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity.*	***MHA***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop tools and ensure auditors are trained	4/30/2009	Binder VII, tab # 27 (Agendas from training and scenarios)	DMH
	- Status: February, 2009 Update: Divisions on Integrated Care and Adult Services have been created within MHA and will among other things, develop tools			

1) Apr 2008 ***3*** *Present data to hospital administration and Social Work chiefs for appropriate follow-up action.* ***MHA***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Present on a monthly basis to Hospital managers data around readmission rates and patient follow up.	6/30/2008		Authority
- Status: Ongoing. In addition, data on care management activities will be reported and bi-weekly meetings of community providers and hospital staff are underway.			
2 Social work to review data and determine if modifications needed to discharge process. If so, work with Authority to address issues.			CVC, Wilhoit, Richardson
- Status: February 2009 status: Data is not always shared in the past, but social work chiefs are working closely with MHA around resolving barriers to discharge for all patients.			

1) Apr 2008 ***4*** *Submit a plan for how many additional staff are needed to implement the above recommendations and a timeline for hiring them.* ***MHA***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Create and staff Division of Integrated Care in MHA	2/20/2009	Binder VII, Tab # 6 (Organizational Chart)	MHA
Complete - Status: Division created and staffed.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior action steps			

VII.F.1

Findings

See VII. F

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

Compliance Status: See VII.F

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps			

VII.F.2

Findings

hiring sufficient staff to implement these provisions with respect to discharge planning.

See VII. F

Compliance Status: See VII. F.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as above. *- Status: Same as above.*			
2) Dec 2008	*Continue with all past recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Continue with prior action steps			

VIII. Specific Treatment Services

Summary of Progress

1. The Hospital expanded its self-assessment activities that monitor the presence of discipline assessments. In addition to completing IRP Process observations and review of discharge records, psychology, social work and rehabilitation services developed audit tools and completed self audits of the initial assessments. Results are provided with this report for social work and rehabilitation services, and will be available during the visit for psychology. Psychiatry developed and tested a tool, but full audits will begin in March.

2. The Hospital is redesigning its treatment mall program to make it more individualized, recovery based with a written curricula. The mall will now have three therapeutic learning centers, serving individuals based upon length of stay. TLC I will be geared for individuals with anticipated lengths of stay of 0-12 weeks. Opening March 16, 2009, TLC I will serve patients whose treatment needs are focused on community living skills, and will utilize the Illness and Recovery Model, SAMHSA. Curricula is written and will be available during the March 30 visit; it includes learning about mental illness, identifying triggers of relapse, developing crisis plans, understanding medication and developing and utilizing supports. TLC III will open April 13, and will serve those whose anticipated length of stay is over 2 years, and will focus on rehabilitation, enrichment, enjoyment and therapeutic learning. It is based upon the Psychiatric Rehabilition Model, Boston University. TLC II will open April 27, 2009 and will focus on those with projected lengths of stay of 12 weeks to 2 years. It will serve individuals presenting with a ranges of behaviors including impulsiveness, aggression, poor attention span and distraction by psychosis. All programs will have the capacity to serve cognitively impaired and will have expanded substance abuse services. Individuals will be able to choose interventions.

3. Medical staff have drafted a series of medication guidelines governing treatment of the elderly, use of mood stabilizers, use of anti-psychotics, polypharmacy, use of stat medications and ant-cholinergics. While still in draft form, they provide standards for practice at the Hospital.

4. Pharmacy began a review of medical records using an instrument that is designed to evaluate use of high risk medications. Results are available and will be presented to Pharmacy and Therapeutics Committee.

5. The Hospital has resolved the majority of issues around AVATAR and medications. A work group with pharmacy, physician, nursing and IT representation met twice weekly to identify issues, determine what was a business process issue and what were system issues, and propose solutions. All critical issues are resolved although staff continue to troubleshoot system or business process issues. Pharmacy verification of orders is occurring, through a process change, which will be confirmed with a software modification that is in development.

6. A new mortality review process has been approved by Executive staff, to include investigation by Risk manager, peer view by medical and nursing staff, and an interdisciplinary review using a sentinel event process. External review will be provided by DMH.

7. The Hospital has taken key steps in developing positive behavioral support through enhanced psychological and ward based services. These include developing a positive behavioral support protocol, structural and functional assessment templates, behavioral guideline template, PBS template, integrity check templates that are incorporated into the underlying guidelines and plans, a draft PBS manual that will be available during the March, 2009 visit, a draft behavior policy and procedure, a description of the role, function and process of a behavioral consultation committee, a Psychology and Behavioral Monitoring form and a prioritization list. To date, the Hospital has implemented structural and functional assessments and also has begun monitoring the quality of assessments. Data may be available during the March, 2009 visit.

In addition, significant training around PBS has occurred. All psychologists have had initial training on the current PBS process; unit based psychologists have had initial training on how to develop a structural assessment. RMB 3/4 psychologists and 4 PNAs have had initial training on how to develop a functional assessment. All psychologists have been trained on how to write a behavioral progress note. Other initial training includes training of RMB 3 and 4 treatment teams on the responsibilities of team members on a behavioral unit, training on trigger criteria for psychology interventions, and how to incorporate behavioral planning (clinical decision trees, assessments, plans, guides, data) into treatment planning. Finally, an in-service (that was videotaped) was held for direct care staff on what is PBS and what is the process in place for the Hospital.

8. In an effort to strengthen nursing services, the Hospital hired a Chief Nurse Executive, who will lead nurse education and development of nursing procedures. Much effort has been made to reduce nursing vacancies, which are now at about 15, if one considers those with EOD dates. Additionally, nursing has addressed the overtime issue, which can cause burn out and errors, but otherwise, there has been little progress in nursing services. A revised initial nursing assessment is expected to be completed by the March, 2009 visit, as well as a strategic plan to address areas in need of improvement.

9. The Hospital finalized its Tardive Dyskinesia policy and now requires AIMS tests at regular intervals. An audit tool and instructions was developed, but audits have not yet begun.

12. The Infection Control Program has not made any progress. A new Infection Control Coordinator was hired and will start March 23, 2009. A consultant has been working with the Chief Nurse Executive to revise the infection control manual which is expected to be revised by the March, 2009 visit.

13. An Environmental Survey was completed during this quarter and results provided to the Senior staff, infection control committee, and risk management and safety committee.

14. A Director of Consumer Affairs was hired and is implementing a consumer satisfaction survey.

VIII. Specific Treatment Services.

Taking into account the limitations of court-imposed confinement and public safety, SEH, 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.

Findings

See specific sub-cells below

Compliance Status: See sub-cells below.

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.

Findings

See Sub-cells

Compliance Status: See sub-cells.

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:

Findings

See sub-cells

Compliance Status: See sub cells.

VIII.A.1.a

documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;

Findings

See VI.A.1- 7.

Review of records shows that Psychiatric assessment and reassessments are occurring but not as frequently as required by the Agreement nor do they consistently meet the quality expected. However, the development of two new psychiatric assessment forms (Comprehensive Initial Psychiatric Assessment), Binder VIII, tab # 1, and the Psychiatric Update, Binder VIII, tab # 2 provide a structure and assessment that meets the requirements of the Settlement Agreement, and upon implementation, should be effective in ensuring assessments meet the requirements. The Initial Psychiatric Assessment form was implemented in January, 2009, and while there has been some inconsistencies in implementation, it has positively impacted the quality of assessment. The use of the psychiatric update is expected to have that same effect (it was implemented beginning end of February, 2009). An audit tool for the initial pscyhiaric assessment was developed and piloted, then modified. Binder VIII, tab # 3 (Comprehensive Initial Psych Assessment audit tool/instructions). A full audit is expected to begin in March, 2009.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c.			
	- Status: Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c			
1) Apr 2008	***2*** *Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.7.			
	- Status: Same as in VI.A.7.			
2) Dec 2008	***1*** *Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c xxx*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c			
2) Dec 2008	***2*** *Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as in VI.A.7.			

VIII.A.1.b

documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;

Findings

See VI.A.7.

Review of records shows that Psychiatric assessment and reassessments are occurring but not as frequently as required by the Agreement nor do they consistently meet the quality expected. However, the development of two new psychiatric assessment forms (Comprehensive Initial Psychiatric Assessment), Binder VIII, tab # 1, and the Psychiatric Update, Binder VIII, tab # 2 provide a structure and assessment that meets the requirements of the SA and upon implementation, should be effective. The Initial Psychiatric Assessment form was implemented in January, 2009, and while there has been some inconsistencies in implementing it, it has positively impacted the quality of assessment. The use of the psychiatric update is expected to have that same effect (it was implemented beginning end of February, 2009). An audit tool for the initial psychiatric assessment was developed and piloted, then modified. Binder VIII, tab # 3 (Comprehensive Initial Psych Assessment audit tool/instructions). A full audit is expected to begin in March, 2009.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1) Apr 2008	***1*** *Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.7. *- Status: Same as in VI.A.7*			
2) Dec 2008	*Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as in VI.A.7.			

VIII.A.1.c

timely and justifiable updates of diagnosis and treatment, as clinically appropriate;

Findings

See VI.A.7

Review of records shows that psychiatric assessment and reassessments are occurring but not as frequently as required by the Agreement nor do they consistently meet the quality expected. However, the development of two new psychiatric assessment forms (Comprehensive Initial Psychiatric Assessment), Binder VIII, tab # 1, and the Psychiatric Update, Binder VIII, tab # 2 provide a structure and assessment that meets the requirements of the SA and upon implementation, should be effective. The Initial Psychiatric Assessment form was implemented in January, 2009, and while there has been some inconsistencies in implementing it, it has positively impacted the quality of assessment. The use of the psychiatric update is expected to have that same effect (it was implemented beginning end of February, 2009). An audit tool for the initial psychiatric assessment was developed and piloted, then modified. Binder VIII, tab # 3 (Comprehensive Initial Psych Assessment audit tool/instructions). A full audit is expected to begin in March, 2009. The audit will provide additional information as to the quality of diagnosis and assessment.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Same as in VI.A.7.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7.			
- Status: Same as in VI.A.7			

2) Dec 2008 *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7.			

VIII.A.1.d

documentation of analyses of risks and benefits of chosen treatment interventions;

Findings

See VI.A.7 and VIII.A.1.c

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7.			
- Status: Same as in VI.A.7			

2) Dec 2008 *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7.			

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;

Findings

See VI.A.7 and VIII.A.1.c.

A small sample review of assessments using the new comprehensive initial psychiatric assessment suggests that staff are not yet fully completing the risk assessment portion of the instrument; in some cases, precautions are not addressed even though an individual has been rated at some risk and mitigating circumstances are rarely addressed. The Medical Directors are working with psychiatrists to ensure the assessment is fully completed.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7.			
- Status: Same as in VI.A.7			

2) Dec 2008 *Same as in VI.A.7.and VI.A.2*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7.and VI.A.2			

VIII.A.1.f

Findings

documentation of, and responses to, side effects of prescribed medications;

See VI.A.7.

In general, psychiatrists are not fully documenting medication side effects or their rationales for changing or not changing medications. However, several changes were recently made that are expected to improve performance on this requirement. Doctors are now required to complete a "reason code" field when changing medications, and eventually, the Hospital will be able to obtain reports by physician, medication and reason code. Second, pharmacists recently began to review charts and will evaluate documentation around side effects. Binder VIII, tab # 4 (Pharmacy Chart review form); tab # 5 (Results of initial chart reviews, Feb, 2009). Third, the new IRP forms include a specific consent for treatment; treatment staff will ensure that individuals understand the risks of treatment interventions.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.7.			
	- Status: Same as in VI.A.7			
2) Dec 2008	*Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as in VI.A.7.			

VIII.A.1.g

Findings

documentation of reasons for complex pharmacological treatment; and

See VI.A.7

Phase I of AVATAR and MedWorks are implemented, but not without some "growing pains". As of December, 2008, the pharmacy modules were fully implemented, and staff are expected to complete all medication ordering and administration recording in the automated system. There were delays in obtaining additional licenses, so a few reports are available at this juncture (e.g. reports are available on PRN/Stat use of medications, use of benzodiazepines and BMI or diabetes diagnosis) and others are in development. Pharmacy initiated a medication chart review process in February. Binder VIII, tab # 4 (Pharmacy Chart review form); tab # 5 (Results of initial chart reviews, Feb, 2009). Results will be presented to Pharmacy and Therapeutics Committee and to the Medical Directors.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Same as in VI.A.7.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Same as in VI.A.7.			
	- Status: Same as in VI.A.7			

2) Dec 2008 *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7.			

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.

Findings

A management report that tracks use of stat and prn medication is available to all medical staff daily. The report recently was refined to track separately use of psychiatric and medical medications. Information is available by ward or physician. A review of the data available shows that for the month of January, 2009, 75 patients were given 5 or more PRN medications and 2 patients were given 5 or more STAT medications; 31 patients had 10 or more PRN medications in the month of January. Binder VIII, tab # 5 (Summary table, Patients given 5 or more Stat or PRN medications). The pharmacy chart reviews also assessed use of PRN and stat medications. Among the 50 cases reviewed, there were no incidents of prn psychiatric medications used. There were six cases involving use of stat medications; one person had two stat orders, 5 had one stat order. Five stat orders were administered by injection, and 0 had four or more PRN or stat orders in a 30 day period. Binder VIII, tab # 5.

The PRN, Stat report also will be used by psychology staff in evaluation need for behavioral interventions. Standards have not yet been set about the point at which stat or prn medications must trigger medication review and then an IRP meeting, but there is an early draft of such a guideline. The pharmacy chart review looks at the use of PRN and stat medications, and data will be available from this time forward for review by the Pharmacy and Therapeutics Committee and Medical Directors.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.7.* ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7.			

- Status: Same as in VI.A.7

1) Apr 2008 ***2*** *Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications.* ***Medical; PID; AS; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review current medical records policy, pharmacy policy and involuntary administration of medication policy to determine if clarification is needed regarding PRN or STAT medication.	7/31/2008	Binder VIII, Tab # 6 (Management report for PRN/Stat meds), tab # 7 (Medication guideline, use of PRN and stat medications.)	Medical Director

Complete - Status: February 2009 Update: Management report tracking use of PRN or stat medications is now available. In addition, draft medication guidelines have been developed for use of PRN and Stat medications

2 Implement AVATAR application relating to pharmacy	7/22/2008		COO; Medical Director

Complete - Status: Completed. Phase I Avatar was implemented on July 22, 2008. stat Medications are included. Management reports on prn/stat have been developed and are being reviewed.

3 Develop report by patient and physician that will track use of STAT medication and PRN medication.	9/30/2008	Binder VIII, Tab # 6 (Management report for PRN/Stat meds)	Lois Branic / Sharmaine Allen
Complete - Status: Completed. Phase I AVATAR was implemented on July 22, 2008. Prnmedications are included. Draft management reports on prn/stat have been developed and are being reviewed.			
4 Monitor use of STAT and PRN medication through management reports	10/31/2008	Binder VIII, Tab # 6 (Management report for PRN/Stat meds)	Medical Director

1) Apr 2008 ***3*** *Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff.* ***Medical; PID; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Design a monitoring tool for record review based upon information from Crystal report to assess compliance with policy.	11/13/2008	Binder VIII, Tab # 4 (Pharmacy chart audit tool)	PID
Complete - Status: Tool developed			
2 Identify and train staff on tool and begin reviews, using 20% sample of prn orders and stat orders	12/10/2008	Binder VIII Tab # 5 (Results of pharmacy audits)	Medical Director
- Status: Pharmacy staff are using tool and recently began to audit records.			

1) Apr 2008 ***4*** *Provide monitoring data based on 20% sample (March to August 2008).* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Review and analyze the sample data and present summarized findings to Exec staff and Medical Staff Executive Committee.	1/30/2009	See prior action recommendation action steps	PID

2) Dec 2008 ***1*** *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7			

2) Dec 2008 ***2*** *Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.A..1.h at recommendation 2			

2) Dec 2008 ***3*** *Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See recommendation 3 above.			

2) Dec 2008 ***4*** *Provide monitoring data based on 20% sample (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See recommendation 4 above			

2) Dec 2008

5 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.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Provide summary of results of chart audit regarding use of PRN and stat medications		Binder VIII, tab # 5 (Pharmacy chart review audit results)	

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:

Findings

See sub-cells

Compliance Status: See sub cells.

VIII.A.2.a

monitoring of the use of psychotropic medications to ensure that they are:

Findings

See sub cells.

Pharmacy developed a tool to review charts assessing certain categories of medication. Binder VIII, tab # 4 (Medication Monitoring Chart review form). The tool was piloted in late February, and audits will continue in March to assess the form. The reviews will look at Medication Orders and Administrations, poly-pharmacy, drug monitoring in geriatric patients, anti-cholinergic medications, diabetes risk, benzodiazepines, PRN/Stat meds and high-alert, or new medications, ADRs and Medication variances. Results are set forth in tab # 5. In general, in49 of 50 cases the persons was prescribed psychotropic medications, and all 50 patients were taking some kind of non-psychotropic medications. There were cases identified where alternative medications might be appropriate to consider. The report also identified 3 of 19 cases in which a benzodiazepine was prescribed for more than 90 days, and 2 cases in which the person has diagnosis of substance abuse.

Compliance Status: See sub cells.

VIII.A.2.a.i

clinically justified;

Findings

See VIII.A.2.a.

As noted in the report, medication guidelines were drafted but deemed insufficient in a number of aspects. Since that time, medical staff are working to draft medication guidelines that track more closely what is expected. To date, medication guidelines are in draft for Mood Stabilizing Agents, Anti-psychotics and treatment of the elderly. An early draft is also developed for use of STAT/PRN. Binder VIII, tab # 7 (Guidelines, Mood Stabilizing Agents); tab # 7(Guidelines, Anti-Psychotics), tab # 7 (Guidelines, treatment of Elderly), tab # 7 (Guidelines, Use of PRN/Stat medications), #7 (Guidelines for use of anticholinergics). Pharmacists also recently began implement a medication monitoring system using a single tool. Binder VIII Tab # 4 (Medication Monitoring form); tab # 5 (Results from Medication Monitoring form). In evaluating use of benzodiazepines, pharmacists review diagnosis, history, and documentation that includes rationale for long term use. Similarly, the chart reviews will evaluate use of anti-cholinergics (assessing duration, whether patient has a cognitive disorder diagnosis, and documented

rationale for use) and use of certain medications with patients with high BMIs or diabetes diagnosis. Information from the pharmacists' reviews will be systematically collected and reviewed by the Pharmacy and Therapeutics committee.

Summary data is now available about drug communications from Pharmacy to doctors. See Tab # 8 (Drug Alert Communications Analysis).

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop and implement monitoring tools with indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).*	***Medical; PID; AS; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Establish guidelines for use of high risk medications.	6/30/2008	Binder VIII, Tab # 7 (Medication Guidelines)	Medical Director
- Status: Guidelines for all high risk catogories are in development.			
2 Pharmacy, P & T Committee and QID develop monitoring tool and operational instructions to monitor compliance with guidelines..	10/31/2008	Binder VIII, Tab # 4 (Pharmacy Chart Audit Form)	Medical Director; QID
Complete - Status: Chart audit tool developed and implemented			
3 Develop Crystal Report that will report patients prescribed high risk medications.	10/15/2008		COO
Complete - Status: Completed. Phase I Avatar was implemented on July 22, 2008. High Risk Medications are included.			
4 Train auditors and begin audits.	11/19/2008	Binder VIII, Tab # 5 (Pharmacy Chart Audit Results)	Medical director
- Status: Initial audit begun. Ongoing			

1) Apr 2008	***2*** *Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008).*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.A.2.a recommendation 1.			PID, Pharmacy, and AF
- Status: See VIII.A.2.a recommendation 1.			
2 Analyze the results of monitoring data.			PID, P and T Committee
- Status: See VIII.A.2.a recommendation 1.			

1) Apr 2008	***3*** *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).*	***Medical; P&T Committee; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).			Dr.Anand/P&T

- Status: Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation)

2) Dec 2008	***1*** *Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.A.2.A recommendation 1			Dr.Anand

2) Dec 2008	***2*** *Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.A.2.A recommendation 2			

2) Dec 2008	***3*** *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.A.2.A recommendation 1 and 2		Binder VIII, Tab # 5 (Summary of Pharmacy Chart reviews)	

2) Dec 2008	***4*** *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).			Dr.Ananad/P&T

VIII.A.2.a.ii

prescribed in therapeutic amounts, and dictated by the needs of the individual;

Findings

Same as above

Compliance Status: Partial

Recommendations	***Responsible Party***
1) Apr 2008	***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Same as above.

- *Status: Same as above.*

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.2.a.iii

tailored to each individual's clinical needs and symptoms;

Findings

Same as above

Compliance Status: Partial

Recommendations	*Responsible Party*
1) Apr 2008 *1 Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- *Status: Same as above.*			

2) Dec 2008 *Same as above.*			
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.2.a.iv

meeting the objectives of the individual's treatment plan;

Findings

Same as above.

Compliance Status: Partial

Recommendations	*Responsible Party*
1) Apr 2008 *1 Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- *Status: Same as above*			

2) Dec 2008 *Same as above.*			
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.2.a.v

evaluated for side effects; and

Findings

Same as above.

Compliance Status: Partial

Recommendations	*Responsible Party*
1) Apr 2008 *1 Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.2.a.vi

documented.

Findings

Same as above.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.2.b

monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:

Findings

See sub-cells for findings.

Compliance Status: See sub cells.

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;

Findings

Medication guidelines are in draft for Mood Stabilizing Agents, Anti-psychotics and treatment of the elderly, use of STAT/PRN, and anticholinergics. Binder VIII, tab #7.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and clinical and laboratory screening and monitoring requirements.* ***Medical; P and T Committee; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop individualized psychotropic medication guidelines.	7/22/2008	Binder VIII, tab # 7(Medication Guidelines)	Dr.Anand
- Status: Medication guidelines are under development by medical and pharmacy staff. To date, the following have been completed			

1) Apr 2008	*2 Revise the clozapine guideline to ensure alignment with current generally accepted standards.*	***Medical; P & T Committee; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Clozapine guideline.	7/22/2008		Dr.Anand/Dr.Redditt

- Status: Drafted revision completed - being reviewed by Pharmacy and Therapeutics Committee. Feb 2009 Update: Civil Medical Director are working to update clozapine protocol.

1) Apr 2008	*3 Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.*	***Medical; P and T Committee; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update S.E.H Medication Guideline Manual regularly.	7/22/2008		Dr.Anand/P&T

- Status: Initial set of guidelines are being developed. Pharmacy and Therapeutics committee with develop review process for guidelines

2) Dec 2008	*1 Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and specific clinical and laboratory screening and monitoring requirements.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.2.b. at recommendation 1			Dr.Anand

2) Dec 2008	*2 Revise the clozapine guideline to ensure alignment with current generally accepted standards.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.2.b. at recommendation 2			Dr.Anand/P&T

2) Dec 2008	*3 Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.2.b. at recommendation 3			Dr.Anand/P&T

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

Findings

See sub-cell VIII.A.1.h.

Compliance Status: Partial

Recommendations	***Responsible Party***
1) Apr 2008 *1 Same as in VIII.A.1.h.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Same as in VIII.A.1.h.

- Status: Same as in VIII.A.1.h.

2) Dec 2008 *Same as in VIII.A.1.h.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VIII.A.1.h.			

VIII.A.2.b.iii

establish a system for the pharmacist to communicate drug alerts to the medical staff; and

Findings

The Pharmacy has the capacity and is communicating drug alerts to physicians. In addition, the Hospital developed a tracking system and is aggregating and categorizing those alerts in a systemic manner. See Binder VIII, Tab # 9 (Summary of Drug Alert Information). This information will be presented to the Pharmacy and Therapeutics Committee on a regular basis.

Compliance Status: Partial

Recommendations — ***Responsible Party***

1) Apr 2008 ***1*** *Develop a tracking log regarding drug alerts that were communicated to the medical staff during the review period.* — ***Medical; PID; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a Tracking Log for drug alerts.	7/31/2008	Binder VIII, Tab #8 (Drug Alert Communications Analysis)	Zerislassie
Complete - Status: Tracking log is in draft. Expected to be finalized by July 31, 2008. February 2009 Update: Drugs alerts are now captured in the automated system.			
2 Work with PID, OMS to develop tracking log on drug alerts, and analyze same.	8/29/2008	Binder VIII, Tab # 9 (Summary of Drug Alerts to Physicians)	OMS
Complete - Status: Drug alerts are now monitored through automated system.			

2) Dec 2008 ***1*** *Present information regarding drug alerts that were communicated to the medical staff (October 2008 to March 2009).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified		Binder VIII, Tab #9 (Summary of Drug Alerts to Physicians)	

2) Dec 2008 ***2*** *Present documentation of review by the P&T Committee of drug alerts.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure P and T committee review data on drug alerts		Binder VIII, Tab # 10 (Pharmacy and Therapeutics Committee minutes.)	
- Status: P andT committee at times reviews drug alert data, but not on a routine basis.			

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.

Findings

The Hospital continues to make some incremental progress in meeting this requirement, but is not yet meeting the requirements.. The medication utilization policy was recently approved, but it has not been implemented. Binder VIII, tab # 11 (Medication utilization policy).

Accurate reporting of adverse reactions and medication variances continues to problematic, despite unit and

discipline based meetings to review the process and purpose behind reporting. Pharmacy staff presented information to medical and nursing staff, and also did unit based training throughout the Hospital. Binder VIII, tab # 12 (Power point, Medication Errors and Adverse Drug Reactions). This is also being tracked through pharmacy chart reviews - are instances of medication variances or ADRs identified through chart reviews being reported. Binder VIII, tab # 4.

New Medication Administration, ADR and Medication variance policies were approved, Binder VIII, tab # 13(Medication Variance and Reporting); tab # 14 (Adverse drug reactions); tab # 15 (Medication Administration). Data shows that 142 medication errors were reported from June 2008 to December, 2008 (none in August, 2008, largely due to implementation of AVATAR). Data still shows that some units may not report errors as required. Data from September to December, 2008 show the largest variances involve prescribing errors, then improper dose or quantity, with nine incidents of extra dosing. Data also shows a total of 25 adverse drug reactions since June, 2008, which is much lower than one would expect. From May, 2008 to Dec, 2008, there were 7 ADRs reported that were life-threatening or involved another medically important condition, and also 7 interventions to prevent incapacity. Binder VIII, tab # 16 (Trend Analysis).

The Hospital now has a number of "crystal report" developers who are beginning to develop the number and type of pharmacy reports so that medication utilization, ADRs and medication variances data by medication, practitioner, unit, etc, can be obtained in a systemic manner and analyzed. In the meantime, pharmacy tracks all reports of ADRs and medication variances, which is then presented monthly to the Pharmacy and Therapeutics Committee. In the meantime, Pharmacy & Therapeutics Committee is receiving monthly data on ADRs and Medication Variances, as well as information about individual cases. Psychiatric peer review has not begun and therefore there is no systemic review of ADRs. It is noteworthy that Pharmacy recently began systematic reviews of medical records that will evaluate the presence of ADR and medication variances, which may provide data on the extent of under-reporting.

The Pharmacy and Therapeutics Committee has developed an intensive case analysis process that will be led by the Risk Manager, and will include the PID director, a Pharmacy and Therapeutics committee member and a pharmacist. However, that panel has not yet met, but is expected to begin its work in March.

Finally, during the last visit, a number of significant issues relating to implementation of AVATAR were identified. A team of clinical staff and IT staff met to identify and resolve issues, and adjustments were made to AVATAR to achieve permanent resolution. See Binder VIII, tab # 17 (IT AVATAR Medication Issues List). The only issue that remains is to create a new process that ensures pharmacy verifies orders before nursing is informed of the order. While that system fixes are being made, a change in the business process was made so that nurses do not administer medications, except in emergency, without pharmacy verification.

The Hospital modified it mortality review process to provide for investigation by the Risk Manager, Review by the Mortality review Committee, as well as review by an interdisciplinary review panel. External review will be completed by DMH or specific contractors. Binder VIII, tab # 18 (Patient Death Review policy); tab # 19 (Sentinel Events Policy). The policies were just finalized in February, 2009, so they have not yet been implemented.

Compliance Status: Partial.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *ADRs: a. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs:*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Campaign to increase reporting of Adverse Drug Reactions and Medication Errors	8/29/2008	Binder VIII, Tab #12 PowerPoint Presentation (Med Errors & ADRs)	Zerislassie/ P&T
- Status: Campaign started 6/16/08. February 2009 Update: Despite campaign, reporting of ADRS is not occurring as required. Issue has been presented repeatedly to medical and nursing staff, additional strategies are being considered by P and T Committee.			
2 Revise ADR reporting form and also place it online to make it more accessible.	3/20/2009	Binder VIII, Tab #20 (Electronic ADR Form)	Zerislassie/ IT
- Status: Form Complete awaiting IT to place form in AVATAR			

1) Apr 2008 — ***1*** *ADRs: b. Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified above* — ***Medical; PID; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop an updated ADR policy.	9/15/2008	Binder VIII, Tab # 14 (ADR policy)	J Taylor
- Status: Policy is working with Pharmacy and researching ADR policy information. February 2009 Update: ADR policy finalized			
2 Pharmacy will collect information about ADRs and will report same to P & T committee monthly.	6/30/2008	Monthly ADR report to P&T	Pharmacy
Complete - Status: Information is reported to P & T Committee monthly.			
3 Data collection tool will be developed and data collected will be analyzed and presented to P & T Committee.	9/30/2008	Binder VIII, Tab #20 (Revised ADR Reporting Form)	Pharmacy
Complete - Status: Data is first reported using new elctronic ADR reporting form and compiled in MEDMARX and presented monthly at P&T. New electronic ADR reporting form is just being released.			
4 Pharmacy and Therapeutics committee to review DOJ recommendations and develop prioritization.	9/17/2008		P & T Committee.
- Status: February 2009 Update: Prioritization included focus on developing medication guidelines.			

1) Apr 2008 — ***1*** *ADRs: c. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs* — ***Medical; PID; AS; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assist the pharmacy in improving ADR data collection from the MEDMARX and analyze the findings.	8/29/2008		PID, & Pharmacy
- Status: Feb 2009 Update: Avatar and Medworks are fully operational. The bi-directional enhancement has been implemented. A ADRs form is to be included in Phase II that will allow for tracking and reporting ADRs.			
2 Implement AVATAR application	8/29/2008		COO; Pharmacy
- Status: An enhancement is needed for bi-directional and has been requested. Avatar implemented July 22, 2008. February 2009 Update: Avatar and Medworks are fully operational. The bi-directional enhancement has been implemented. A ADRs form is to be included in Phase II that will allow for tracking and reporting ADRs.			

1) Apr 2008 ***1*** *ADRs: d. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations* ***P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Establish severity/outcome thresholds.	12/31/2008		Medical Director, P & T Committee
- Status: Feb 2009 Udpate: No action taken.			
2 Develop system for intensive case analysis.	2/28/2009		Medical Director
- Status: February 2009 Update: P and T Committee developed work group to review cases that reach threshold level. First round of reviews have been conducted.			
3 Begin case analysis.	3/31/2009		Meical Director, Pharmacy&TherapeuticsCommittee/PID
- Status: See action step #2 above			

Not Identified

1) Apr 2008 ***2*** *DUEs: a.Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines:* ***Medical; PID; AS; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a DUE policy.	9/15/2008	Binder VIII, Tab # 11 (Drug Utilization Policy)	J Taylor
- Status: Researching DUE policy and expect final policy by 9/15. February 2009: Durg utilization policy finalized.			
2 Implement the AVATAR	9/30/2008		COO;I/T
- Status: An enhancement is needed for a bi-directional interface between Avatar and the Pharmacy system and this has been requested. Once the enhancement has been implemented a management report will be developed. February 2009 Update: Management reports reflecting drug utilization in queue for development.			
3 Pharmacy to evaluate medication use in context of medication guidelines, with consultation from P & T Committee.	6/18/2010		Pharmacy
- Status: Worx System requires report writer to produce reports that identify drug usage			
4 Develop reports relating to drug utilization.	12/31/2008		COO
- Status: An enhancement is needed for a bi-directional interface between Avatar and the Pharmacy system and this has been requested. Once the enhancement has been implemented a management report will be developed. February 2009 Update: Management reports reflecting drug utilization in queue for development.			

1) Apr 2008 — ***2*** *DUEs: b. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses* — ***Medical; AS; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VIII.A.2.b recommendation #2			
- Status: See VIII.A.2.b recommendation #2			

1) Apr 2008 — ***2*** *DUEs: c. Determine the 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* — ***PID; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Drug utilization policy.	9/15/2008	Binder VIII, Tab # 11 (Drug utilization policy)	Taylor
Complete - Status: Policy is expected by 9/15/08. February 2009 Update: Drug Utilization policy is finalized			
2 P & T committee to make recommendations about the method and timing of a system to evaluate medications uses.	9/15/2008		P & T committee
- Status: February 2009 Update: This is not yet occurring. Once management reports are available to track drug utilization and patterns, P and T committee will evaluate data and make recommendations. New target is June, 2009			
3 See action steps for VIII.2.A.b recommendation 2 a			

1) Apr 2008 — ***2*** *DUEs: d. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends* — ***Medical; PID; AS; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 OMS to support Pharmacy and AVATAR system by developing analysis of available information at least quarterly	9/17/2009		Pharmacy, OMS
- Status: Feb 2009 Update: Management reports are still in development.			
2 Develop Crystal Report needed to support data collection.	2/28/2009		COO
- Status: An enhancement is needed for a bi-directional interface between Avatar and the Pharmacy system and this has been requested. Once the enhancement has been implemented a management report will be developed.			

1) Apr 2008 — ***3*** *MVR: a. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above* — ***Medical; PID; P & T committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assist the Medical Director to design a user-friendly data tracking tool to collect MVR information.	10/31/2008	Binder VIII, Tab # 13 (MVR policy)	PID
- Status: February 2009 Update: Med variance policy is finalized. New forms have been developed to facilitate reporting and data collection			

2 Analyze the data from the tools and present summarized findings and results.	12/31/2008		PID, Med Director
- Status: No information is available			
3 Pharmacy/P & T Committee to lead policy development with support from PID.	9/15/2008	Binder VIII, Tab # 13 (MVR policy)	Pharmacy, PID
- Status: February 2009 Update: Med variance policy is finalized			
4 Data to be presented to Exec staff and P & T Committee.			
- Status: Data is not yet available.			

1) Apr 2008 ***3*** *MVR: b. Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances* — ***Medical; PID; Chief Nurse Executive; P & T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Campaign to increase reporting of Adverse Drug Reactions and Medication Errors	6/27/2008	Binder VIII, Tab #12 (PowerPoint Presentation - Med Errors & ADRs)	Zerislassie
Complete - Status: Campaign started 6/16/08. February 2009 status: Campaign not successful, medication variances not yet routinely reported by all staff. Education continues, and Avatar/Medworks system may be useful in identifying MVR, but that is still under review.			
2 Develop system to input medication variance reports that will allow for analysis of type, cause and staff involved.	9/19/2008		Zerislassie; OMS
Complete - Status: No update to report. Significant increase in reporting noticed as Avatar mangement reports have been created.			
3 Develop reports that reflect data and analysis.	10/31/2008		COO; OMS
- Status: Data that has been reported in captured and reported in the trend analysis, but additional data and analysis is needed.			

1) Apr 2008 ***3*** *MVR: c. Provide instruction to all clinicians regarding the significance of and proper methods in MVR* — ***Medical; CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop new Medication Variance Policy.	10/15/2008	Binder VIII, Tab # 13 (Medication Variance Policy)	J Taylor
Complete - Status: February 2009 Update: Medication variance policy finalized			
2 Train all clinical staff in medication variance policy and reporting.	12/31/2008		CNE; Medical Director
- Status: Policy just finalized. Training of nursing and physicans to follow.			
3 Campaign to increase reporting of Medication Variance Reporting	9/15/2008		Chief Pharmacist
Complete - Status: Staff where provided follow-up inservices to emphasize importance of reporting as well as instructions on how to report			

1) Apr 2008 — ***3*** *MVR: d. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances* — ***Medical; PID; AS; PID with P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.A.2.b.iv.3.a			
- Status: See VIII.A.2.b.iv.3.a			

1) Apr 2008 — ***3*** *MVR: e. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations* — ***Medical; PID; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify severity/outcome thresholds		Binder VIII, Tab # 10 (P and T Committee minutes)	Medical director, PID
- Status: February, 2009: P and T Committee has decided to have intensive case review for all cases rated as a "3" which means??????????			
2 Intensive case review process initiated for ??????cases			PID
- Status: February 2009: XXX cases have been reviewed and results reported to the P and T committee. Other reviews will continue			

1) Apr 2008 — ***3*** *MVR: f. Ensure that MVR is a non-punitive process* — ***Medical; P and T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Monitor to ensure that MVR are not utilized in disciplinary matters.			

1) Apr 2008 — ***4*** *Mortality reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following:* — ***Medical; PID; PID***

- *a Definitions of expected and unexpected deaths;*
- *b Delineation of first response activities, including the roles/responsibilities of different parties in the facility;*
- *c An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and death summaries;*
- *d An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and*
- *e Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise an integrated Mortality Review policy that includes peer review and incorporates the DOJ requirements to include an interdisciplinary review and external review.	9/15/2008	Binder VIII, Tab # 18 (Patient Death Review), Tab # 19 (Sentinel Event Policy)	J Taylor
- Status: Incorporating DOJ requirements into the existing Mortality Review policy. Feb 2009 Update: Policy is finalized			

2 Assess sentinel event policy as well		9/17/2008	Binder VIII, Tab # 19 (Sentinel Event Policy)	J. Taylor

- Status: Feb 2009 Update: Policy is finalized

2) Dec 2008 **1** *ADRs: a. Develop and implement a policy and procedure regarding ADRs that includes an updated data collection tool and instructions to staff regarding proper methods in the reporting and investigating of ADRs. The procedure and the tool must correct the deficiencies identified in the previous report.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.A.2.b above			

2) Dec 2008 **1** *ADRs: b. Present data to demonstrate the number of ADRs reported October 2007 to March 2009, compared to the previous six month period.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete data analysis of ADRs for period of January 2008 to January, 2009 by type and number.		Binder VIII, Tab #21 (Analysis of ADRs from January 2008 to January 2009)	OMS; PID

Complete - Status: This analysis reflects the ADRs reported, but as the information reveals, there is in all likelihood a significant underrreporting of ADRs.

2) Dec 2008 **1** *ADRs: c. Provide an aggregated summary of ADRs by severity outcome.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 **1** *ADRs: d. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 **1** *ADRs: e. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.A.2.b above			

2) Dec 2008 **1** *ADRs: f. Provide documentation of reviews by the P & T committee and Medical Staff Executive Committee to assess trends and patterns related to ADRs and to recommend systemic corrective/educational actions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 P and T Committee and Medical Staff Executive Committee to begin to receive data	3/31/2009		PID

- Status: Not yet begun

2) Dec 2008 ***2*** *DUEs: a.Ensure systematic review of all medications, with priority given to high-risk, high-volume uses*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII. A.2.b			

2) Dec 2008 ***2*** *DUEs: b.Determine the 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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***2*** *DUEs: c.Perform DUEs and present summary of the methods, findings, conclusions and recommendations in these DUEs.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop management reports that track medication usage and patterns identified as priority by P and T committee.	6/10/2009		Medical Director, COO; PID
- Status: management reports in development.			
2 PID to assist P and T Committee is data analysis.			

2) Dec 2008 ***2*** *DUEs: d.Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

2) Dec 2008 ***3*** *MVR: a. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

2) Dec 2008 ***3*** *MVR: b. Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step.			

2) Dec 2008 ***3*** *MVR: c. Provide instruction to all clinicians regarding the significance of and proper methods in MVR.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Provide ongoing training to all doctors and nursing about Medication variance reporting	5/1/2009		Medical Director, CNE

2) Dec 2008 ***3*** *MVR: d. Present data to demonstrate the number of variances reported October 2007 to March 2009, compared to the previous six month period.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

2) Dec 2008 ***3*** *MVR: e. Provide an aggregated summary of ADRs by category of variance (prescription, documentation, administration, ordering, procurement, dispensing, monitoring and medication security), severity outcome and actual vs. potential variances.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *MVR: f. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *MVR: g. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See action step VIII.A.2.b, MVR, #3.			

2) Dec 2008 ***3*** *MVR: h. Provide documentation of reviews by the P & T Committee and the Medical Staff Executive Committee to analyze trends and patterns and recommend systemic corrective/educational actions regarding MVR.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Medical Staff Executive Committee and P and T Committee will begin reviews of data around MVRs and ADRs and drug utilizations.	5/1/2009		Medical Director, PID
PID to support review by presenting data.	4/22/2009		PID
Develop management reports from Medworks system to help track MDR.	4/23/2009		COO

2) Dec 2008 **4** *Mortality Reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: a) Definitions of expected and unexpected deaths; b) Delineation of first response activities, including the roles/responsibilities of different parties in the facility; c) An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and nursing death summaries; d) An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and e) Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Finalize policy of patient death review and sentinel event review	2/20/2009	Binder VIII, Tab # 18 (Patient Death review), Tab # 19 (Sentinel Event policy)	PID
Complete			

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.

Findings

The Hospital continues to be successful in recruiting psychologists and psychiatrists. In FY 2008 (10/1/07 - 9/30/08), ten psychiatrists and 12 psychologists were hired. As of 1/31/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009. See Binder VIII, Tab # 22 (HR report).

However, despite this success, the Hospital is not meeting required caseload ratios for psychiatrists. Census data from February 18th, 2009 shows that on 11 of 18 units, caseload ratios are met. On seven units, caseload ratios are not met. On three units, the caseload exceeds the standard by one patient. On one unit (CT3A/B), the caseload ratio exceeds the standard by 11 patients. The two JHP admissions units have only one full-time psychiatrist, and they exceed caseload ratios by 6 and 8 respectively. See Binder VIII, Tab # 23 (Caseload Summary Chart); Tab # 23 (AVATAR caseload report)

Although there are no specific requirements of caseloads for psychologists, there currently are fifteen psychologists (not including clinical administrators who are also psychologists), one half time neuropsychologist and two supervisors. Each ward is supported by a psychologist. See Binder VIII, Tab # 24(List of Psychologists), tab # 25 (Psychology staff ward assignments)

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 **1** *Identify and resolve barriers towards recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units.* ***CVC; JH; Medical; AS; PJC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Prioritize filling clinical vacancies including psychiatrists.			James Gallo

- Status: Six new Medical Officers (Psychiatrists) will join the medical staff before the end of the fiscal year and the Hospital is continuing to recruit for additional psychiatric staff. Two will be assigned to JHP and 4 to civil programs. With these psychiatrists, both civil admissions units will have 2 psychiatrists. February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009.

2 HR will provide bi-weekly the on board strength (separations vs. hires including projected hires) for FY 2008.	7/7/2008	Binder VIII Tab # 26(Report of Clinical Hires: 8-2008 through 1-2009)	James Gallo

- Status: Ongoing February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009.

1) Apr 2008 ***2*** *Provide summary data of case loads of current psychiatrists in all admission and long-term units. The case loads should be based on FTE status.* ***Medical; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.A.3 at recommendation 1		Binder VIII, Tab # 23 (Caseloads of Psychiatrists by Ward)	

2) Dec 2008 ***1*** *Identify and resolve barriers to recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units.* ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Medical Director to work with DMH Medical director to identify barriers to recruitment and resolve.			Medical Director

- Status: Ongoing.

2) Dec 2008 ***2*** *Provide summary data of case loads of psychiatrists currently serving in all admission and long-term units. The case loads should be based on FTE status.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Caseloads monitored in Avatar.		See Binder VIII, Tab # 23(Caseloads for Psychiatrist by Unit)	

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:

Findings

See findings in V.A.2.e and VI.A.7.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Same as in V.A.2.e and VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.A.2.e and VI.A.7.			

- Status: Same as in V.A.2.e and VI.A.7

2) Dec 2008 *Same as in V.A.2.e and VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in V.A.2.e and VI.A.7.			

VIII.A.4.a

ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;

Findings

Same as above. See also VIII. B. The Hospital is only now expanding the use of behavior plans, and staff are being trained on development and implementation of the plans. Modifications have been made to Psychology reports to track the communication between psychologists and psychologists.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.4.b

ensure regular exchanges of data between the psychiatrist and the psychologist; and

Findings

Same as above.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- Status: Same as above.			

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.4.c

integrate psychiatric and behavioral treatments.

Findings

Same as above

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Same as above.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
- *Status: Same as above.*			

2) Dec 2008 *Same as above.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as above.			

VIII.A.5

By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.

Findings

Same as in VI.A.7 and subsections VIII.A.1 and A.2.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008 ***1*** *Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2			
- *Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*			

1) Apr 2008 ***1*** *Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2			
- *Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*			

1) Apr 2008 ***1*** *Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2			
- *Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2*			

2) Dec 2008 *Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.			

VIII.A.6

By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.

Findings

A substance abuse screening has been included in the new Comprehensive Initial Psychiatric Assessment. Binder VIII, tab # 1(Comprehensive Initial Psychiatric Assessment), In addition, the Hospital recently finalized a policy that describes assessment and treatment for those with substance abuse diagnoses.

The new comprehensive initial assessment form began being used in January, 2009, so there is not much data to

evaluate. The psychiatric audit tool does evaluate whether it has been completed, but audits have not yet begun as the tool was only piloted in February, 2009. The IRP now includes a specific focus relating to substance abuse, and incorporates stage of change principles. Binder VIII, tab # 27(IRP Form) Stage of change also has been a focus of IRP training.

PID completed a special audit reviewing substance abuse assessments and treatment. Binder VIII, tab # 28 (Substance abuse audit tool). In general, the audit showed persons were being assessed by psychiatrists for substance abuse and dependence upon admission, and that nursing and social work were also assessing persons for substance abuse or dependence. Binder VIII, tab # 29 (Results of Substance abuse audit). However, the audit also shows that despite substance abuse diagnoses, the IRPs are not including objectives and interventions around substance abuse.

Capacity for substance abuse treatment is expected to increase with the treatment mall redesign. See Section VIII, tab #49 about treatment mall redesign.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Present the facility's policy and procedure regarding the screening of substance use disorders.*	***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy to include requirements around assessment for substance abuse.	7/15/2008	Binder VIII, tab # 30 (Assessment Policy, revised)	Medical Director; PID
Complete - Status: Completed. Feb 2009 update: In addition to the substance abuse assessment in the psychiatric assessment, the Hospital approved a Substance abuse policy			
2 Incorporate substance abuse screening questions into initial psychiatric assessment.		Binder VIII, tab # 1 (Comprehensive Initial Psychiatric Assessment Form)	
Complete - Status: Piloting of initial psychiatric assessment will begin August 1, 2008. Feb 2009 Update: Piloting of comprehensive initial psychiatric assessment was delayed, but now tool is in use. It includes substance abuse screening.			

1) Apr 2008	***2*** *Develop and implement a substance use chart audit tool with indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP.*	***Medical; PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Make decision whether to include substance abuse standards in clinical chart audit tool; if so revise tool, if not develop new tool.	9/25/2008	Binder VIII, Tab # 1 (Comprehensive Initial Psychiatric Assessment Form); Tab # 3 (Psychiatric Assessment Audit Tool)	Medical director; Chief of staff, PID
- Status: Consultant on board to assist in evaluating current clinical chart audit tool and to provide technical assistance in development of tools. February 2009 update: Substance abuse assessment is included in psychiatric assessment and is psychiatric assesment tool.			
2 Finalize tool and begin audits.	11/3/2008		Medical director
- Status: Included in psychiatric assessment audit but only in very preliminary manner.			

3 Compile the data and analyze them for further review and presentation.	12/22/2008		OMS

- Status: Initial chart audits of psych assessments completed.

1) Apr 2008 ***3*** *Provide monitoring data based on at least 20% sample (March to August 2008).* ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze the monitoring data.	11/28/2008		PID & QIC

- Status: No monitoring has begun yet.

1) Apr 2008 ***4*** *Same as V.D.1.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as V.D.1.			

- Status: Same as V.D.1

2) Dec 2008 ***1*** *Implement the revised initial psychiatric assessment (see VI.A.1).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement the revised initial psychiatric assessment (see VI.A.1).			Medical director

Complete - Status: Began being used in December2008 -, January, 2009

2) Dec 2008 ***2*** *Develop and implement a substance use chart audit tool with complete indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *Provide monitoring data based on at least 20% sample (March to August 2008).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Monitor substance abuse assessments using chart audit tool	5/29/2009		N. hamilton

- Status: Not yet begun, so no data is available.

2) Dec 2008 ***4*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Within 45 days of completion of first audit, and then monthly thereafter, complete analysis of chart audit for substance abuse assessments.			N Hamilton; PID

- Status: No mointor has yet begun

2) Dec 2008 ***5*** *Same as V.D.1.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Same as V.D.1.			

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.

Findings

A tardive dyskinesia audit tool was developed, with instructions but data is not yet available. Binder VIII, tab # 31 (TD audit tool). The audit form was tested in February, and audits are expected to begin in March.

There is some concern that tardive dyskinesia diagnosis is not always entered into the AVATAR database. The Medical director is consulting with the Director of Neurology to try to resolve issues.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *Finalize the policy and procedure regarding TD, including the information suggested by this expert consultant above.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review and revise TD policy.	5/30/2008		Medical Director; PID

Complete - Status: Policy completed. February 2009. No changes to policy made or required.

1) Apr 2008	***2*** *Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement.*	***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 QID to work with Neurology to develop monitoring tool, with support from consultant. Also will develop operational instructions and indicators	10/1/2008	Binder VIII, tab # 34 (TD Audit Tool)	Medical Director
2 Train auditors and begin audits	11/17/2008		medical Director

Complete - Status: Not yet begun
February 2009 update: Audit tool developed

- Status: Feb 2009 update: Initial audit has been conducted, results available.

1) Apr 2008	***3*** *Provide monitoring data based on a review of a 100% sample (March to August 2008).*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID will analyze the collected data on TD using data in the Patient Data base until Phase II in AVATAR is implemented.	8/29/2008		PID, AF

- Status: Patient data base is operational, but data entry is still not reliable. Feb 2009 update: Initial audit has been conducted but not an 100% sample, results available.

2) Dec 2008 ***1*** *Implement the policy and procedure regarding TD.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008 ***2*** *Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
see prior action steps			

2) Dec 2008 ***3*** *Provide monitoring data based on a review of a 100% sample (March to August 2008).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
see prior action steps			

2) Dec 2008 ***4*** *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.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps.			

VIII.B. Psychological 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.

Findings

See sub cells for findings

Compliance Status: See sub cells for findings

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:

Findings

The Hospital has taken key steps in developing positive behavioral support through enhanced psychological and ward based services. Key foundational elements have been developed. These include a positive behavioral support protocol (Binder VIII, tab # 32), structural and functional assessment templates, tab # 33 (structural assessment template); tab # 34 (functional assessment template); behavioral guideline template (tab # 35), PBS template (tab # 36), integrity check templates that are incorporated into the underlying guidelines and plans, a draft PBS manual that will be available during the March, 2009 visit, a draft behavior policy and procedure (tab # 38), a PBS resource for all psychologists (tab # 39), a description of the role, function and process of a behavioral consultation committee (tab # 38), a Psychology and Behavioral Monitoring form (tab # 41) and a prioritization list (tab # 42).

To date, the Hospital has implemented structural and functional assessments (See Advanced document request, Boggio tab # 19, 20) and also has begun monitoring the quality of assessments. See tab # (Psychology and Behavioral Monitoring services review, Monitoring form). Data may be available during the March, 2009 visit.

In addition, significant training has occurred. Binder VIII, tab # 43 (Outline of PBS training). All psychologists have

had initial training on the current PBS process; unit based psychologists have had initial training on how to develop a structural assessment. RMB 3/4 psychologists and 4 PNAs have had initial training on how to develop a functional assessment. All psychologists have been trained on how to write a behavioral progress note. Other initial training includes training of RMB 3 and 4 treatment teams on the responsibilities of team members on a behavioral unit, on trigger criteria for psychology interventions, and how to incorporate behavioral planning (clinical decision trees, assessments, plans, guides, data) into treatment planning. Finally, an in-service (that was videotaped) was held for direct care staff on what is PBS and what is the process in place for the Hospital)

The consultant is also working with the Hospital administration and making recommendations about how to structure PBS units, how to include behavior units into the new Therapeutic Learning Centers, and how to align Risk management and behavioral services.

Sources of needed data for completion of assessments and development of guidelines and plans have been identified for seclusion and restraint usage, prn and stat medication usages, and information about assaults and other UIs. The Hospital is still identifying potential data sources for information about mall attendance/participation and use of 1:1.

Other activities underway include the revamping of the token economy program and engagement activities available on and off RMB 3 and 4, providing a 2 day certification training on PBS and engagement skills for direct care staff, and identifying all current behavior plans from all units, and converting them to the revised format as appropriate.

Compliance Status: Partial

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 re

Findings

See VIII.B.1

There are currently 15 psychologists in the psychology department and 1 part time neuropsychologist, excluding supervisors and clinical administrator psychologists. Psychologists are completing Initial Assessments for all admissions which include a behavioral intervention screen. Binder VIII, tab # 44(Initial Psychological Assessment, parts A and B). Psychology also developed and is using a audit tool to evaluate the completion of the IPA. Binder VIII, tab # 45 (IPA Audit tool/instructions). Results should be available by the March, 2009 visit.

No new behavior plans incorporate seclusion or restraint.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	**1** *Develop and implement a mechanism to ensure that all individuals who may be in need of Positive Behavior Support Plans/Behavioral Guidelines receive appropriate screening for such services. This will likely necessitate that psychologists provide an initial assessment of all newly admitted individuals and that the Department develops and implements a timeline for the assessment of those individuals who were admitted in the past and are still at the hospital.*	***CVC; JH; Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 The Psychology Department will develop a transfer summary for all patients transferred from the admissions/pretrial areas that will specifically address the need for any needed psychological assessment/behavioral plans.	9/30/2008		Dr. Patterson

- Status: Not yet developed. February 2009 Update: Expected to be completed by March 31, 2009.

2 The Psychology Department will re-evaluate all patients that are currently in the hospital for the need for further testing/behavioral plans.	12/30/2008		R. Patterson

- Status: February, 2009 Update: ???

3 Assessments/behavioral plans will be completed on those patients identified through the above referenced review.	3/27/2009	Binder VIII, Tab # 46 (Current list of individuals in need of PBS plans or guidelines.	R Patterson

- Status: February 2009 Update: There is not yet a comprehensive list of patients in need of PBS plans or behavioral guidelines. To date, psychology staff are being trained on structural and functional assessments. Most direct clinical staff have been provided an overview of positive behavioral supports by a consultant (Angela Adkins), and plans/guidelines are being developed for individuals on RMB 3. The training is designed in part to help the identification of individuals in need of behavior plans or guidelines. A partial list has been created.

1) Apr 2008

2 *It does not seem possible that the hospital would be able to achieve the above and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists.*

Medical; AS;

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Prioritize filling psychologist vacancies.	8/25/2008		James Gallo

- Status: Six Clinical Psychology Interns joined the hospital and one new Clinical Psychologist.February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009.

2 HR will provide the on board strength for psychologists (separations vs. hires including projected hires) for FY 2008.	7/7/2008	Binder VIII, Tab # 22 (HR Report), Tab # 26 (H.R. Report of Clinical Hires: 8-2008 through 1-2009)	James Gallo

- Status: We had an increase of one psychologist. No psychologists left. 2008February 2009 Status: In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 1 psychologist have been hired in FY 2009.

3 The Psychology Department will submit a request to the hospital administration for sufficient additional psychology positions to correspond with the recommendation of the DOJ if needed; one psychologists for every ward of the Hospital and three additional psychologists with expertise in behavioral plan development..	8/29/2008		Dr. Patterson

- Status: February 2009 Update: The hospital currently has 19 units (One unit at JHP was closed in January), and 17 psychologists are on staff. This 17 does not include those treatment team leader/clinical administrators who are psychologists by training.

1) Apr 2008 *3 Develop and implement an auditing tool that is used for the review of medical records to assure that when all newly admitted individuals are required to receive a psychological screening to determine the need for Positive Behavior Support Plans/Behavioral Guidelines, compliance with this requirement can be tracked.* ***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include assessment of this requirement in psychology peer review process.	8/30/2008	Binder VIII, Tab # 44 (Revised Initial Psychological Assessments, Part A & B), Tab # (Audit Tool & Instruct. for initial psychological assessments)	Dr. Patterson

- Status: February 2009 Update: A behavioral screening was added to the initial psychological assessment and is included in the audit tool for evaluating initial psychological assessments.

1) Apr 2008 *4 Develop and implement an auditing tool for the review of the records of those individuals already admitted to the hospital to determine if they would benefit from the use of Positive Behavior Support Plans/Behavioral Guidelines. Among the items that the tool must audit are: individuals with multiple acts of self-harm or aggression; individuals with multiple instances of seclusion and/or restraint; individuals who are not making appropriate progress toward discharge; and individuals who are subject to polypharmacy.* ***Medical; PID; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Behavioral Consultant will work with Dr. Patterson to develop method/tool for assessing patients	12/30/2008		R Patterson
- Status: February 2009 Update: Tool not yet developed, but is expected to be completed and piloted in March, 2009.			
2 Implement assessment tool as psychologists are hired to work on each ward.	3/27/2009		R Patterson

1) Apr 2008 *5 Train auditors to acceptable levels of reliability and provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify staff to serve as auditors.	2/13/2009		R Patterson
2 Train on tools and instructions.	4/17/2009		R Patterson
- Status: No information is available.			

1) Apr 2008 *6 Establish by clear policy that the planned use of seclusion and/or restraint as part of a behavioral intervention is clearly prohibited.* ***Medical; PID; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Seclusion and Restraint policy to include restriction into policy.	6/15/2008	Document provided last review.	J Taylor

Complete - Status: Restrictive language has been incorporated into policy document.

2	Psychology Director to disseminate a memo and discuss with staff in Department Meetings that there is to be no mention of S/R as an integral part of behavioral programs.	6/30/2008	Document provided last review	Dr. Patterson

Complete

2) Dec 2008 ***1*** *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps related to recommendations.			

2) Dec 2008 ***2*** *Revise the IPA so that it includes a section regarding the appropriateness of Behavioral Guidelines as well as Positive Behavior Support Plans.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IPA to provide a behavioral screen to facilitate in early identification of persons who may benefit from behavioral plan		Binder VIII, tab # 44 (Initial Psychological Assessment, part B)	Rose Patterson

Complete

2) Dec 2008 ***3*** *Revise the Restraint and Seclusion for Behavioral Reasons Policy so that it clearly contains a prohibition against the use of seclusion or restraint as part of any planned behavioral intervention (Behavioral Guideline, Positive Behavior Support Plan).*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Restraint and Seclusion for Behavioral Reasons Policy so that it clearly contains a prohibition against the use of seclusion or restraint as part of any planned behavioral intervention (Behavioral Guideline, Positive Behavior Support Plan).	2/27/2009	Binder VIII, Tab # 47 (Revised S/R policy)	PID

Complete

VIII.B.1.b

ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the indiv

Findings

See VIII.B.1

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. At a minimum, such plans include:*	***Medical; BG; Sam Feinberg***

a A description of the maladaptive behavior

b A functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior

c Documentation of how reinforcers for the individual were chosen and what input the individual had in their development

d The system for earning reinforcement

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Consultant and begin training Psychology staff.	6/27/2008		Rose Patterson

Complete - Status: Consultant has begun work. Chief Psychologist has shared the needed information with the consultant to ascertain that these issues are addressed in the training.
Feb 2009 Update: Consultation well underway. Consultant is working with staff at RMB 3 on development of behavior plans and guidelines. She also provided an overview of PBS to most direct care clinical staff (videotapes were made and are available), and has been working with psychology staff on structural and functional assessments.

2 Training to begin in mid-July and will be ongoing.	7/30/2008		Rose Patterson

- Status: See above update

1) Apr 2008 — ***CVC; Medical; BG; Psychology Director***

2 *The use of individualized token economies in the development of behavioral interventions is strongly discouraged, as the more individuals are placed on such plans the more unwieldy individualized token economies will be to implement. Rather, it is recommended that the hospital consider the adoption of a unit-based token economy in which all individuals are rewarded over the course of the day for generally accepted prosocial behaviors appropriate to specific time frames, e.g., attention to ADLS; meal attendance; mall attendance; and appropriate use of unstructured time. These systems are much easier to administer, and the hospital may find it advantageous to develop and pilot such a program on one unit or series of units as part of an overall plan of implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Establish a pilot ward-based token economy for RMB 3, the designated behavioral treatment ward.	7/1/2008	Provided last report	Dr. Michele Marsh with Dr. Patterson

Complete - Status: Ongoing

2 Restart the Clinical Consultation Support Team (CCST) as a multi-disciplinary team, led by a licensed psychologist, Dr. Michele Marsh.	7/25/2008		Dr. Marsh with Dr. Patterson

Complete - Status: THE CCST did not function between March and July, as the prior team leader left the Hospital. It has been reconstituted. February 2009 Udpate: CCST is being reviewed, as few consults have been sought

3 Define the role of the ward psychologist regarding behavioral programming; .	9/30/2008		

- Status: The ward psychologist will be the liaison between the treatment team and the CCST regarding behavioral programs for patients assigned to their ward

4 The Behavioral Consultant will provide training to the staff on RMB 3 in addition to training the Psychology Staff.	8/30/2008		Dr. Marsh with Dr. Patterson

- Status: This is intended to be ongoing beginning by 8/30/2008.
Feb 2009 Update: Consultation well underway. Consultant is working with staff at RMB 3 on development of behavior plans and guidelines. She also provided an overview of PBS to most direct care clinical staff (videotapes were made and are available), and has been working with psychology staff on structural and functional assessments.

1) Apr 2008 — ***3*** *Form one Positive Behavior Support Team. Led by a clinical psychologist skilled in behavior analysis and consisting of a registered nurse, 2 psychiatric technicians and 2 data analysts, this team will be the hospital's front line for the development of appropriate Positive Behavior Support Plans/Behavioral Guidelines. They will assist in the training of all clinical staff in the appropriate use of these technologies.* — ***CVC; Medical; BG; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify a unit in Civil Services that will serve as the positive support team and provide psychology support..	5/1/2008		CVC
Complete - Status: RMB 3 identified. Psychologist assigned to unit.			
2 Consultants Angela Adkins will work with RMB 3 staff on implementation of PBS	8/29/2008		Chief of Staff
- Status: This is on-going			

2) Dec 2008 — ***1*** *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with all prior action steps.			

2) Dec 2008 — ***2*** *Proceed with training and consultation with Angela Adkins.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with training and consultation			
- Status: Ongoing			

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;

Findings

See VIII.B.1

Compliance Status: Partial

Recommendations — ***Responsible Party***

1) Apr 2008 — ***1*** *See Recommendation 1 in cell VIII.B.1.b.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Recommendation 1 in cell VIII.B.1.b.			
- Status: See Recommendation 1 in cell VIII.B.1.b.			

1) Apr 2008	***2*** *Develop and implement a training program for nursing and level of care staff on the various means of positive reinforcement that are available in the hospital's therapeutic milieu.*	***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify additional consulting assistance to train nursing staff on positive reinforcement.	9/30/2008		CNE
2 Once consultant is arranged for, begin training, focusing first on staff on behavior units and behavior program in treatment mall and RMB 3.	10/31/2008		CNE

- Status: February 2009 Update: Consultant Angela Adkins is working with nursing staff on RMB 3 directly. She also provided an overview of PBS to all direct care clinical staff, which was videotaped. Additional training is needed

2) Dec 2008 *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with all prior action steps			

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 re

Findings

See VIII.B.1.

There are currently 15 psychologists in the psychology department and one neuropsychologist, excluding supervisors and clinical administrator psychologists. Psychologists are completing Initial Assessments for all admissions which include a behavioral intervention screen. Binder VIII, tab # 44 (Initial Psychological Assessment, parts A and B). Psychology also developed and is using a audit tool to evaluate the completion of the IPA. Binder VIII, tab # 45 (IPA Audit tool/instructions).

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *See cell VIII.B.1.a.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VIII.B.1.a.			

- Status: See cell VIII.B.1.a

2) Dec 2008 ***1*** *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps			

2) Dec 2008 ***2*** *Revise the IPA so that it includes a section regarding the appropriateness of Behavioral Guidelines as well as Positive Behavior Support Plans.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the IPA so that it includes a section regarding the appropriateness of Behavioral Guidelines as well as Positive Behavior Support Plans.	2/2/2009	Binder VIII, tab # 44 (Revised Initial Psychological Assessment, Part A and B)	Rose Patterson

Complete

VIII.B.1.e

ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and

Findings

See VIII.B.1.

Psychologists have been trained in completing a behavioral progress note.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop a policy that directs psychology staff about when and how to monitor and document an individual's therapeutic progress(or lack thereof) when they are making use of Positive Behavior Support Plans/Behavioral Guidelines. At a minimum this documentation must occur monthly and most directly document the individual's progress toward achieving the behavioral goals for which the plan was created, including the decrease in targeted maladaptive behaviors and increase in adaptive behaviors.*	***Medical; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain consultation on how to implement this recommendation.	3/31/2009		Rose Patterson

- Status: February 2009 Update: Policy is in draft form and provided to consultant Angela Adkins. Comments will be incorporated and this is expected to be completed by March 31, 2009.

2 Based upon consultation, psychology will develop protocols for monitoring and documenting patients' responses to behavior plans	9/17/2008		Rose Patterson

- Status: No progress to date.

1) Apr 2008	***2*** *Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans.*	***Medical; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training plan with consultant Angela Adkins.	9/30/2008		Chief of staff

- Status: February 2009 Update: Consultant Angela Adkins is working with nursing staff on RMB 3 directly. She also provided an overview of PBS to all direct care clinical staff, which was videotaped. Additional training is needed

1) Apr 2008	***3*** *Develop and implement a Behavior Consultation Committee (BCC) for the regular review of individuals who are placed on Positive Behavior Support Plans. The BCC will also serve as a consultative committee to which treatment teams may come for clinical advice and consultation regarding individuals who are having difficulty progressing in treatment. The membership of the BCC is such to ensure that clinical and administrative decision makers are present so the necessary resources and support can be provided to help treatment teams implement suggested clinical strategies. At a minimum, membership would include the Executive Director (or delegate); the Medical Director (or delegate); the Chiefs of Psychology, Social Work, Nursing and Rehabilitation Therapy, and representatives of the Positive Behavior Support Team.*	***Medical; Psychology director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Restart the CCST (multidisciplinary team) to serve as consultative support to treatment teams with patients on positive support plans or who pose challenging clinical or behavioral issues.	2/13/2009		Drs. Patterson and Gouse

- Status: Team identified and new chair appointed.

2) Dec 2008	*Continue past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with prior action steps			

VIII.B.1.f

ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs.

Findings

See VIII.B.1.

There are currently 15 psychologists in the psychology department and one part time neuropsychologist, excluding supervisors and clinical administrator psychologists. Psychologists are completing Initial Assessments for all admissions which include a behavioral intervention screen. Binder VIII, tab # 44 (Initial Psychological Assessment, parts A and B). Psychology also developed and is using a audit tool to evaluate the completion of the IPA. Binder VIII, tab # 45(IPA Audit tool/instructions).

Compliance Status: Partial

Recommendations	*Responsible Party*

1) Apr 2008 *1 Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards.* ***Medical; BG; Sam Feinberg***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify consultant with experience in developing and implementing positive behavior support plans/behavioral guidelines.	8/15/2008		Dr. Patterson to arrange with Dr. Arnheim.

- Status: Behavioral consultant is training psychology staff in the development of positive behavior support plans. He will also provide an overview of behavior plans and positive reinforcement to nursing staff on the behavior management unit (RMB 3).
February 2009 Update: Consultant Angela Adkins is working with nursing staff on RMB 3 directly. She also provided an overview of PBS to all direct care clinical staff, which was videotaped. Additional training is needed

1) Apr 2008 *2 It does not seem possible that the hospital would be able to achieve this part of the agreement and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists.* ***Medical; AS; Psychology Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 HR will provide bi-weekly the on board strength for psychologists (separations vs. hires including projected hires) for FY 2008.	7/7/2008	Binder VIII Tab # 26 (H.R. Report of Clinical Hires: 8-2008 through 1-2009)	James Gallo

- Status: Ongoing; February 2009 Status: The HR database has been developed and is used by HR to track position status. In FY 2008, ten psychiatrists and 12 psychologists were hired. As of 2/11/09, 2 psychiatrists and 1 psychologists have been hired in FY 2009.

2 Upon receipt of applications, interview and select as appropriate to fill three vacant positions within the next 60 days.	9/1/2008		Rose Patterson

- Status: A report showing the status of each vacancy is produced weekly and provided to the Executive Staff. It also includes new hires and separations and each report can be sorted by occupation and date. A comprehensive HR database is in the final stages of development and will have the capability of producing targeted reports focusing on specific occupations.
The hospital made one selection for a staff psychologist and expects to fill the other vacancies before the end of the fiscal year.

2) Dec 2008 *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

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.

Findings

The Hospital is implementing a major redesign of the treatment mall that will be phased in through April, 2009. Binder VIII, tab # 49 (TLC Strategic Plan The current structure of 5 programs will be eliminated, and instead, three therapeutic learning centers (TLC) will be created. The TLCs will focus on rehabilitation and enrichment, will be curricula based and will use evidence based models. TLCI will serve individuals with short term anticipated lengths of stay (0-12 weeks), TLC II will serve individuals with lengths of stay of 12 weeks to 2 years, and TLC III will serve persons with anticipated lengths of stay over 2 years. A protocol has been developed that will identify the

appropriate learning center for individuals. Binder VIII tab # 49 (Assessment and assignment of persons to TLCs). While it will first focus on civil side persons, forensic patients will be eligible after full implementation and stabilization. Ward based programming will continue for Forensic patients, for RMB 3 patients, and for those in the Gerimall and restorative care programs. Binder VIII tab # 49 (Assessment and assignment of persons to TLCs) The combination of TLC groups and ward based groups will ensure individuals have more than 20 hours of active treatment each week.

Under the plan, TLC I will open March 16, 2009. TLC I will focus on community re-entry, and will use the Illness Management and Recovery Model, SAMSHA. Curricula will be available during the March, 2009 visit. Content is described in tab # 49 (Treatment Mall Announces Transformation) TLC II will serve persons with a range of behaviors from intrusiveness, impulsiveness, aggressiveness, and will serve those with mild cognitive impairment, poor attention concentration and psychosis. TLC III will provide integrative psychiatric and social learning approach and will focus on rehabilitation, enrichment, enjoyment and therapeutic learning. Groups in both TLC II (opening April 27) and III (opening April 13) will be based upon the Psychiatric Rehabilitation Model, Boston University.

Substantial planning has occurred. For TLC I, groups will be led by virtually all disciplines and will include expanded groups for those with co-occurring disorders. Binder VIII, tab # 49 (TLC 1 Discipline Group List and Schedule). Similar schedules are being developed for TLC II and III. Each individual will participate in a week long orientation before starting any of the TLCs. TLC staff will work with the individual and treatment teams to select interventions that support the foci and objectives in the IRP. Binder VIII, tab # 49 (Patient Orientation and Treatment planning process). Two group leaders will be leading 15 groups per week so that nursing can attend rounds and IRPs. In addition, a space allocation plan was developed. Binder VIII, tab # 49 (treatment mall space allocation plan). Focus groups were held with individuals serve and staff. The Plan was presented to senior staff and feedback elicited. Binder VIII, tab # 49 (Treatment Mall changes, Feedback from Focus groups).

A curriculum format for TLC I has been developed and staff will utilize SAMSA curricula. All group leaders will be required to attend a basic group skills training that includes a 12 hour course of training. Binder VIII, tab # 49 (Basic Group Course/training schedule). Curricula for TLC II and III is in development.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	*1 Assure that the initial assessments of all disciplines include an assessment of the types of group interventions from which the individual would most clearly benefit based on diagnosis, symptoms status, functional level and discharge setting.*	***CVC; JH; Medical; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy and discipline assessment forms to capture recommendations about group therapies	6/30/2008	Binder VIII, Tab # 30 Assesment Policy; Discipline Assessment Forms: Tab # 1 (Psychiatric assessment form); Tab # 50 (Social Work Assessment Form); Tab # 44 (Psychology Assessment Form; Tab # 52 (Rehab Services Assessment Form)	Beth Gouse
Complete - Status: February 2009: Assessment policy updated			
2 Hire Treatment Mall Administrator.	9/15/2008		CVC
Complete - Status: Interviews are being scheduled. February 2009 Update: Treatment Mall Administrator hired 9-15-08			

3	Reassess patients attending treatment mall using treatment mall referral form that is based on multidisciplinary assessment of patients' functional level-based on this assessment determine the type and number of groups that are required in treatment mall programs	6/11/2008	Binder VIII, Tab # 49 (Treatment Mall Redesign Documents)	CVC

- Status: This will follow once initial psychological assessments are routinely done. Data will be used to assist in determining each patient's appropriate level/groups. Feb 2009 Update: Treatment mall is being redesigned to allow for more individualized programming based upon individual needs.

4	Update initial assessments for disciplines	2/27/2009	Binder VIII, Tab # 1 (Comprehensive Initial Psychiatric Assessment Form), Tab # 50 (Initial Social Work Assessment Form); Tab # 44 (Initial Psychological Assessment (A & B);Tab # 52 (Rehab Assessment Form)	Discipline chiefs

Complete

1) Apr 2008 ***2*** *Determine, based on the hospital's current census, the type and number of the various groups that must be offered in each of the treatment malls.* ***CVC; JH; Medical; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Using data from clinical profile initially and later AVATAR, PID to assist civil and forensic services based on the monthly trend analysis and the mgmt report from AVATAR in determining group therapy needs.	10/31/2008	Binder VIII, tab # 49 (Treatment Mall Redesign Documents)	PID, CVC, JH

- Status: February 2009 Update: Treatment mall is being redesigned.

1) Apr 2008 ***3*** *Develop a process for assigning individual clinicians as group leaders for those therapeutic modalities for which they are adequately trained.* ***CVC; JH; Medical; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create a training program for nursing staff that will foster development of basic group treatment skills.		Binder VIII, tab # 49 (Treatment Mall Redesign Documents)	Medical Director, Clo-Vidoni-Clark, Joe Henneberry

- Status: A group treatment training program for nursing staff will begin in October 2008. February 2009 Udpate: Group leaders not yet trained. Delays due to staffing. Plan to train leaders in included in Treatment mall redesign.

2	For group therapies that require special expertise (e.g., sex offender groups, trauma groups), ensure groups will be led or co-led by a licensed and where indicated, credentialed professional.	10/31/2008		Medical Director

- Status: Credentialing process for psychologists is in the process of being revised and is expected to resume by October 31, 2008.

3 To ensure staff understand group interventions develop two-tier curriculum on group therapy for group providers. 1) Basic didactic course to start 9-08 2) Advanced course that awards certification & ability to supervise other group providers. Provide staffing data to group trainers on number of staff by discipline who are providing group interventions in treatment mall.	8/29/2008		Medical Director
4 Begin basic group therapy didactic course	9/30/2008		Medical Director
5 Design group supervision process	10/31/2008		Medical Director
6 Develop example group curriculum outline that will be used as model by group providers in developing individualized group curriculum	11/28/2008		Medical Director

1) Apr 2008 ***4*** *Develop group treatment offerings that are manual-based. Empirically validated and part of a curriculum development process.* ***CVC;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the Behavior Management Program in the Treatment Mall:	6/27/2008	Binder VIII, tab # 49(Treatment Mall Redesign Documents)	CVC
Complete - Status: The token economy program was modified to include a point system has been implemented based on behavior during group. February 2009 Update: Treatment mall is being redesigned - there will be three programs, all curriculum based.			
2 Hire a program administrator for the Treatment Mall	8/29/2008	7	CVC
Complete - Status: Interviews are being scheduled December 2008 Update: Treatment Mall Administrator hired 9-15-08.			
3 Develop manual and curricula for all mall groups	1/30/2009	Binder VIII, tab # 49 (Treatment Mall Redesign Documents)	CVC
- Status: February 2009 Update: Treatment mall is being redesigned - there will be three programs, all curriculum based. This plan discusses improvement in patient assessments, treatment planning, mall referrals, staffing, resources, education, training and space allocation.			
4 Rehab services will develop manuals for groups offered, with information on treatment methodology and will be available on each unit.	1/30/2009	Binder VIII, tab # (Draft manuals for rehab)	Robinson, Coleman
- Status: Drafts of protocol manuals for all group therapies offered by Rehabilitation Services have been completed. Final manuals will be completed and distributed to all civil and forensic units by January 31, 2009. February 2009 Update: manuals developed and distributed, but expected to be modified as treatment mall changes are implemented.			

1) Apr 2008 ***5*** *Develop an auditing process to assure that clinicians are appropriately trained in all therapeutic modalities they are providing and that there is adequate fidelity to the curriculum and the manual for the group.* ***CVC; JH; Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII B 2 recommendation 3 and 4.			

2	Develop auditing tools that will address the curriculum of each group and that clinicians are keeping to curriculum.	2/27/2009	CVC

- Status: Feb Update: Auditing tools not in development yet as treatment mall is being reorganized in significant manner. Tools will be developed.

3	Rehab services will audit 5 records per month to assess quality of progress notes and track results	10/1/2008	OMS;; Rehab services

- Status: Format of revised progress note finalized in October 2008 and is being used by clinicians. The discipline chiefs in conjuction with the Director of Monitoring Systems are developing an auditiing tool. Audits scheduled to begin March 2, 2009.

4	Discipline chiefs will attend at least two groups led by the discipline per month to assess competency of leaders and provide individual feedback. Schedule shall ensure each group leader is assessed at least once per quarter. NOTE: SHOULD READ DISCIPLINE SUPERVISORS SEE DECEMBER 2008 STATUS UPDATE.	11/24/2008	Discipline chiefs.

- Status: Tools will need to be developed in advance.
February 09 Update: Discipline supervisors will attend at least two discipline specific groups per month. The Rehabilitation Services chiefs will attend a group conducted by each discipline supervisor quarterly.

1) Apr 2008 — ***6*** *Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity..* — ***CVC; JH; Medical; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify auditors and train once tools developed.	3/31/2009		CVC

1) Apr 2008 — ***7*** *Periodically, conduct a needs assessment based on current census to determine necessary changes to the mall curriculum.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Use information from AVATAR and patient data base to get patient profile.	12/31/2008		OMS

Complete - Status: Ongoing. Patient database will be supplanted by AVATAR.
February 2009 Update: AVATAR Phase I is implemented, Phase II, clinical work station will be implemented beginning in Spring, 2009 through Septembe,r 2009,

2	Treatment mall administrator and PID work to develop protocol for needs assessment using available data.	4/30/2009		CVC; PID

- Status: Feb 2009. Work has been done on needs as part of treatment mall redesign.

3	Conduct needs assessment and report on same.	9/30/2009		CVC; PID

2) Dec 2008 — ***1*** *Continue past recommendations.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Continue past action steps			

2) Dec 2008 *2 Revise Psychiatric and Nursing assessments to include recommendations about group therapies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

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.

Findings

See findings for cell VIII.B.2.

The Hospital continues its community reentry program, Pathways to Independence, that targets discharge resistant individuals or persons that need to develop skills. Binder VIII, tab # 53 (Description of Community Reentry Program and participation). The program is held 3 days a week and includes community trips as well as activities at the Hospital. To date, the program has included 4 cohorts. Of the 18 who have completed the program, 7 have been successfully discharged, two refuse to leave the hospital, and the remaining are awaiting various types of housing. There are currently 4 patients in cohort # 4 with three additional persons expected to start this month. This program will likely be modified as part of the Treatment mall redesign.

Other programs include the Hospital's Work Adjustment Treatment program where patients are provide job opportunities and given work skills in a supportive environment, as well as several day programs in the community A small cadre of patients (about 20-25) attend the McClendon Center, Green Door, Anchor Mental Health and other community based programs as a transition to community living.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 *1 See the Recommendations from Cell VIII.B.2.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See the Recommendations from Cell VIII.B.2.			

1) Apr 2008 *2 Additionally, demonstrate that the development of group treatment curriculum is based on the discharge needs of individuals.* ***CVC; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Create database that tracks barriers to discharge.	5/21/2008	Binder VIII, tab # 54 (Spreadsheet on Discharge Barriers)	OMS
Complete - Status: February 2009 Update: Due to some technical problems both with the database and staff use of the database, the discharge barriers are being tracked weekly through an excel spreadsheet. Information is shared weekly with MHA staff			
2 Provide periodic reports that track barriers.	7/11/2008		CVC
- Status: On-going			

3	Work with Authority to obtain data on post discharge patient progress and needs and modify treatment mall groups as needed.	4/1/2009	Binder VIII, Tab #55 (Revised Discharge Instruction Sheet)	CVC; Authority

- Status: Feb 2009 Update: Workgroup established with DMH authorities to track patients after discharge. One completed task thus far has been the redesign of the Discharge Instruction Sheet which is faxed (as of 11-2008) to designated authority officials who are to track patient services after discharge. Also, another workgroup established with DMH authorities to look at "frequent users" of the hospital (those admitted more than 3 times within a year) to "flag" them at admissions and discuss how to better handle treatment and eventual discharge to prevent another unsuccessful stay in the community.

2) Dec 2008 *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps			

VIII.B.4

By 18 months from the Effective Date hereof, SEH shall ensure that:

Findings

See sub cells for specific findings.

Compliance Status: See sub cells.

VIII.B.4.a

behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;

Findings

See findings for cell VIII.B.1

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See cell VIII.B1.c.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VIII.B1.c.			

2) Dec 2008 *Continue with all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps			

VIII.B.4.b

programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;

Findings

See VIII.B.2 and VIII.A.6.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Develop and implement a process that assures that all individuals with substance abuse diagnoses are being referred to appropriate substance abuse groups and treatments.* ***CVC; JH; Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Revise assessment policy to ensure substance abuse is assessed upon admission and at appropriate intervals thereafter.	7/16/2008	Binder VIII, Tab # 30 (Assessment Policy), Tab # 1 (Comprehensive Initial Psychiatric Assessment)	Taylor; CEO
Complete - Status: Feb 2009 Udpate: Assessment policy revised. Psychiatric assessment form revised.			
2 Revise treatment mall referral form to capture substance abuse information for consideration in assigning groups.	7/1/2008	Binder VIII, Tab # 56 (Treatment Mall Referral Form)	CVC
Complete			
3 Use information from AVATAR and patient data base to track diagnosis and treatment interventions; Develop report that can link diagnosis with treatment interventions.	3/2/2009	Clinical Profile of Inpatient Population, Tab # 55	COO; Medical Director
- Status: Patient database has been created but provides limited capacity. Will need expanded reports through AVATAR system. Feb 2009 Update: Avatar diagnosis now active. Management reports in development			

2) Dec 2008 ***1*** *Assure that assignments to specific groups are based on individualized assessment and not simply by virtue of being eligible for the Dual Disorders Mall.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Redesign treatment mall to be more individualized and reflect individual needs	4/30/2009	Binder VIII, tab # 49 (Treatment Mall Redesign Documents)	CVC
- Status: Redesign underway, implementation begins end of Feb or early March			

2) Dec 2008 ***2*** *Develop specific group offerings that are aligned with the different Stages of Change.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

VIII.B.4.c

where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;

Findings

A cognitive functioning screen is now completed on all new admissions. Programming in the new TLCs will include groups and interventions for those with cognitive impairments.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008 ***1*** *Undertake a systematic analysis of the care needs and community placement supports and services required for all individuals with cognitive impairments, and where appropriate develop community living plans for these individuals that optimize community tenure.* — ***Authority, Barbara Bazron***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct inventory of housing and supports.			Authority
- Status: Housing inventory complete, suport inventory not complete			
2 See action steps in Section VII F			

2) Dec 2008 *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all prior action steps			

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;

Findings

Prior level of practice continues to be implemented.

Compliance Status: Substantial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Continue current policy and procedure.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice *- Status: Current practice continues*			

2) Dec 2008 *Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice.			

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;

Findings

See V.A.2.a and c. Documentation continues to be inadequate on this requirement. Staff do not routinely or comprehensively document the individual's response to particular treatment interventions, so it is not clear from chart reviews which interventions are effective and which are not. Entries into the charts are often generic e.g. "patient is responding to treatment"; "patient continues to be a management problem". Treatment plan reviews often continue the same intervention without clear consideration of the effectiveness of the intervention.

However, changes to policies and forms that are just being implemented should improve practice. A clinical formulation update will be completed before each IRP conference and is focused evaluation of progress. Binder VIII, tab # 57 (clinical formulation update). In addition, disciplines updates before the IRP conferences as well as the therapeutic progress note all prompt the assessment of progress or lack thereof. Binder VIII, tab # 2 (Psychiatric Update), tab # 58 (Social Work Update); Tab # 59(Therapeutic progress note).

Further, IRP process observations are also evaluating whether disciplines are presenting updates that reflect the individual's present status. Binder VIII, tab # 64. The reviews conducted in February, 2009 suggest that such presentation occur in anywhere from 25% to 73% of cases depending on the discipline. Binder VIII, tab # 64.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See Recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 See Recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e.

- Status: See related status

2) Dec 2008 ***1*** *Continue with past recommendations*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with past action steps			

2) Dec 2008 ***2*** *Assure that this element is addressed in the overall treatment planning training.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Ensure IRP training reflects need to assess effectiveness/lack thereof of interventions and need to make changes as needed.			

- Status: Ongoing

VIII.B.4.f

clinically relevant information remains readily accessible; and

Findings

A therapeutic monthly progress note is being used. Binder VIII, tab # 59 (Therapeutic progress note)

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Develop a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about necessary changes if treatment when treatment has been successful and there is a need to implement the next step in treatment or when treatment is unsuccessful and further assessment.* ***CVC; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop progress note template	6/30/2008	Binder VIII, Tab # 59 (Therapeutic Progress Note Template)	Chief of staff

Complete - Status: Template is in use. Template is being reviewed by consultant. Comments will be incorporated. Feb Update: template revised.

2) Dec 2008 ***1*** *Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue all past action steps			

2) Dec 2008 ***2*** *Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Modify progress note template	2/4/2009	Binder VIII, tab # 59 (Therapeutic Progress Note Template)	Beth gouse

Complete

VIII.B.4.g

Findings

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 behavi

See VIII.B.1.

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans.*	***CVC; JH; Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with consultant(s) to provide technical assistance to units in implementing PBS plans, and to train staff	6/30/2008		COO
Complete			
2 Training for Psychology staff to begin by the end of July and continue for at least 6 months.	7/30/2008		R Patterson
- Status: Training has started. A Adkins provided overview of PBS to direct care staff (video tape made) and is working directly with psychology staff on plan development. She is also working directly with RMB 3 staff.			
3 Consultant(s) to provide intensive training to the treatment team on RMB 3, a designated behavioral treatment unit beginning by the end of July.	7/31/2008		R Patterson
- Status: A Adkins provided overview of PBS to direct care staff (video tape made) and is working directly with psychology staff on plan development. She is also working directly with RMB 3 staff.			

1) Apr 2008	***2*** *Train auditors to acceptable levels of reliability.*	***Medical; Rose Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Behavioral programs will be coordinated by the ward psychologist the later will randomly audit on-going behavioral treatment plans for effectiveness and fidelity to the PBS model.	4/30/2009		Rose Patterson
- Status: No updated information			

1) Apr 2008	***3*** *Provide operational definitions of all terms in a written format to aid in data reliability and validity.*	***Medical; Rose Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Not Identified	12/31/2008		

2) Dec 2008	*Continue all past recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue with prior action steps			

VIII.C. Pharmacy Services

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.

Findings

See sub-cells for findings.

Compliance Status: See sub cells.

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

Findings

The Hospital recently appointed a new Chief Pharmacist and has a pharmacist vacancy. Pharmacy developed a medication monitoring tool (Binder VIII, tab # 4 (Medication Monitoring Form) and has completed a review of 50 records using the tool, which will continue on an ongoing basis. Binder VIII, Tab # 5. The Hospital, led my its medical staff, is working on a series of Medication guidelines; to date, draft guidelines have been completed for mood stabilizing agents, antipsychotics, use of anti-cholenergics, and medications for the elderly. Binder VIII, tab # 7 (Medication guidelines). Work is continuing on guidelines for use of benzodiazepines.

The Hospital developed a system for pharmacy verification of medication orders; a short term process is in place until the necessary software changes can be made to the AVATAR system. Effective mid January, 2009, the Hospital's pharmacy provides verification of orders through an on-call pharmacist until 10 p.m. weekdays and from during the day on weekends. The on call pharmacist accesses the system remotely to do so, and is available the other hours as well. The only orders not being verified are the emergency stat orders. Under the new process, while medication orders continue to go to pharmacy and nursing at the same time, the workflow has been modified, and nursing does not administer medications until the AVATAR system reflects verification by pharmacist (A color change in the order screen reflects verification). In addition, it is working with the technical team from AVATAR to modify software so that is not notified of orders until verification occurs. Binder VIII, tab # 60 (Pharmacy flow sheets and memorandum). Additional numerous other changes to the AVATAR medication system were made to improve the medication ordering and administration process. Binder VIII, tab # 17(AVATAR EMAR issues list). Among some of the changes is a requirement that doctors provide a reason for changes in medication and making completion of allergies field mandatory.

The Hospital continues to track communication between pharmacists and doctors. See Binder VIII, tab # 9(Summary of Drug communications.)

Compliance Status: Progress has been made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments.*	***Medical; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1	Develop a monitoring system for pharmacists to provide medication management.	7/22/2008	Binder VIII, Tab # 61 (Description of Verification Procedures & Pharmacy Communication to Doctor Procedures)	Harrison/Zerislassie
	Complete - Status: Guidelines - completed / Mediware WORx - file build 90% complete. *February 2009 Update: New procedure in place which requires pharmacy verification of med orders before nursing administers. Pharmacist on call 24/7*			
2	Develop a monitoring system for pharmacists to review each patient's medication monthly and make recommendations	7/22/2008	Binder VIII, Tab # 61 (Description of Verification Procedures & Pharmacy Communication to Doctor Procedures)	Harrison/Zerislassie
	Complete - Status: Pharmacy Medication Review Form - completed / Mediware WORx - file build 90% complete *February 2009 Update: New procedure in place which requires pharmacy verification of med orders before nursing administers. Pharmacist on call 24/7*			
3	Track results of review to identify trends or other issues.	9/17/2008		Harrison/ OMS
	- Status: ongoing			

1) Apr 2008 — ***2*** *Develop tracking and follow-up mechanisms to address situations when the physician has not addressed the pharmacist's concerns.* — ***Medical; Chief Pharmacist***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a tracking system to document medication interventions by pharmacists	7/22/2008		Harrison/Zerislassie
	- Status: Tracking Form - completed / Mediware WORx - file build 90% complete			
2	PID to provide technical assistance to pharmacy for implementing tracking form and data collection	9/12/2008		PID & Pharmacy
	Complete - Status: Ongoing			
3	Share data with senior staff and Medical staff Executive Committee.			CEO
	- Status: Ongoing			

1) Apr 2008 — ***3*** *Develop and implement self-monitoring mechanisms to assess compliance with the requirements in VIII.C.1 and VIII.C.2.* — ***Medical; Chief Pharmacist***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a peer review system to monitor compliance.	7/22/2008	Binder VIII, Tab #4 (Medication Review Form)	Harrison/Zerislassie
	- Status: Peer review procedure in development/ Mediware WORx - file build 90 % complete			
2	See also action steps in related sections.			
3	Provide reports to P & T committee.	8/29/2008		
	- Status: will be ongoing			

2) Dec 2008	***1*** *Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			
2) Dec 2008	***2*** *Develop tracking and follow up mechanisms to address all situations when the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			
2) Dec 2008	***3*** *Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			

VIII.C.2

physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.

Findings

Same as VIII.C.1

Compliance Status: Progress has been made toward the June, 2010 compliance date.

Recommendations				***Responsible Party***
2) Dec 2008	*Same as above.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Same as above			

VIII.D. Nursing and Unit-Based Services

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.

Findings

See sub-cells for findings.

A new Chief Nurse Executive was hired and began in mid October, 2008. However, improvement in nursing services continues to lag behind that in other disciplines. Substantial effort was placed on filling vacancies, and while vacancies remain, there are fewer than was the case previously. Binder VIII, tab # 62, (Nursing staffing report). Another critical strategy was the reduction in overtime, in order to improve clinical care. Basic training continued during this period and included training on reporting suspected abuse and neglect, physical assessment, and mental health symptomotology.

A strategic plan, expected by March 31st, is being developed that will improve the pace and type of reforms. Strategies include:

1) Developing clear role delineation for nursing staff by type (nurse manager, shift nurse RN, LPN,

paraprofessionals), expected by March 31, 2009, to include responsibility for supervising overall care and the milieu, unit level quality of care and supervising the competency and quality of individual nursing care. For example, nurse managers will be responsible for practice of individual nursing staff, but shift nurses will be responsible for the practice of the unit. The clear delineation of responsibility will allow for an accountability structure that can use data driven decision-making to ensure a standard quality of nursing care throughout the Hospital.

2) Developing clear practice standards, and train to practice standards on a more intensive level. Training of new staff will be separated from retraining of existing staff, so that focus can be placed on skill development or redevelopment. Nursing will clarify the training expectations for new and existing staff. New staff training will include orientation and a series of basic concepts and competency training that will orient them to the requirements of the Hospital with regards to recovery environments, components of the person-centered milieu, patient engagement, and the quality of physical and psychiatric care. Current staff training will focus on milieu and cultural changes as well as a basic set of competencies that new nursing staff come equipped with: basic physical assessment, mental illness and medication management, critical thinking and a new paradigm in partnering with both the physician and the patient. Current staff have a number of older habits that need to be addressed and re-engineered. By dividing our efforts between new and current nursing staff it is anticipated that progress will occur more quickly and evenly. In addition, by mixing current and new staff together, nursing believes that it loses the opportunity to exploit the enthusiasm of new staff who are eager to learn and to adopt evidence based practices. Nursing would like the pressure to change to come not just from administration but from peers as well.

3) Increasing focus on reducing turnover, use of overtime so that a core stable set of nursing staff are on each unit, which will stabilize the unit and allow for development of a therapeutic relationship with patients. Nursing is currently working on a policy and procedure that will standardize nursing practice with regards to assigning patients to nursing staff but we need to reduce turnover and overtime for the impact of this policy to be felt in quality of care. Currently there are three meetings weekly to address overtime, 1 to 1 observation status, nursing schedules, etc. We hope that through an on-going analysis we can better match the demand for nursing to our capacity to provide it and that through this process will develop a more stable reliable staffing pattern on the units.

4) Updating the nurse recruitment plan. Currently there is a nurse recruiter and an assistant working to update the recruitment plan. This plan will support our effort to reduce turnover and allow for longer term stable therapeutic relationships to develop between patients and staff.

5) Completing hiring of ward clerks, 1 for every 2 units. Nursing is responsible for a great deal of administrative work that could be delegated to a ward clerk. The reduction of administrative duties will allow the nurse managers to be more accountable for the treatment environment, the competency of individual staff, and the individualization of care on the units. Three clerk positions were filled in February.

6) Continuing nurse manager meetings. Nurse managers continue to meet weekly in order to communicate, standardize practice, provide each other with technical assistance, and to finalize for management their suggested changes to policy and procedures and client flow.

7) Implementing evidenced based nursing practices, and work with nursing programs in the area. The Hospital recognized that it cannot provide the level of care to which it is committed without ensuring that nursing staff find the work environment supportive and intellectually challenging. The nurse managers and the nurse consultants will be responsible for regularly reviewing and evaluating evidence based practices for inclusion in the nursing practice at the hospital. In addition, nurse trainers will be responsible for assisting in the training of staff in these practices and working with the nurse managers to develop competency based testing and patient outcomes to evaluate

implementation and on-going practice. One of the sources for information, training, and evaluation will be local university-based nursing programs. The Hospital is working with local programs at both the undergraduate and graduate level. In addition, the consultants working with the hospital to develop the nursing strategic plan include a master's level and PhD level nurse.

8) Developing and implementing nursing practices and competencies so that the milieu is wellness and recovery oriented and person centered. Nursing will have clear roles and accountability for special circumstances (i.e., seclusion or restraint, emergency medication, elopements etc). Standard nursing protocols that must be implemented on both forensic and civil units that are focused on defusing and preventing special circumstances are being developed. These protocols will allow for a uniform measurement of staff adherence and will reduce variation in practice when nurses cover new units. In addition, all nursing staff will be expected to understand and implement recovery and person-centered approaches on each of their units on all shifts. This expectation will carry over into the treatment mall where nursing staff provide much of the infrastructure, oversight and safety protocols. Time frames for completion will be reflected in the strategic plan.

9) Developing individualized programming on units, to include evenings and weekends. Nurse managers will be responsible to individualize care on their units and to develop programming that meets the needs of their patients to learn, heal, recover 7 days per week. The Directors of Volunteer Services and Consumer Affairs are expected to expand the opportunities to engage in learning, social and recreational activities, and peer affirmation on the units.

10) Fully participation in IRP trainings and group leadership training in treatment mall redesign. Tab # 63 (IRP curricula), tab # 49 (Treatment mall redesign documents). Nursing will play a significant role in the treatment mall which has been redesigned to incorporate basic psychiatric rehabilitation evidence based models of care. These models are person-centered and as a result are very individualized. Changes at the mall include the need to allow patients to change locations in order to take advantage of the scheduled activities they have chosen. Nursing staff will be responsible for ensuring that staff are available, accountable, and involved in assisting patients to make these transitions safely. In addition nursing staff will be responsible for facilitating or co-facilitating a number of groups as well. They will be trained to fulfill these responsibilities as well as develop more individualized nursing interventions in IRPs.

11) Implementing evidenced- based nursing protocols around common co-morbidities (i.e. HTN, DM). Currently, the management of medical co-morbidities is left up to the individual unit. Nursing will standardize (as much as this is possible) nursing practice with regards to the most common medical problems. These protocols will include nursing interventions, nursing management and observation activities, as well as patient education, and patient discharge planning. In addition to medical co-morbidities, nursing also intends to address wellness planning as a protocol throughout the hospital as well.

12) Holding weekly case conferences using a structured format that are designed to strengthen critical thinking about medication management of the milieu, individual patient strategies, etc. Critical thinking teaching will use both didactic and case conferencing by nursing using a standard meeting protocol. This is intended to be a learning opportunity where strategy can be explored, agreed on and then communicated by the nurse manager to the team. It should increase adherence to treatment team strategies by examining positive changes in the patient and nursing's contribution or alternatively to look at how nursing might change the milieu to make it more excepting and supportive for the individual patient. These include individual nursing strategies as well as suggestions for changes to the psychopharmacological plan and the IRP. The protocol and implementation schedule is expected by April.

13) Training in use of new assessment form and documentation. Training will include how to use the nursing assessment as a vehicle for engaging the individual as well as assessing their current mental health needs, the use

of nursing progress and shift notes (including shift reports) to promote person-centeredness, and the use of various other forms of documentation such as comfort plans, etc. to assist in the development of an individualize therapeutic milieu.

Compliance Status: See sub cells.

VIII.D.1

Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;

Findings

See VIII.D for overall description of progress.

Training has begun on improving nursing competencies around mental health diagnosis and nursing interventions but most nurses have not completed training. Tab # 72, (Nursing training outline and data)

DMH issued scopes of work for consultant trainers to train nursing staff on recognizing signs and symptoms of physical illness and other training relating to seclusion and restraint. Unfortunately, to date there have been no bidders despite repeated solicitations.

Overall, nursing practice is not meeting this requirement. Nursing staff often still see patient behavior as "willful" or controllable, fail to recognize early triggers, and they are not meeting best practice standards around recognizing symptoms of mental illness or implementing therapeutic interventions. Interventions by some nursing staff can at times aggravate a situation rather than diffuse it and there are times when the tone and language used by nursing staff are not therapeutic.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Clearly differentiate the purpose and content of nursing staff orientation that occurs in the Education and Staff Development Office and that which occurs within the Nursing Department.*	***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire a Director of Nursing and an additional Nurse Educator.	9/30/2008		COO
Complete - Status: Nurse educator began 7/7/08. DON is being recruited. Feb 2009 Update: CNE hired. Nursing education consolidated under her responsibility.			
2 Nurse Educator to develop curriculum and clarify training responsibilities in writing.	8/15/2008		Chief Nurse Executive
- Status: Feb 2009 Update: CNE hired. Nursing education consolidated under her responsibility.			
3 Nurse educator to coordinate training with Psychology Training Director	9/18/2008		Medical Director, CNE
- Status: Ongoing			
4 Begin training of nursing staff.	9/30/2008		CNE
- Status: Ongoing			

1) Apr 2008 *2 Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.1 recommendation 1.	8/1/2008		COO; Chief of Staff
2 Provide competency-based training and track attendance and results of competency assessments.	9/30/2008	Binder VIII, Tab # 72 (Curricula, attendance and competency results for nursing training)	CNE; Training
Complete			

1) Apr 2008 *3 Develop/revise nursing competency policies and procedures to assure: clear time lines and accountability for determining individual staff orientation and annual competencies; that nursing staff members are only assigned/perform duties after achieving/maintaining competency.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Executive Director for Nursing	9/30/2008		CEO
- Status: Interviews are on-going. Feb 2009 Update: CNE hired. And began work in mid October, 2009.			
2 DON to work with Associate DONs to revise nursing policies around competency and procedures that satisfy this recommendation.	12/31/2008		CNE
- Status: Ongoing.			

1) Apr 2008 *4 Report compliance and noncompliance in the aggregate to evaluate effectiveness of processes to assure competency.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.1 recommendation 3.			
- Status: February Update: No progress to report			

1) Apr 2008 *5 Augment CPI with content that is consistent with St. E's policies/philosophy and the desired culture change. Consider incorporating content that supports trauma informed services.* ***CVC; JH; Medical; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training Director to work with internal hospital trauma-informed care expert to revise NCVI curriculum	9/1/2008		Medical Director
2 Expand number of staff trained directly in CVI through attendance at training in Nov.	7/31/2008		Training Director; JH; CVC
- Status: Civil and Forensic are identifying staff to participate in training			
3 Revise curriculum as appropriate.	9/10/2008		Training Director

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue implementing prior action steps.			

2) Dec 2008 ***2*** *Clarify if the treatment plan is to be called a treatment plan, a person centered plan, or an individual recovery plan then develop competency based training to be conducted during orientation and annually thereafter.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Clarify the title of treatment plans	11/28/2008		CNE
- Status: Treatment plans will be called Interdisciplinary recovery plans. Feb, 2009 Update: Will revise forms to reflect name change and ensure uniform name usage.			
2 Update all nursing training modules to reflect interdisciplinary recovery plan.			CNE
- Status: Ongoing			

2) Dec 2008 ***3*** *Assure that all nursing staff attend mental health diagnoses training and achieve competency by December 31, 2008.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See action steps in VIII.D.2			

2) Dec 2008 ***4*** *Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Design case conferences based on past clinical situtations.	3/9/2009		CNE
- Status: no progress			
2 Conduct pilot of module on several forensic and civil units that suffer from higher acuity rates.	3/16/2009		CNE
3 Assess usefulness of information if an actual incident occurs during pilot, and revise case conferences as necessary.	2/23/2009		
4 Implement hospital-wide.	4/6/2009		

2) Dec 2008 ***5*** *Nursing Unit Managers and/or Nurse Consultants should conduct weekly Nursing Care Conferences on the unit that focus on an individual whose behaviors are challenging for nursing staff and an individual with whom nursing staff work effectively. These conferences should integrate training on mental health concerns/diagnoses, should contrast effective/ineffective interventions, and should result in recommendations for the IRP.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Consultants have drafted a generic format for weekly case conferences;	2/26/2009		CNE
- Status: draft			
2 Consultants will share format with CNE, Program Analyst and Nurse Managers in late February 2009; Input will be provided on format; ,	2/26/2009		CNE
- Status: no progress			
3 Topics and curriculum will be developed in March-April 2009	3/19/2009		CNE
- Status: no progress			
4 Case conferences will begin in April-May 2009. Will aim to do weekly case conferences but will likely start on monthly or bi-monthly basis.	5/7/2009		CNE
- Status: no progress			

2) Dec 2008 ***6*** *Develop and implement a unit based training experience on non-confrontational limit setting.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Develop a competency-based curriculum and exam that focuses on non-confrontational limit setting.	4/1/2009		CNE
- Status: Draft			
2 Train Nurse Managers on trauma-informed care and non-confrontational limit setting.	4/8/2009		CNE
- Status: no progress			
3 Nurse managers will take a competency exam to ensure understanding of materials. We will determine requirements to pass at a later date.	4/16/2009		CNE
- Status: no progress			
4 Upon passage, nurse managers will teach theories and methods to trauma-informed care and non-confrontational limit setting to staff.	4/23/2009		CNE
- Status: no progress			

5 Staff members will take a competency exam to ensure understanding.	5/1/2009		CNE
- *Status: no progress*			

2) Dec 2008 *7 Develop a basic competency based training program for nursing staff who conduct rehabilitative and enhancement groups. Utilize staff who are competent in running these groups to train other nursing staff.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Develop a competency-based training program to teach staff about group dynamics, group facilitation, lesson plan development and implementation.	4/20/2009		CNE
- *Status: mininal progress*			
2 Pilot program at Treatment Mall	5/11/2009		CNE
- *Status: no progress*			
3 Survey patients regarding the pilot.	5/25/2009		CNE
- *Status: no progress*			
4 Revise program as needed and implement in a sustainable manner consistent with best practices.	6/8/2009		CNE
- *Status: no progress*			

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;

Findings

See VIII.D.

The Hospital discontinued the use of nursing diagnoses. The initial nursing assessment form is being revised and will be available for review in March, 2009.

The Hospital also is monitoring nursing staff attendance and participation in IRPs as well as the timeliness of assessments through the IRP process monitoring tool. Results from the reviews in July through September, 2008 show RNs attended 97% of IPR conferences, but paraprofessionals attended only 48%. Binder VIII, Tab # 64 (IRP Process Observation Results July to Sept, 2008). IRP process reviews in February, 2009, showed RN attendance at 75% of conferences with paraprofessional staff attendance at 35% Binder VIII, Tab # 64 (IRP Process Observation Results, Feb, 2009). The RNs presented an update of their assessment in less than 60% of cases.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008 *1 Discontinue the use of Nursing Diagnoses and utilize IRP with problem numbers to formulate plans and document interventions and progress toward goals.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1	Revise NSP 300-Documentation of Nursing Process	7/3/2008		DJ/DK
Complete - Status: Discontinued use of nursing diagnosis				
2	Revise form for chart monitoring of nursing process	7/15/2008		DK/DJ
Complete				
3	Implement Nursing Process Monitoring System.	8/29/2008		DK/DJ
- Status: Implementation pending				
4	Monthly reports of results.	9/30/2008		DK/DJ
5	Develop and implement revised initial treatment plan form.	7/17/2008	Binder VIII, Tab # 65 (Initial IRP)	Beth Gouse
Complete - Status: February 2009 Update: IRP form for initial plans was revised to ensure nursing, psychiatric and medical interventions are in one form. Implementation of the new form began end of February, 2009				

1) Apr 2008 ***2*** *Develop standardized areas of assessment/goal focus for all disciplines to utilize. Pending this common framework, nursing assessments and contributions to the IRP must immediately address the following minimum priority areas: psychiatric/mental health concerns, medical/health and wellness concerns, dangerousness to self or others.* ***BG; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in VIII D 2 recommendation 1.	7/31/2008		
- Status: February Update: No progress to report				
2	Revise all discipline assessment forms to ensure they are consistent in addressing goals.	7/31/2008	Binder VIII, Tab # 1 (Comprehensive Initial Psychiatric Assessment Form); Tab # 50 (Social Work Initial Assessment Form); Tab # 44 (Initial Psychological Assessment, Part A & B); Tab # 52 (Initial Rehab Assessment Forms A, B, C; C is most current)	Beth Gouse
Complete				

1) Apr 2008 ***3*** *Explore physical/environmental changes that would afford nursing staff a private area to work, and also allow them to provide active treatment/be fully "with" individuals when not doing paperwork.* ***AS; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Reconfigure nursing stations as appropriate.	7/31/2008		Gilbert Taylor
Complete - Status: Reconfigured stations on RMB 3, 4, 5 and 6. Feb 2009 Update: No progress to report.				
2	Complete construction of the prototype if the modified nursing station on ward 3.	3/31/2008		Gilbert Taylor Samuel Feinberg
Complete				
3	Award the contract to modify nursing stations on wards RMB 4, 5 and 6.	7/15/2008		Samuel Feinberg
Complete - Status: Construction completed.				

4 Identify funding to modify nursing stations on wards 1,2,7, and 8.	8/1/2008		COO
Complete - Status: Completed - . All nursing stations were modified by the established deadline.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement previously identified action steps.			

2) Dec 2008 ***2*** *Clarify the time intervals and content of Nursing Assessments that occur within 8 hours of admission and those which occur in preparation for the IRP. If there is no additional assessment prior to the IRP, establish a process to review and update the admission assessment information.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Develop nursing assessment so nurses can assess/plan the interventions prior to the IRP meeting.	3/9/2009		CNE
- Status: minimal progress			
2 Provide training as necessary and helpful.	4/13/2009		CNE
- Status: no progress			
3 Implement usage hospital wide	4/20/2009		CNE
- Status: no progress			

2) Dec 2008 ***3*** *Establish a Nursing Assessment Policy/Procedure that emphasizes the purpose of the initial nursing interviews rather than form completion. The existing Nursing Admission Assessment Guidelines can be used to guide form completion, with additional details specified.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Work with Director of Policy and Procedure to review current policy and revise to reflect that staff must engage patient in the Nursing Assessment process, and appropriately converse with patient rather than simply complete form.	2/20/2009		CNE
- Status: minimal progress			
2 Implement policy and train staff on new procedures.	3/9/2009		CNE
- Status: no progress			

2) Dec 2008 ***4*** *Revise the Comprehensive 8-Hour Nursing Assessment using more interview questions that actively involve the patient, that uncover strengths, and that focus on his/her lived experience e.g. how his/her physical or psychiatric status impacts daily life and what s/he would want to change.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Feb 2009 Update: Revise the 8 hour nursing assessment to learn more about individual's perception.	3/9/2009		CNE

2) Dec 2008 ***5*** *Revise and implement nursing assessment monitoring.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Feb 2009 Update: Consult nurse managers, internal and external consultants, and nurse educators to determine what the nursing assessment should require and how can we monitor it.	3/16/2009		CNE
	- Status: on-going			
2	Review draft of nursing assessment, discuss opportunities and challenges for implementation.	3/16/2009		CNE
	- Status: on-going			
3	Meet with Director of Policy and Procedure to draft a policy reflecting the existence of the nursing assessment monitoring tool, and create policies and procedures as required.	4/13/2009		CNE
	- Status: no progress			
4	Implement nursing assessment monitoring program.	4/29/2009		CNE
	- Status: no progress			

2) Dec 2008 ***6*** *Clarify the treatment model. Revise the nursing portion of the hospital Assessments policy so that it is more aligned with the discipline's focus and contribution.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise assessment policy	2/27/2009	Binder VIII, Tab # 30 (Assessment policy)	PID
	Complete			

2) Dec 2008 *7 Establish a mentoring system to support treatment teams to conduct treatment planning sessions according to the protocol.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Converse with internal and external nurse consultants and treatment team staff to discuss enhancement methods and barriers to said enhancement.	5/4/2009		CNE
- Status: minimal progress			
2 Identify potential mentors and provide requisite training.	5/13/2009		CNE
- Status: no progress			
3 Train mentors and try program on a pilot basis for 30 days.	5/25/2009		CNE
- Status: no progress			
4 Assess pilot program mentors and participants, and revise as necessary.	6/29/2009		CNE
- Status: no progress			
5 Implement hospital wide.	7/6/2009		CNE
- Status: no progress			

2) Dec 2008 *8 Establish a process for nursing staff to prepare for treatment planning sessions in advance in order to present relevant information/observations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

VIII.D.3

Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;

Findings

See VIII.D.

The Physical observation form and change of shift report have not yet been updated as recommended in the December, 2008 report.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Develop a real-time monitor of documentation related to physical status so that improvements are immediate.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise SEH 506 Physical Observation Form and Physical Observation Policy NCP-600.24	6/30/2008	SEH Form 506, Tab # 105	CNE
Complete			

2	Submit revised form to Medical Records Committee for approval	7/31/2008		CNE
	- Status: Will be submitted			
3	Train nursing staff on revised policy and use of form.	8/27/2008		CNE
4	Implement revised form	8/28/2008		CNE
5	Nurse Managers will initiate monthly monitoring	9/1/2008		CNE

1) Apr 2008 ***2*** *Develop a template for change of shift report that contains prompts so that important information is reported that relates to the IRP as well as physical/medical status.* ***Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise change of shift report form to include prompts and GNA-100.3 Change of shift policy	7/1/2008	Change of Shift template Tab # 81	CNE
	Complete			
2	Train nursing staff on revised form & policy.	7/31/2008		CNE
3	Implement revised form & process.	8/1/2008		CNE
4	Nurse Managers will observe & evaluate unit shift report process on a routine basis	8/15/2008		CNE

1) Apr 2008 ***3*** *Develop/revise policies to specify expectations relative to RN to MD interface as it relates to medical and behavioral emergencies, transfers to and from other treatment settings, and changes in physical condition. The expectations should include timeframes for reporting to the MD and timeframes for the MD response based on the severity of the issue/individual's need.* ***Medical; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Physician Notification Policy & Log to include timeframes	7/1/2008		CNE
	Complete			
2	Train nursing staff on revised policy & log.	7/30/2008		CNE
3	Implement revised log & process.	8/1/2008		CNE
4	Nurse Managers will initiate monitoring of process.	8/15/2008		CNE
5	Ensure that timeframes for MD assessment upon return from a medical facility are clarified.	8/29/2008		Medical Director
	- Status: Assessment policy revised to include specific timeframes.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue to implement action steps that are incomplete or not yet initiated.			

2) Dec 2008 ***2*** *Revise the Physician Notification Policy and issue it as a Joint Medical Nursing Policy. Include clear operational definitions and response timelines for emergent, urgent, and non-urgent situations. Consider using the SBAR approach (situation, background, assessment, recommendation) to structure the RN assessment, documentation, and report to the physician.* ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Physician Notification Policy was revised in June 2008 and specifies time guidelines that nurses should follow in emergency and non-emergency situations.	6/30/2008		
Complete - Status: complete			
2 Issue Joint Medical Nursing Policy and revise Physician Notifiction policy to include operational definitions for emergency, urgent and non-emergency situations while possibly using the SBAR approach.	4/10/2009		Chief Medical Officer and CNE
- Status: no progress			

2) Dec 2008 ***3*** *Revise the Physical Observations form or develop another form to document precise intake and output as well as treatments such as dressing changes.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Revise Physical Observation Form to include oxygen saturation. Alternatively, we will develop an Oxygen Saturation form.	2/24/2009		CNE
- Status: draft			
2 Assuming draft is sufficient, finalize Oxygen Saturation form or revised Physical Observation Form.	3/3/2009		CNE
- Status: no progress			

2) Dec 2008 ***4*** *Develop a monitoring instrument and monitor documentation, analyze trends, take action when improvement opportunities are identified, monitor the effectiveness of actions taken.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

Ensure that nursing staff document properly and monitor accurately the administration of medications;

See VIII.D.

The Hospital developed a system for pharmacy verification of medication orders; a short term process is in place until the necessary software changes can be made to the AVATAR system. Effective mid January, 2009, the Hospital's pharmacy provides verification of orders through an on-call pharmacist until 10 p.m. weekdays and from during the day on weekends. The on call pharmacist accesses the system remotely to do so, and is available the other hours as well. The only orders not being verified are the emergency stat orders. Under the new process, while medication orders continue to go to pharmacy and nursing at the same time, the workflow has been modified, and nursing does not administer medications until the AVATAR system reflects verification by pharmacist (A color change in the order screen reflects verification). In addition, it is working with the technical team from AVATAR to modify software so that is not notified of orders until verification occurs. Binder VIII, tab # 60 (Pharmacy flow sheets and memorandum). Additional numerous other changes to the AVATAR medication system were made to improve the medication ordering and administration process. Binder VIII, tab # 17 (AVATAR EMAR issues list). Among some of the changes is a requirement that doctors provide a reason for changes in medication and making completion of allergies field mandatory.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop/revise policies that describe medication variances, a subcategory of which would be medication errors.*	***Medical; PID; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Pharmacy SOP Policy 1.22 Medication Errors and 1.23 Alerting Orders	6/27/2008	Binder VIII, tab # 13 (Medication Variance and Reporting Policy)	PID; Harrison/Zerislassie
Complete - Status: Policies are being revised. February 2009 Update: Hospital wide Medication variance policy developed and approved.			

1) Apr 2008	***2*** *Designate one form for medication variance reporting.*	***Medical; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Create single form for reporting medication variance.	8/22/2008		Harrison

1) Apr 2008	***3*** *Review/revise processes used to analyze, identify trends, take actions for improvement, and monitor the effectiveness of actions taken to reduce medication variances.*	***Medical; PID; P and T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop reports from AVATAR system that track medication variances.	9/30/2008		COO; Pharmacy
- Status: Report developers to meet with Pharmacy and P & T Committee to discuss reports and priorities. February 2009 Update: Refinements being made to automated system to allow better tracking, reporting and trending of medication variance.			
2 Provide data to P & T committee for analysis.	10/31/2008		Pharmacy
- Status: Feb Update: Information is being provided to P and T Committee and is trended over time. However, not all aspects are captured, and modifications to tracking are needed.			
3 Develop recommendations and implement as appropriate.	11/28/2008		Medical Director

1) Apr 2008 ***4*** *Require that nursing staff monitor individuals' response to the first dose of a medication and that they document the response on the MAR.* ***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Pharmacy and Therapeutics Committee to develop guidelines relating to definition of first dose of medication.	9/26/2008		Medical Director
2 Revise Nursing Medication Policy and MAR to correspond to guidelines.	10/31/2008		CNE/DJ/DK

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement incomplete or not yet started action steps			

2) Dec 2008 ***2*** *Determine and define terms for medication variances and/or medication errors.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop hospital wide policy in which terms are clearly defined.	2/4/2009	binder VIII, Tab # 13 (Medication Variance & Reporting Policy)	PID
Complete			
Not Identified			

2) Dec 2008 ***3*** *Develop a hospital policy that will cast a wide net for reporting and that reflects a contemporary understanding of the factors that contribute to medication variances/errors.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop hospital wide policy in which terms are clearly defined and reflects understanding of why variances happen.		Binder VIII, Tab # 13 (Medication Variance & Reporting Policy)	PID
Complete			
2 Conduct intensive case analysis of variances that meet a threshold level			PID
Complete - Status: Initial case reviews completed			

2) Dec 2008 ***4*** *Eliminate duplicate reports. Assure that the form used to report medication variances and/or medication errors takes into account the process changes associated with AVATAR. Assure that the form provides sufficient structure and well-differentiated categories necessary to identify breakdowns in any/every part of the medication administration process.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Nurse Consultants will work with COO to raise relevant issues with AVATAR as it relates to medication variances and error reporting.	3/5/2009		CNE
- Status: minimal progress if any			
2 Nurse Consultants and COO will raise issues with AVATAR service provider, and determine appropriate action.	4/21/2009		CNE
- Status: no progress			
3 Will assure that the form addresses breakdowns in medication variance/error reporting.	4/28/2009		CNE
- Status: no progress			

2) Dec 2008 ***5*** *Resolve AVATAR issues.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Establish on-going work group that includes nursing, physician, pharmacy and technical staff to identify, address and resolve IT issues			
Complete			

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;

Findings

The training database is completed, and has the capacity to track courses and scores on a competency exam. However, the business process around data entry is not yet finalized but is expected to be completed within the next few weeks. Discussion around consequences for failing to meet competency standards is occurring with Labor Management Committee.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications.* ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training data base that reflects results of competency based training	8/29/2008		PID; CNE, training
- Status: Feb 2009: training database created. Nurse educators and Training director are meeting to finalize business processes around data entry.			

2 Enter/maintain data as appropriate.	9/30/2008			Training
- Status: Feb 2009 Update: System only just being utilized				
3 Produce reports and analyze results.	10/31/2008			OMS
- Status: Feb 2009 Update: reports not yet generated due to data not yet being entered routinely.				
4 Develop system to inform Civil and Forensic Services if staff fails training or training expires	7/18/2008			Training

1) Apr 2008 — ***2*** *Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.* — ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training to notify Directors of Civil and Forensic Services when employee does not successfully complete competency based training.	7/3/2008		Training
Complete			
2 DON and Discipline Directors to complete procedures that limit practice.	10/31/2008		CVC

1) Apr 2008 — ***3*** *Develop competency measures for medication teaching and for staff interactions that would support an understanding of individuals' potential side effects and/or barriers to adherence. Models associated with stages of change would be useful to accomplish the latter.* — ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 — ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps that are not completed or initiated.			

2) Dec 2008 — ***2*** *Revise medication administration training content and competency measures to reflect implementation of AVATAR.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Will work with hospital training department and AVATAR representatives to make sure relevant training and compentency measures reflect AVATAR's implementation and any pending changes to the system.	6/16/2009		CNE

2) Dec 2008 ***3*** *If control drugs are going to be counted in the nursing station, both doors need to be closed and access to the area limited until the count is completed.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Develop and/or clarify policy on the handling of controlled substances on the units, and the usage of the medication cart.	3/3/2009		CNE
- Status: ongoing			
2 Nurse Managers and Program Analyst will make rounds to ensure that controlled substances and medication cart is being handled properly.	3/10/2009		CNE
- Status: ongoing			

2) Dec 2008 ***4*** *Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: See VII.D.5			

2) Dec 2008 ***5*** *Examine processes for preparing and administering medications using the AVATAR system. Establish clear practice standards and manage the surrounding environment to support RNs to adhere to these standards.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

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;

Findings

See VIII.D.4

Compliance Status: No progress has been made.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See VIII.D.4*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.4			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps that are not yet complete or initiated.			

2) Dec 2008 *2 See VIII.D.4*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.4			

VIII.D.7

Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;

Findings

See VIII.D

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Revise Medication Administration policy to include expectations for medication education, queries regarding side effects and response to medications, and ways to understand and explore barriers to adherence* ***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate DOJ recommendations into Medication Administration policy draft.	9/15/2008	Binder VIII, tab # 15 (Medication Administration Policy)	J Taylor
- Status: Revising Medication Administration Policy draft Feb Update: Finalized Medication administration policy			
2 Track through IRP clinical chart audit monitoring that patients are regularly informed about side effects of medication	6/30/2008	IRP Process Observation results Tab # 7	QID
Complete - Status: feb Update: Not yet implemented.			
3 Revise Nursing Medication Procedures	9/8/2008		CNE

1) Apr 2008 *2 See VIII.D.5, Recommendation 3.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.5, Recommendation 3.			

2) Dec 2008 *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps that are not completed or initiated.			

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;

Findings

See findings for VIII.D and VIII.D..2

Compliance Status: No progress to report

Recommendations		Responsible Party
1) Apr 2008	*1 See VIII.D.2.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.2.			

Recommendations		Responsible Party
2) Dec 2008	*Take action on previous recommendations that are currently incomplete and monitor implementation.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps that are not complete or not yet initiated			

VIII.D.9

Ensure that each individual's treatment plan identifies:

Findings

Please see sub cells for findings.

The Hospital has revised its initial IRP form and its IRP form to improve the content of IRPs and to ensure they better address the individual's needs. Binder VIII, tab # 65 (IIRP), tab # 27 (IRP form). The initial IRP is completed by the psychiatrist with input from the general medical doctor about medical intervention and with input from nursing about nursing interventions. The forms are just being implemented, so data is not yet available about the quality of the interventions identified. However, there has been some modest improvement and most IRPs now identify specific individuals who are responsible for nursing interventions. However, RNs are not attending all IRP conferences nor are paraprofessional staff, which are affecting the development of nursing interventions in the IRP. Binder VIII, tab # 64 (IRP Process results).

Compliance Status: See sub cells for findings.

VIII.D.9.a

the diagnoses, treatments, and interventions that nursing and other staff are to implement;

Findings

The compliance office reviewed a small sample of nursing assessments for admissions in January, 2009. All were timely completed, and the quality somewhat better than in the past, but there was still a lack on individualized interventions or strengths identification. There has not been significant improvement around individualized nursing interventions generally, although there is some progress on those units which have had the IRP training.

A revised choking assessment is completed. Binder VIII, tab # 66 (Choking/swallowing assessment)

IRP observers are evaluating nursing attendance and participation in treatment plans. Nursing is not active enough in conferences, as in only 58% of cases did nursing present their assessments. Bindrer VIII, Tab # 64 (IRP Process Results).

The quality of nursing interventions will be subject to the clinical audits, but those have not begun. Nor has nursing developed an audit tool for any the new initial assessment. Thus there is no information available as to whether the nursing interventions in the IRP address each objective or issue.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Discontinue Nursing Diagnoses*	***PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discontinue nursing diagnoses.	7/11/2008		CNE/DJ/DK
Complete - Status: Nursing diagnosis discontinued.			

1) Apr 2008 *2 Develop one Initial Treatment Planning document that both the MD and RN use to direct initial treatment and nursing care.* ***Medical; PID; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop single initial treatment plan instrument that integrates psychiatric, nursing and GMO plans	7/11/2008	Binder VIII, Tab # 65 (Initial IRP)	Chief of Staff
Complete - Status: Feb Update: New form developed			

1) Apr 2008 *3 Eliminate/do not transcribe orders for which there are no policies or protocols.* ***Medical; Chief Nurse Executive; Chief Pharmacist***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			Medical Director; CVC; JH

1) Apr 2008 *4 Establish and implement a training program to teach nursing staff about diagnoses, the underlying issues associated with behaviors, and generally accepted nursing interventions.* ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Recruit and hire DON and nurse educator.	9/30/2008		CEO
- Status: Nurse educator began on 7/7/08. DON in active recruitment. February 2009 Update: CNE hired as of Mid October, 2009.			
2 Nurse educator in conjunction with the Director of Training of Psychology Department to provide nursing staff training on diagnosis and behavior underlying symptoms.	12/31/2008		Training
- Status: Nurse educator hired.			

1) Apr 2008 *5 Develop triggers for and a comprehensive dysphagia assessment.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft choking/swallowing assessment.	6/9/2008	Binder VIII, Tab # 66 (Choking/Swallowing Assessment revised)	CNE
Complete - Status: Feb Update: Choking instrument updated.			
2 Pilot for one week.	6/10/2008		CNE
Complete			
3 Revise assessment & submit to Chief of staff.	6/23/2008	Binder VIII, tab # 66 (Choking/Swallowing Assessment revised)	CNE
Complete - Status: Feb Update: Choking instrument updated.			
4 Develop choking assessment guidelines	7/3/2008	Guidelines previously produced.	CNE
Complete			

5 Train Nursing staff	8/29/2008		CNE
Complete			
6 Implement choking/swallowing assessment	8/5/2008		CNE

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps not completed or implemented			

2) Dec 2008 ***2*** *Develop a policy that guides implementation of the Initial Treatment Plan that includes a focus on priority issues pending completion of the IRP.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *Monitor ITP implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *See VIII.D.2.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.2.			

2) Dec 2008 ***5*** *Develop a comprehensive interdisciplinary dysphagia program that involves dentistry, dietary, and rehabilitative therapies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Will consult dentistry, dietary and rehabilitative therapies to discuss dysphagia.	4/6/2009		CNE
- Status: No progress			

VIII.D.9.b

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

Findings

The change of shift template is being used and nursing staff are able to address medication and behavior at change of shift, but it has not yet been modified to include prompts about IRP interventions. A new Level of Observation flow sheet was developed for use in observations related to restraint of seclusion. Tab # 67 (Level of Observation Form)

Nursing documentation still often is tied to "problems" as opposed to IRP foci and objectives, but to date most nurses have not yet received training on the new IRP process.

No other information is available.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*

1) Apr 2008 — *1 Revise nursing flow sheets to prompt observations/documentation that will contribute to an understanding of the individual, especially as it relates to psychiatric mental health issues, medical/health and wellness issues, and issues of potential dangerousness to self or others.* — ***AS; Chief Nurse Executive; Med Records***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008 — *2 Develop template for change of shift report. Consider ways to use the data on this template as a basis for progress notes in order to minimize duplicative documentation.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop change of shift template. *Complete*	6/30/2008		CNE
2 Train staff and nurse managers to observe change of shift reports.	7/31/2008		CNE
3 Revise change of shift report to include reprting on IRP interventions.			

1) Apr 2008 — *3 Review/evaluate/revise nursing documentation requirements to eliminate duplication in record entries, and to determine the degree to which the current "BIRP" model facilitates documenting to IRP.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 — *1 Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implment action steps previously incomplete or not initiated.			

2) Dec 2008 — *2 Consider the potential for flow sheets that would include IRP objectives/interventions that could serve as a basis for notes.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Nurse managers will design flow sheets that include relevant IRP information that are easily accessible to staff for review of patient's IRP objectives and nursing interventions. Will ensure flow sheets are HIPAA compliant and safeguarded. *- Status: no progress*	4/20/2009		CNE

2) Dec 2008 ***3*** *Differentiate RN and Psych Tech documentation expectations in a way that limits duplication yet maximizes opportunities to reflect relevant observations, interventions, and patient response.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Review all existing forms currently being used in units.	3/4/2009		CNE
- Status: no progress			
2 If necessary, amend forms to clearly state if RN, LPN, Psych Tech or FPT is authorized to complete.	3/18/2009		CNE
- Status: no progress			
3 Implement revised forms and make restrictions on use known to all clinical staff.	3/23/2009		CNE
- Status: no progress			

2) Dec 2008 ***4*** *See VIII.D.2.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.2			

VIII.D.9.c

the frequency by which staff need to monitor such symptoms.

Findings

See VIII.D.

To date, many IRPs still do not specify the frequency of nursing observations or monitoring on a consistent basis, or the name of person who is to provide the intervention, although data is not available since nursing audit and clinical chart audits have not begun. The training on IRP will include some component of nursing discipline specific training.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Fully integrate goals and interventions that involve nursing staff into IRP.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train nursing staff on treatment planning to ensure they understand how to identify appropriate nursing goals and interventions.	12/31/2008		CNE
- Status: Trainer for treatment planning identified and meeting held July 25th to set up training plan			
2 Develop monitoring tool or amend clinical audit tool to address this requirement. Obtain TA from consultant as needed to refine tool	9/17/2008		CNE
- Status: Not yet begun			

3 Complete staff training and use clinical audit tool/peer review to evaluate whether nursing interventions are appropriate to goals set forth in IRP, with technical assistance from consultant	10/31/2008		CNE

1) Apr 2008 *2 Develop clear expectations for monitoring individuals at risk for choking during meal times.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 The Civil/Forensic Directors to work with nurse management to identify the triggers for dysphasia and frontline nursing staff will be educated by nurse consultant and monitored by the respective unit nurse manager.	7/31/2008		CNE,DJ,DK
- Status: On-going.			
2 Distribute Heimlich maneuver posters in all areas where patients may be eating.	6/30/2008		CNE, DJ,DK
- Status: Since February 2007 all JHP Day Rooms and Dining Rooms have posters.			
3 Identify patients at risk for choking	7/31/2008		CNE,DJ,DK
- Status: Forensic Services has identified 5 patients who are at risk.			
4 At all meals, nursing staff are assigned to sit at table with high risk patients and monitor for choking.	7/31/2008		CNE,DJ,DK
- Status: Ongoing since March 1, 2008 in JHP			

1) Apr 2008 *3 Assure that there are posters depicting the Heimlich maneuver in all eating areas.* ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain and deploy posters noting Heimlich maneuver in all dining rooms, dayrooms, treatment mall areas and lobbies where patients may eat.	6/30/2008		Amelia Peterson
Complete - Status: Completed - Posters were affixed to the wall in each day room area and on each patient nourishment refrigerator in the nurse's station in RMB on 7/7/08. Additionally, a First Aid for Choking poster was hung in the day rooms of RMB wards 1 and 2 since these wards eat every meal on the ward daily. Both the First Aid for Choking poster and the Heimlich maneuver poster were also taped to the wall beside the vending machines in the lobby of RMB.			

2) Dec 2008 *1 Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps not yet completed or initiated			

2) Dec 2008 *2 Evaluate how diabetic diets are calculated including food and fluids provided during meal times and on the unit.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 *3 Identify barriers to adhering to a scheduled dining room meal time and resolve identified issues.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Nurse Consultants will work with Dietary Department to identify barriers to adhering to scheduled meal time, and discuss solutions to the problem. Solutions will be patient centered and address needs of patients with health conditions that require scheduled meal times that are not likely to change.	4/1/2009		CNE
- Status: on-going			
2 Create a list of patients with			

2) Dec 2008 *4 Establish clear processes for monitoring the status of patients who have received insulin and whose mealtime is delayed.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Feb 2009 Update: Identify patients known to have diabetes.	2/20/2009		CNE
- Status: no progress			
2 Create a list of identified patients based on those who require insulin and those who do not require insulin.	2/24/2009		CNE
- Status: no progress			
3 If possible, determine if any of the identified patients are at high risk for choking or suffer from dysphasia.	3/11/2009		CNE
- Status: no progress			
4 Consult with Nurse Managers, Dietary Department and Transportation Services (if necessary) to determine whether its feasible to provide these patients with priority status for meal time.	3/18/2009		CNE

VIII.D.10

Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:

Findings

See sub-cells for findings

The Infection Control officer resigned in October, 2008; a new one has been selected and begins work on March 23, 2009. Binder VIII, tab # 68 (CV. Malcolm Cook) This has delayed progress in implementing infection control

reforms, although some improvements have occurred. A consultant has been working on updating the Infection Control Manual to reflect both DOH and DOJ findings. This is expected to be completed by the March 2009 visit.

Compliance Status: See sub cells.

VIII.D.10.a

actively collect data with regard to infections and communicable diseases;

Findings

See VIII.D.10.

Some data on a small number of conditions (MRSA, Hepatitis B and C and HIV/Aids) is included in the Trend Analysis (See Tab # 16), but no action has otherwise been taken on the specific recommendations set out in the baseline report.

The Hospital continues regular environmental surveys. Binder VIII, Tab # 69 (Environmental surveys 4th Q 2008 and 1st Q 2009). Results are shared with key staff as well as published to the Infection Control Committee, the Risk Management and Safety Committee of Medical Staff Executive Committee and the Performance Improvement Committee. The Safety Officer continues to do regular inspections of units. See Binder VIII, tab # 70 (Safety Officer checklist)

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *The Medical Director should pursue his current plan to review the Infection Control Program. Consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise infection control policy manual	8/15/2008		Med Director
- Status: Not yet complete.			
2 Hire new infection control officer			Medical director
- Status: Feb Udpate: Selection certificate has been prepared and interviews are underway.			

1) Apr 2008	***2*** *Immediately develop a clear TB screening program based on CDC guidelines, including those related to risk level.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008	***3*** *Identify categories of data to be collected with initial focus on those data that relate to risks for this population.*	***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Expand current reporting system by adding other key indicators.	9/30/2008		AF, Infection Control Coordinator

2 After data is collected, OMS and Infection Control to begin trending and analysis	11/20/2008			Medical Director, OMS

1) Apr 2008 ***4*** *Develop monitoring instruments and define intervals for the ICC on site monitoring of specific areas in the hospital.* — ***Medical; with PID***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008 ***5*** *Develop policies and procedures to identify cluster outbreaks.* — ***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action step to VIII.D.10 recommendation #1			

1) Apr 2008 ***6*** *Develop policies and procedures for food borne illness, flu, and norovirus.* — ***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action step to VIII.D.10 recommendation #1			

1) Apr 2008 ***7*** *Promote unit staff ownership for the unit environment. The Nursing Unit Manager should provide oversight for unit staff to complete the ES on a weekly basis, assuring inter-rater reliability, and a user- friendly way to document actions taken on deficiencies.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Nursing procedure QIR-206 Environmental Monitoring Developed, Environmental Survey completed on monthly basis, nursing deficits corrected			CNE/DJ/DK
Complete			

1) Apr 2008 ***8*** *A mechanism should be established for regular senior level review of ES findings to assure resolution since in most instances multiple departments will need to be involved.* — ***CVC; JH; PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Share results of Environmental survey to all senior staff.	5/1/2008		PID
Complete - Status: Feb 2009 Status: The 4th Quarter 2008 Environmental Survey Findings were distributed to responsible Directors on 12/30/2008.			
2 Develop a Corrective Action Plan which immediately address red and yellow zone issues identified in the Environmental Assessment	6/16/2008	Environmental Survey Corrective Action Plan, Tab # 69	Gilbert Taylor, Donna Moran, Robert Winfrey
Complete - Status: A corrective action plan to address red and yellow zone issues identified in the quarterly Environmental Self Assessment issued in March 2008 was developed by the Directors of Facilities & Environment and Materials Management & Logistics			

3 Environmental Survey forwarded to Administrative Officer for correction by facility & maintenance departments	7/31/2008		COO

Complete - Status: Feb 2009 Status: The 4th Quarter 2008 Environmental Survey Findings were distributed to responsible Directors on 12/30/2008.

4 Red and yellow zone issues identified in the Environmental Survey are to be corrected by 7/15/2008.	7/15/2008		Donna Moran, Gilbert Taylor, Robert Winfrey

Complete - Status: All red and yellow zone issues relative to Support Services were corrected by the established deadline date.

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps not yet complete or initiated			

2) Dec 2008 ***2*** *Develop a clear structure for the IC Program that includes a description of the ICC responsibilities.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *Develop a TB Control policy consistent with generally accepted standards.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level, and across the hospital.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

VIII.D.10.b

assess these data for trends;

Findings

No progress to report. See VIII.D.10

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Identify priorities for data collection and analysis* ***Medical; PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Review the current data and finalize the data collection with the Medial Director	9/30/2008		PID, AF, Infection Control

1) Apr 2008 ***2*** *The Infection Control Coordinator should provide preliminary written analysis.* ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008 *3 Infection Control Committee should review data/data analysis no less than quarterly.* ***Medical; Infection Control Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Data will be provided to infection control committee, who will identify other data to track	9/26/2008	Trend Analysis Tab # 16	Medical Director

Complete - Status: Some data is in trend analysis, but additional data will be available once Phase II of Avatar is implemented, which is set for Winter, 2008

1) Apr 2008 *4 Aggregate data from the ES should be reviewed and analyzed by the Infection Control Coordinator on a monthly basis and reported to the Medical Director and the Assistant Directors of Nursing.* ***Medical; AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide results of ES to Environment and Risk Management Committee as well as Infection Control Committee.	6/30/2008		PID

Complete

2 Develop a tool to identify assess potential safety hazards including suicide risks, infection control risks and other occupational safety hazards.	7/31/2008		AS; Med Dir, Robert Winfrey

- Status: The monthly safety inspection tool has been modified to assess potential safety hazards, infection control risks and other occupational safety hazards (see attached document Behavioral Health Patient Safety Assessment Tool).

3 Conduct monthly inspections of all occupied areas.	8/7/2008	Binder VIII, Tab # 71(Hospital Safety Inspection and Reporting Schedule)	Robert Winfrey

- Status: The Safety Officer began inspections of all patient occupied areas in September 2008. These findings were distributed to responsible department heads on 10/29/08. Findings from the most recent monthly inspection will be distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by 12/19/08. The 1st Quarter 2009 Environmental Survey data collection is kicking-off the week of 12/8/08.Feb 2009 Status: The Safety Officer continued monthly inspections of all patient occupied areas in November 2008. These findings were distributed to responsible department heads on 12/9/08. Findings from the January monthly inspection were distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors on 2/11/09. The 1st Quarter 2009 Environmental Survey data collection kicked-off the week of 12/8/08 and was completed 1/30/09. A draft report is expected to be completed in mid-March 2009.

2) Dec 2008 *1 Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps not previously complete or initiated.			

2) Dec 2008 *2 See VIII.D.10.a*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.10.a			

2) Dec 2008	***3*** *Assure that all housekeeping carts have working locks to store chemicals and that they are not left unattended in patient areas.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			
2) Dec 2008	***4*** *Assure that the proper dilution of bleach is utilized.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			

VIII.D.10.c

initiate inquiries regarding problematic trends;

Findings

No progress to report. See VIII.D.10.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *The Infection Control Committee should determine areas for further "drill down" based on trends in data.*	***Medical; Infection Control Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008	***2*** *The Medical Director and Assistant Directors of Nursing should review the ES findings on a monthly basis.*	***Medical; AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Safety officer will submit environmental survey findings each month to COO, Medical Director, ADON, and Civil and Forensic Directors	8/7/2008	Binder VIII, Tab # 71(Hospital Safety Inspection and Reporting Schedule)	Safety Officer

- Status: The Safety Officer began inspections of all patient occupied areas in September 2008. These findings were distributed to responsible department heads on 10/29/08. Findings from the most recent monthly inspection will be distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by12/19/08. The 1st Quarter 2009 Feb 2009 Status: The Safety Officer continued monthly inspections of all patient occupied areas in November 2008. These findings were distributed to responsible department heads on 12/9/08. Findings from the January monthly inspection were distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors on 2/11/09. The 1st Quarter 2009 Environmental Survey data collection kicked-off the week of 12/8/08 and was completed 1/30/09. A draft report is expected to be completed in mid-March 2009.

Environmental Survey data collection is kicking-off the week of 12/8/08.

2 Med Director, Chief Nurse Executive and Civil and Forensic Directors and their respective Administrative Officers will implement corrective actions as needed, supported by COO.

- Status: Ongoing.

2) Dec 2008 *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement action steps that are not yet complete or initiated			

VIII.D.10.d

identify necessary corrective action;

Findings

See VIII.10.D.a

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Document corrective actions in an attachment to aggregate data/reports, specifying names and due dates.* ***CVC; JH; Medical; PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 OMS will work with Safety Officer to develop database to track environment survey results and corrective actions.	9/24/2008		Safety Officer; OMS
2 Safety officer to ensure findings included in database and produce reports monthly	10/31/2008		Safety Officer
3 Safety officer to track implementation of recommendations and report monthly to Risk Management Committee.	10/31/2008		Safety officer

1) Apr 2008 *2 The Medical Director and Assistant Directors of Nursing should initiate actions on ES findings and document the action taken.* ***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 *1 Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet implemented or completed			

2) Dec 2008 *2 See VIII.D.10.a through VIII.D.10.c.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.10.a through VIII.D.10.c.			

VIII.D.10.e

monitor to ensure that appropriate remedies are achieved;

Findings

No progress to report. See VIII.D.10.a

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Develop a policy/procedure/process to monitor effectiveness of actions taken to resolve findings relative to infection and communicable diseases.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

Recommendations		Responsible Party
1) Apr 2008	*2 Develop an instrument to monitor that the process was followed.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

Recommendations	
2) Dec 2008	*Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

VIII.D.10.f

integrate this information into SEH's quality assurance review; and

Findings

No progress to report. See VIII.D.10.a

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 See VIII.D.10.a through VIII.D.10.d.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.10.a through VIII.D.10.d.			

Recommendations	
2) Dec 2008	*Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

VIII.D.10.g

ensure that nursing staff implement the infection control program.

Findings

See VIII.D.10.a. Nursing amended policy of wearing gloves in dining room that limit it to specific circumstances warranted by infection control practices. Nursing conducts regular environmental surveys of units. No other progress to report.

Compliance Status: No progress has been made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Develop policies/procedures that clearly define precautions, the steps to implement each type, and to document implementation of precautions. Consider developing a flow sheet to streamline this documentation.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Infection Control Manual.	8/29/2008		Medical Director

1) Apr 2008 *2 Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

1) Apr 2008 *3 Evaluate the routine need for gloves in the dining room as it is not individualized and does not contribute to a recovery informed environment.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discontinue nursing practice of use of gloves in dining room except in specific circumstances	7/1/2008	Document previously provided	CNE

Complete - Status: Policy amended to limit use for specific circumstances

2) Dec 2008 *1 Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 *2 See VIII.D.2. and VIII.D.10.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.2. and VIII.D.10.			

VIII.D.11

Ensure sufficient nursing staff to provide nursing care and services.

Findings

The Hospital hired a Chief Nurse Executive. Progress is being made in nurse staffing, although there are now several nurse manager vacancies. Binder VIII, tab # 62 (HR report, Nursing)

See also VIII.D for strategies around training and recruitment.

Compliance Status: Minimal progress has been made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008 *1 Develop a comprehensive SEH Plan for Nursing Services that includes the components described in findings (above).* — ***AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Recruitment of Nursing Staff-Revise GNA-100.4 Staffing Standards	7/1/2008		CNE
2 Continue to recruit nurses.	6/30/2008		COO

- Status: The Hospital filled eleven vacant nurse manager positions during the fiscal year and is currently screening applications for three more vacancies and is in the early stages of the recruitment process for the DON position. Other nursing hires include 13 RNs, 3 LPNs, 11 PNAs and 13 FPTs.

3 Hire DON	8/29/2008		CEO
- Status: Interviews underway.			
4 DON to review all nursing services and procedures and modify as appropriate.	2/12/2009		CNE

1) Apr 2008 ***2 Prioritize filling Nursing Unit Manager positions, the Forensic Nurse Consultant position, and an assistant position to the ADONs in both services.*** ***AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Fill vacant Nurse Manager, Forensic Nurse Consultant and Assistant to the ADON positions.	7/31/2008		James Gallo
Complete - Status: The Hospital is in the final stages of filling these positions. EOD dates for all nurse manager incumbents are staggered throughout the eight week period beginning 6/23/2008.			
2 Produce regular HR reports that track recruitment activities	7/31/2008		James Gallo
- Status: The Office of Monitoring Systems worked with SEH HR to develop a database which tracks all vacancies through the various hiring stages and immediate produces reports on hiring activities. The database became operational in September 2008.			

1) Apr 2008 ***3 Ensure at least one RN on duty on every unit 24/7.*** ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Fill vacant RN positions	9/30/2008		HR
2 Pilot scheduling software to assist in scheduling nurse coverage	9/30/2008		COO; Chief Nurse Executive

1) Apr 2008 ***4 Clarify the nursing organizational structure at the most senior levels, especially the roles of the "DON" and "ADON".*** ***AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the new Chief Nursing Executive position description to clarity the roles of the DON and the ADON	4/30/2008		Human Resources
Complete			

2) Dec 2008 ***1 Take action on previous recommendations that are currently incomplete and monitor implementation.***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *Report NCHPPD by unit on a monthly basis.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Feb 2009 Update: CEO, CNE, CAO, COO and other executive staff are studying a way to accurately determine the NCHPPD by unit and capture information daily.	5/4/2009		

- Status: on going

2) Dec 2008 ***3*** *Evaluate both the numbers and mix of nursing personnel against the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required numbers and mix of nursing personnel.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *Monitor the numbers of patients on 1:1 observations and the length of time they remain on this intensive observation. Establish triggers that require IRP review and revision to address behaviors that require this level of observation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***5*** *Establish regular meetings involving all Nursing Unit Managers from both civil and forensic units. The purpose of the meetings would be to systematically evaluate progress toward necessary improvements, share strategies for success, and provide mutual support.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Ensure all nurse managers meet on regular basis			CNE

Complete - Status: Nurse managers meet weekly.

2) Dec 2008 ***6*** *Consider hiring Ward Clerks for each unit.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Identify positions and recruit			

Complete - Status: Three ward clerks hired and on board in February, 2009

2) Dec 2008

7 Evaluate processes associated with off unit appointments. Examine personnel resources for accompaniment. Limit nursing staff accompaniment to situations where off the unit unless required to accompany a patient based on his/her clinical status.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct time study of all off ward escorts and evaluate results. Recommendations to follow *Complete*	2/27/2009		CNE
2 present recommendations to CEO/Exec and establish time frames for implementation.			

IX. Documentation

Summary of Progress

See Sections V, VII, VIII, and X for progress summary.

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.

Findings

See sections V, VI, VII, VIII and X concerning documentation issues.

Compliance Status: See related compliance findings.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications

Summary of Progress

1. The Hospital revised its Seclusion and Restraint for Behavioral Reasons policy, its Protective Measures policy and the Involuntary Administration of Medication policies to incorporate DOJ additional recommendations. The polices now use the CMS definition of "drug used as a restraint.".

2. The Hospital continues to use a tracking system for monitoring seclusion and restraint episodes that has improved the accuracy of data, but which is not wholly accurate. Further, it modified the Unusual Incident policy to require the filing of an unusual incident form each time seclusion or restraint is used, but staff largely are not completing UIs as required. Data shows a reduction in number of restraint episodes from May, 2008 (45) to December, 2008 (8). Seclusion episodes increased between May (6) and December, 2008 (9). During the last three months of 2008, 30 patients were involved in a total of 58 restraint or seclusion episodes; only three were involved in more than three episodes, a marked improvement from prior months.

3. The Hospital still lacks the capacity to track incidents of emergency involuntary administration of medication. However, a report is available that tracks provision of STAT medication and method of administration. While this does not necessarily equate to emergency involuntary medication, it provides a source to try to identify those persons. The Hospital is able to track the non-emergency involuntary administration on medication.

4. Trauma informed care training occurred on two wards during the prior rating period, but has not yet been expanded to other units. There has not been other training for nursing staff around alternatives to seclusion or restraint.

5. The Performance Improvement Department and Compliance office conducted an audit of 25% of seclusion and restraint episodes from the period August, 2008 to December, 2008, using a modified tool. Results found that UIs were completed in only 13% of cases, and 100% of staff supervising the person in restraint or seclusion had current competency and CPI training. Other findings includes that in none of the cases was there documentation that staff utilized strategies identified in the Advanced Instructions, that in 65% of cases low level of interventions were used, but moderate level of interventions were used in only 30% of cases. Finally, findings around duration of seclusion and restraint suggest staff are not terminating it as soon as the individual was no longer an imminent threat to self or others.

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.

Findings

See sub cells for findings.

Compliance Status: See sub cells for findings.

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:

Findings

See sub-cells for status.

The Seclusion and Restraint for Behavioral Reasons policy was revised to clarify the definition of "drug used as a restraint" and physical hold. Binder X, tab # 1 (Seclusion and Restraint For Behavioral Reasons Policy). Nursing has not yet developed step by step guidelines to implement the policy, but nursing standards that will include standards around use and monitoring of seclusion and restraint are expected to be developed over the next

months. A seclusion and restraint monitoring tool was drafted, piloted and revised, and data is available. Binder X, tab # 2 (R/S audit form), tab # 3 (S/R audit results). Based upon the audit, the tool will likely require some additional modification, but useful data was obtained. (See specific subcells).

Seclusion and restraint data continues to be reported in the Trend Analysis. Binder X, tab # 4 (Trend analysis). Data suggests that seclusion spiked in March, 2008 and restraints spiked in May, 2008. Seclusion episodes have increased in October, November and December on the civil side; episodes of restraint have ranged from 21 in August, 2008 to a low of 8 in December, 2008. The most recent data suggests that only 3 patients had more than 3 episodes of restraint or seclusion over the last three months of 2008, a change from prior months when more patients have more frequent episodes.

An audit of seclusion or restraint of 25% of episodes from August to December, 2008, was done by PID with the compliance office participation. See Binder X Tab # 3 (Seclusion/Restraint audit results). Specific findings can be located in the relevant subcells.

Compliance Status: Partial

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.

Findings

See X. A.

Compliance Status: Partial

Recommendations — ***Responsible Party***

1) Apr 2008 — *1 Consider developing a separate policy for medical and protective restraints that would also include voluntary mechanical supports and/or positioning devices since these are governed by different standards (see CMS interpretive guidelines).* — ***Medical; PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a separate policy for medical and protective restraints using CMS standards.	6/15/2008	Binder X, Tab # 5 (Medical or Protective Devices and Techniques Policy)	J Taylor

Complete - Status: Policies have been drafted and approved by Executive staff.

1) Apr 2008 — *2 Provide step-by-step operational direction in this policy, or charge the Nursing Department to develop the operational direction to assure consistent implementation of the umbrella policy.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Nursing department shall incorporate operational guidelines into nursing procedures	8/29/2008		Chief Nurse Executive

Complete - Status: Policy only just finalized. Guidelines will now be developed

2) Dec 2008 ***1*** *Revise the Restraint and Seclusion for Behavioral Reasons policy to comport with CMS definitions. Using the interpretive guidelines that accompany the regulations could be very helpful.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***2*** *Provide competency based training on the new policies.* ***Trg; CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training on r/s policy and policy around use of medical devices to be conducted.	6/19/2009		CNE, Lewis Mayo and Shelita Snyder
- Status: February 2009 Update: R/S policy revised per DOJ recommendations. Training in development, and expected to be completed by 6/19/2009			
2 Conduct training and maintain data of results of competency determinations.	6/19/2009		CNE, Lewis Mayo and Shelita Snyder

2) Dec 2008 ***3*** *Finalize the monitoring tool. monitor implementation, identify and act on improvement opportunities, monitor the effectiveness of actions taken.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 S/R auditing tool modified.	2/2/2009	Binder X, Tab # 2 (S/R Audit Tool, revised)	PID
Complete			
2 Begin audits as pilot using revised tool	2/9/2009	Binder X,Tab 3 (S/R Audit Results)	PID
Complete - Status: Audits begun in February, 2009			
3 Develop recommendations based upon audit results and follow implementation of recommendations			PID

X.A.2

training in the management of the individual crisis cycle and the use of restrictive procedures; and

Findings

See VIII.D.and X.A.

Staff are generally not yet using interventions other than redirection in managing an individual in crisis, with some few exceptions. Staff on RMB 3 began initial training on positive behavioral support in November, 2008, and preliminary data shows reduction in use of seclusion or restraint, from a high of 46 episodes in May, 2008 to just 3 in December, 2008. Binder X, tab # 4 (Trend analysis). It is too early to tell if this is a trend. Nonviolent crisis intervention training is still required of nursing staff, and the Chief Nurse Executive is reviewing this and other training options to strengthen identification of crisis intervention alternatives. Additionally, policy has now been clarified and nursing will be obtaining the advanced instructions and completing the comfort plan which is expected to facilitate use of patient identified alternatives. Binder X, tab # 6 (Advanced instructions/comfort plan); #13 (Nursing training outlines and data).

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Augment CPI with a module that incorporates some of the content from the training on Trauma Informed Services.*	***Medical; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.D.1 recommendation 5.			

2) Dec 2008 *1 Carefully review scope of work proposals to assure relevant content directed toward preventing circumstances that give rise to seclusion and restraint use.* — ***CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Scope of work reviewed, and training will focus on alternatives to s/r as well as nursing documentation.	4/30/2009		CNE

2) Dec 2008 *2 Provide competency based training on new policies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training on r/s policy and policy around use of medical devices to be conducted.	6/19/2009		CNE, Shelita Snyder, Lewis Mayo
- Status: February 2009 Update: R/S policy revised per DOJ recommendations. Training in development, and expected to be completed by 6/19/2009			
2 Conduct training and maintain data of results of competency determinations.	6/19/2009		CNE, Lewis Mayo and Shelita Snyder
- Status: February 2009 Update: R/S policy revised per DOJ recommendations. Training in development, and expected to be completed by 6/19/2009.			

X.A.3

the use of side rails on beds, including a plan:

Findings

Use of side rails continue to be governed by the Medical and Protective Devices Policy. Currently 3 patients in RMB use some form of side rails each night, and 3 patients at JHP use them intermittently. Nursing procedures have not yet been updated to reflect the revised Hospital policy.

Compliance Status: Substantial

Recommendations — ***Responsible Party***

1) Apr 2008 *1 See XA.1 above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XA.1 above.			

1) Apr 2008 *2 Develop a tool and process to monitor side rail use.* — ***PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update nursing policy and develop revised tool.	7/31/2008		Chief Nurse Executive
Complete - Status: Revised policy and nursing monitoring form developed			
2 Train nursing staff on revised policy.	8/29/2008		Chief Nurse Executive
- Status: Tool has not yet been developed nor training done.			
3 Monitor use of side rails.	2/27/2009		Chief Nurse Executive
- Status: Tool has not yet been developed nor training done.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *Use the CMS interpretive guidelines as a foundation for revising the policy with special attention to definitions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise R/S policy to clarify definitions	2/27/2009	Binder X, Tab # 1 (Seclusion and Restraint for Behavioral Reasons Policy, revised)	PID

Complete

2) Dec 2008 ***3*** *Revise Nursing Procedure to incorporate recommendations above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *Provide competency based training on the new policies.* ***Trg; CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training on r/s policy and policy around use of medical devices to be conducted.	6/19/2009		Shelita Snyder; Lewis Mayo
2 Conduct training and maintain data of results of competency determinations.	6/19/2009	Binder X, Tab # 1 (Seclusion and Restraint For Behavioral Reasons Policy	Shelita Snyder; Lewis Mayo

- Status: Training in Development and expected to be completed by 06/19/2009.

2) Dec 2008 ***5*** *Finalize the monitoring tool. monitor implementation, identify and act on improvement opportunities, monitor the effectiveness of actions taken.* ***PID; CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop monitoring tool to review use of side rails and evaluate compliance with policy	4/15/2009		PID, CNE
2 Begin audits on side rail use and report results	5/15/2009		PID, CNE

X.A.3.a

to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and

Findings

See X.A.1 and 2 above.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See XA.1 and 2 above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XA.1 and 2 above.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *See X.A.1 and 2 above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See X.A.1 and 2 above			

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.

Findings

The Hospital policy includes a requirement to include use of side rails into a patient's treatment plan. These interventions are in the IRP.

Compliance Status: Substantial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See XA.1 and 2 above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XA.1 and 2 above.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *See X.A.1 and 2 above*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See X.A.1 and 2 above			

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:

Findings

See sub-cells for status

Compliance Status: See sub cells.

X.B.1

are used after a hierarchy of less restrictive measures has been considered and documented;

Findings

The revised policy on Seclusion and Restraints for Behavioral Reasons includes additional examples of alternatives to use of seclusion and restraint. Nursing is also now clearly charged with completing the Advanced

Instructions Comfort Plan. Binder X, tab # 6 (Advanced Instructions Comfort Plan) The recent audit of seclusion and restraint records show that in 0% of the cases, was information contained in the Advances Instructions used to try to calm the patient. Binder X, tab # 3 (Restraint and Seclusion Audit Results).

Use of alternatives before use of seclusion or restraint was included in the recent audit. The audit shows that in 65% of cases, there was documented evidence that at least one low level of interventions was used, but in only 30% of cases, was there documented evidence that moderate levels of interventions were used. "Redirection", still remains the most common alternative tried by staff, and often when medication is offered, it is too late to effectively manage the situation.

The Risk Manager conducted a review of three months of UI data to determine the frequency of use of seclusion or restraint following a patient on staff assault. In 21 cases of patient on staff assault, 14 resulted in a episode of seclusion or restraint. Binder X, Tab # 14 (Email summarizing data)

Compliance Status: Partial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Augment CPI with a module that emphasizes alternatives to restrictive measures. Consider incorporating some of the content from the training on Trauma Informed Services.*	***BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in section VIII.D.1 recommendation 5.			

1) Apr 2008	***2*** *Determine whether or not individuals are routinely restrained following staff assault.*	***CVC; JH; PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review UI reports for three month period to identify incidents of patient on staff assault.	4/30/2008	Binder X, Tab # 3 (Seclusion and Restraint Audit Results)	Compliance officer

Complete - Status: Compliance office conducted a review of UI reports for the three month period of February to April, 2008 to determine if all incidents of patient on staff assault resulted in seclusion or restraint. Review showed that there were six incidents of patient on staff assault in which seclusion or restraint was not utilized. February 2009 Update: Risk Manager reviewed UI database and identified 21 assaults on staff by patients for the four month period from October 1, 2008 through January 28, 2009. There were 21 patient of staff assaults during this period, 14 of which resulted in restraint or seclusion. It should be noted that only 17 unusual incidents for seclusion or restraint were received during this period, but the patient on staff assault data was cross referenced against the seclusion and restraint tracking log as well, which is far more accurate.

2 Not Identified

2) Dec 2008	***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *See VIII.D.1 and X.A.2*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.1 and X.A.2			

2) Dec 2008 ***3*** *Implement the new Nursing Admission Assessment and assure that the findings from the assessment relative to behavioral emergency triggers, and effective strategies to manage surges of emotion, are included in the ITP. Assure integration with the Advanced Directives.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise initial nursing assessment per DOJ recommendations	2/27/2009		CNE
Complete			
2 Train staff on new tool	3/31/2009		CNE
3 Implement new tool hospital wide.	4/6/2009		CNE

2) Dec 2008 ***4*** *Continue to monitor actions taken with patients following staff assault.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue to monitor			Risk Manager
- Status: Ongoing			

X.B.2

are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

Findings

The recent audit of seclusion and restraint episodes evaluated whether the restrictive interventions were used in violation of the Settlement Agreement. The audit showed that in 35% of cases, the record reflected that seclusion or restraint was used as an alternative to active treatment and in 9% of cases, it was used as punishment or for convenience of staff. Binder X, tab # 3 (Restraint and Seclusion audit results).

For the most part, there remains too few activities on the units, although the hiring of additional rehabilitation services staff may also improve activities for evenings and weekends. Binder X, tab # 15 (Ward schedules) A Director of Volunteer Services was hired in December and is developing enrichment activities for the units.

Compliance Status: Noncompliance

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning.* ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.D.1 recommendation 1.			
2 Develop special training curricula to retrain nursing staff on mental health diagnosis, symptoms and role of behavior in treatment.	9/30/2008		Nurse educator
- Status: Nurse educator hired, but training not yet begun.			

3 Begin training for all nursing staff, and complete by January 31, 2009.	10/31/2008		Nurse Educator

1) Apr 2008 *2 Train all nursing staff on how to initiate conversations and activities to improve the individuals' quality of life.* ***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.D.1 Recommendation 1 and 5			
2 Develop curricula and begin training staff	8/29/2008		Nurse educator
- Status: February 2009: No update to report.			
3 Expand trauma informed care training to all units over the next 9-12 months.	7/31/2009		Medical director
- Status: Feb. 2009 Update: No additional units have been trained, but new employees receive orientation as part of new employee orientation.			

1) Apr 2008 *3 Provide games, reading material, and other supplies to each unit that staff can use to involve individuals in leisure activities.* ***CVC; JH; Volunteer Services***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a plan for the Mayor's High School Intern group at Saint Elizabeths Hospital to organize and implement a drive to collect leisure supplies	6/20/2008		Candyce Hughes
- Status: In Process - The plan has been developed by the students, but requires some feedback prior to implementation. The tentative date for setting up collection points is 7/14/2008. Target date for distribution of donated items to the wards is 8/4/2008.			
2 Civil and Forensic Administrative officers to collaborate with Clinical Administrators and Nurse Managers around collection and distribution	8/29/2008		JH; CVC
Complete - Status: Once plan finalized, it will be presented to Civil and Forensic managers. December 2008 Update: As of June 2008 Administrative Officer purchased with impressed funds board and card games, outdoor activity equipment for units in the Civil Program. In Forensic Serivces as a result of the "Field Day" funds, staff purchased 6-8 board and card games per unit as well as outdoor activity equipment and satisfied a specific request from Unit 6 (practicing trama informed care) for Yoga mats.			
Hire new director of volunteer services who will provide leisure activities to individuals			CEO
Complete - Status: February 2009 Update: Director of Volunteer Services is currently collecting leisure activity items and will distribute as available.			

1) Apr 2008 *4 Consider ways to identify and utilize nursing staff, especially PTs, to act as unit level leaders for culture change.* ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue implementation of Trauma informed care on RMB 6. Plans to introduce to RMB 3 as mentored by RMB 6 staff.	8/1/2008		CNE
- Status: February 2009: Trauma informed care has not yet been expanded beyond two units.			

2 Continue to implement patient focused treatment planning on RMB 1/2. Plans to introduce treatment planning training to other RMB units by the RMB 1/2 Clinical Administrator as mentor and consultants as trainers.	8/29/2008			CNE
- Status: Mary Thornton and Associates have been engaged to provide Treatment Planning services to the Hospital. There is a signed contract and approved Purchase Order for Fiscal Year 2009. February 2009 Update: Person-centered treatment planning training initiated on JHP 1, JHP 3, JHP 6, RMB 1, and RMB 5 in September and October 2008. Training continues on these units with recently revised IRP forms. Training on JHP 8, JHP 10, RMB 4, RMB 6, and CT 3C/D began January 2009. Expect that the remaining units (JHP7, JHP 9, JHP 12, RMB 3, RMB 7, and RMB 8 will begin training in April 2009.				
3 Civil And Forensic Directors to consult with respective Associate Directors of Nursing regarding utilizing nursing staff as unit level leaders for cultural change.	7/25/2008			CNE
- Status: Ongoing				
4 Revise Dress code Policy-GNA 100.6	6/30/2008	Previously provided		CNE
Complete - Status: Policy completed				
5 Train Nursing staff on policy	7/31/2008			CNE
6 Train all units hospital wide in trauma informed care within 9-12 months.	7/31/2009			Medical Director

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not yet completed or initiated.			

2) Dec 2008 ***2*** *Re-examine "boarding" or otherwise temporarily moving an agitated patient onto another clinical unit.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *Evaluate the RMB 3 program and assure full integration of all disciplines into the daily program activities.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *Consider hiring Ward Clerks for each unit to free nursing staff from duties that could be effectively performed by an administrative support professional.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify positions for ward clerks	11/28/2008		COO
Complete - Status: Feb Update: Three positions were identified			

2 Fill identified vacancies	2/26/2009	CVC, COO
- Status: Feb 2009 Update: Three medical record clerks were hired		

X.B.3

are not used as part of a behavioral intervention; and

Findings

Significant training has occurred around implementation of PBS. Binder XI, tab # 8 (Outline of PBS training). All psychologists have had initial training on the current PBS process; unit based psychologists have had initial training on how to develop a structural assessment. RMB 3/4 psychologists and 4 PNAs have had initial training on how to develop a functional assessment. All psychologists have been trained on how to write a behavioral progress note. Other initial training includes training of RMB 3 and 4 treatment teams on the responsibilities of team members on a behavioral unit, training on trigger criteria for psychology interventions, and how to incorporate behavioral planning (clinical decision trees, assessments, plans, guides, data) into treatment planning. Finally, an in-service (that was videotaped) was held for direct care staff on what is PBS and what is the process in place for the Hospital). Early data suggests that training has been effective where it has occurred, as restraint and seclusion on RMB 3 has decreased. Further the plan is in March, 2009 to review all previously developed PBS plans to ensure fidelity to the model, and that will include revising older plans that may directly or indirectly suggest use of restraint or seclusion.

Compliance Status: Partial.

Recommendations — ***Responsible Party***

1) Apr 2008 — ***1*** *Use positive behavior support team/psychologist to assist treatment team to develop alternative interventions.* — ***CVC; JH; Medical; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Enter into contract with consultant to provide training to psychology staff and targeted ward staff on Behavioral support strategies.	6/30/2008		Chief of staff
Complete - Status: February 2009 Update: PBS training underway. Trainer has worked closely with RMB 3 staff in developing guidelines and plans for individuals on unit. She also has met (and is continuing to train) psychology staff on functional/structural analysis in order to develop appropriate plans. Finally, she provided an overview of PBS to all direct care staff (which was videotaped).			
2 Expand trauma informed care to RMB 3 and by July 31, 2009 to all units in Hospital.	8/29/2008		Medical Director; JH; CVC
- Status: February 2009: Training around trauma informed care has not expanded to units, but is provided as part of new employee orientation.			
3 Psychology staff to mentor staff on positive behavior support	7/31/2008		

1) Apr 2008 — ***2*** *Establish date by which the use of seclusion or restraint as part of a behavioral intervention will be prohibited.* — ***Medical;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Chief Psychologist has clarified that behavioral plans will never include seclusion or restraint as a behavioral intervention.	6/30/2008		Rose Patterson
Complete			

2 Provide training to RMB 3 on PSB plans and their implementation	7/21/2008		Rose Patterson
- Status: Contract has been signed and training to begin by July 31, 2008			
3 Chief Psychologist is monitoring and approving all behavioral plans being proposed by staff to ascertain that seclusion and restraint is not mentioned as a behavioral intervention and for quality assurance.			Dr. Patterson
- Status: Ongoing			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *Clarify that certain actions/interventions may constitute seclusion or restraint even if those specific terms are not used.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Clarify use of quiet room		Binder X, Tab # 9 (Reporting Suspected Abuse and Neglect Training Curricula)	
- Status: Feb Update: Staff were trained on reporting abuse and neglect, and information about use of quiet room and how it may become seclusion was included.			

2) Dec 2008 ***3*** *Add an explicit statement prohibiting use as a part of a behavioral intervention to the "standards" portion of the restraint/seclusion policy.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise S/R policy to include a specific prohibition prohibiting use of s/r as a behavioral intervention.	2/19/2009	Binder X, tab # 1 (S/R Policy)	PID
Complete			

X.B.4

are terminated as soon as the individual is no longer an imminent danger to self or others.

Findings

The seclusion and restraint audit reviewed issues around duration of a seclusion or restraint episode. In 78% of cases reviewed, the order specified a duration not to exceed one hour. In only 52% of cases, seclusion or restraint was discontinued as soon as the individual met behavioral criteria for release and in 57% of cases, was released when no longer an imminent danger to self or others. Binder X, tab # 3 (Results, restraint and seclusion audit).

The Level of Observation form has been modified to prompt discussions with the individual about re-integration into the ward milieu which should improve compliance on this requirement. Binder X, tab # 10 (Level of Observation form)

A new doctor's order form for seclusion and restraint has been developed that incorporates recommendations from DOJ. Binder X, tab # 11 (Doctor's order form for seclusion and restraint).

Compliance Status: Partial.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop a tool and implement a monitoring process to identify and resolve incidences where the individual remains in seclusion or restraint when no longer an imminent danger to self or others. This tool/process should also identify any indicators of "routine" restrictions following seclusion or restraint.*	***Medical; PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize S/R policy and draft monitoring tool	7/15/2008	Binder X, Tab # 1 (S/R Policy); Tab # 2 (S/R Audit Tool)	PID; CEO
Complete - Status: Tool drafted and policy completed. February 2009 Update: Policy revised, and tool revised as well.			
2 Modify S/R monitoring tool and obtain technical assistance from consultant	8/29/2008	Tab # 2 (S/R Audit Tool) Results of Monitoring, Tab # 49	PID
- Status: Tool provided to consultant for feedback. Feb 2009 Update: Tool modified			
3 Train staff, begin monitoring and report on same.	9/12/2008	Binder X, Tab # 3 (S/R Audit results)	PID
- Status: Feb 2009 Update: Audits for period 8/1/08 to 12/31/08 conducted			
4 Revise tool as needed.	11/3/2008		PID

1) Apr 2008	***2*** *Revise documentation forms to prompt a discussion with the individual and document the individual's ideas about what would most help him/her to successfully re-integrate into the treatment milieu.*	***BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise policy to require staff to have discussion and related forms	7/16/2008		Policy Director
Complete			
2 Include this requirement in monitoring tool.	8/18/2008	Binder X, tab # 3 (S/R Audit Results)	compliance officer
- Status: Tool not yet modified. Feb 2009 Update: Tool modified and audits evaluating if there is documentation about successfully intergrating individual into milieu			

2) Dec 2008	***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008	***2*** *Re-evaluate the policy and use of Day Room Restriction and consider alternatives that are informed by a focus on the individual and what will support his/her recovery.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

X.C.

By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:

Findings

See sub cells

Compliance Status: See sub cells.

X.C.1

the specific behaviors requiring the procedure;

Findings

A doctor's order form for seclusion and restraint has been developed and should be used beginning March 10, 2009. Binder X, tab # 11 (Doctor's order form for seclusion and restraint.) The order form prompts doctors to specify the behaviors warranting restraint or seclusion. In the past, this information, iwhen recorded, was generally found in the progress note section of the record.

The recent seclusion and restraint audit data suggests that while the record overall includes evidence that the patient posed an imminent risk of injury to self or others (70%), in only 43% of cases did the doctor's order (using old form) reflect such risk. Binder X, tab # 3 (Results, restraint and seclusion audit).

Compliance Status: Partial.

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Develop a tool and implement a monitoring process to identify and evaluate trends in standards adherence.*			***PID;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See action steps to X.B.4.			
2) Dec 2008	***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Implement prior action steps not implemented or initiated.			
2) Dec 2008	***2*** *Revise the Doctor's Order Form for Restraint and Seclusion.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			

X.C.2

the maximum duration of the order;

Findings

There was a pilot review of seclusion/restraint information using a draft tool. In 78% of cases reviewed, the physician's order included a maximum duration. Binder X, Tab # 3 (Seclusion/restraint audit data results)

Compliance Status: Partial

Recommendations				***Responsible Party***
1) Apr 2008	***1*** *Continue current practice.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Continue current practice.

- Status: Current practice continues.

2) Dec 2008 *Monitor for sustained compliance.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Monitoring for sustained compliance		Binder X, Tab # 3 (S/R Audit Results)	

X.C.3

behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;

Findings

In the audit conducted by PID and the compliance office, criteria for release generally included statements such as "when not at high risk of violence"; "when calm and appropriate". Only 35% of records were rated as including individualized behavioral criteria for release. Binder X, Tab # 3 (Seclusion/restraint audit data results)

The revised doctor's order includes some examples of behavioral criteria for release.

Compliance Status: Noncompliance

Recommendations — ***Responsible Party***

1) Apr 2008 ***1*** *In order "jump start" a change in their thinking about criteria for release, provide RNs and MDs with a 'cheat sheet" of examples of how to write behavioral criteria for release.* — ***Medical; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop curriculum and train RN's and MD's on newly revised seclusion and restraint policy which includes a revised order form.	8/31/2008		Medical Director, Chief Nurse
2 Develop list of examples of how to write behavioral criteria for release	10/15/2008		Medical Director

- Status: No action yet taken.

1) Apr 2008 ***2*** *Make an addition to the policy that directs the RN to contact the physician to review individual behaviors that may be different from the release criteria but that do, in fact, indicate readiness for release.* — ***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in revised S/R policy that RN must contact physician to review patient behaviors that indicate readiness for release	6/15/2008	Binder X, Tab # 1 (S/R Policy Revised)	J Taylor

Complete - Status: Inserted required statement into policy
February 2009 Update: Policy revised

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *Refine administrative monitoring to assure real-time information to interrupt unacceptable seclusion/restraint orders.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Not Identified			

2) Dec 2008 ***3*** *Revise the Doctor's Order Form for Restraint and Seclusion.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

X.C.4

ensure that the individual's physician be promptly consulted regarding the restrictive intervention;

Findings

The PID/Compliance office audited a 25% sample of seclusion and restraint episodes. It found that the treating physician was either the ordering doctor (74%) or where not the ordering doctor, was notified in 44% of cases. Binder X, Tab # 3 (Seclusion/restraint audit data results)

Compliance Status: Substantial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice. *- Status: Current practice continues.*			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *Monitor for sustained compliance.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Monitor for sustained compliance			

X.C.5

ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;

Findings

According to the audit, in only 30% of cases is there evidence that the patient was notified of the behavioral criteria for release every thirty minutes. Binder X, Tab # 3 (Seclusion/restraint audit data results) However, the new level of observation form is now just being utilized by nursing staff; because it specifically prompts nursing staff to inform the patient of the criteria for release, implementation of this requirement may be improved.

Compliance Status: Partial.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Act on trends identified through monitoring to resolve discrepancies.* ***PID; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Modify tracking of S/R (nursing monitoring forms) to ensure nursing staff re-inform patients of criteria for release and document same.	7/17/2008	Binder X, Tab # 2 (S/R Audit Tool)	CNE
Complete - Status: Nursing log modified. February 2009 Update: new audit tool developed and piloted.			
2 Track this in S/R monitoring form	7/16/2008	Binder X, Tab # 2 (S/R Audit Tool)	
Complete - Status: S/R monitoring tool modified and under review by consultant. February 2009 Udpate: S/R monitoring form updated to include assessment of accuracy,			
3 Track data and respond as trends identified.	7/16/2008	Binder X Tab # 3 (S/R Audit Results)	PID
- Status: Feb 2009 Update: Results analyzed and recommendations pending.			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *The Post Event Analysis Report should include a critical evaluation of behavioral release criteria with recommendations for changes.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***3*** *Evaluate the nursing policy for transcribing MD orders and include the requirement that the flow sheets contain the exact physician order for release criteria.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

X.C.6

ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;

Findings

This still is not being consistently met. The seclusion and restraint audit shows that in 5% cases was there documented evidence of treatment team debriefing within 24 hours of the seclusion or restraint episode. Binder X, Tab # 3 (Seclusion/restraint audit data results).

Compliance Status: Noncompliance

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Act on trends identified through monitoring to understand and resolve barriers.* ***PID; AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure S/R monitoring tool checks for compliance	6/5/2008	Binder X, tab # 2 (S/R Audit Tool)	PID
Complete - Status: Tool includes this requirement; tool is being reviewed by consultant. Feb 2009 Update: Audit tool revised and audit taling place			

2 Begin monitoring this aspect and report on same, by unit.	8/29/2008			CNE
- Status: See action step 1				
3 Use data to identify problem areas, issues and modify practice through training, policy clarification or other appropriate intervention.	9/30/2008	Binder X, Tab # 3 (S/R Audit Results)		PID
- Status: Audit recently concluded. Recommendations being made.				
4 Develop capacity in AVATAR to monitor S/R usage, data entry and post S/R interventions.	2/27/2009			COO
- Status: February update: AVATAR is not yet being used for s/r orders. Expected to be phased in over next six months.				

2) Dec 2008 *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

X.C.7

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

Findings

There were no instances noted where a patient was secluded or restrained without a doctors order.

Compliance Status: Substantial

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice			
- Status: Continue current practice			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *Require an RN to be present when seclusion/restraint is implemented.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise policy to ensure that of the three staff required when restraint or seclusion is used.	2/18/2009	Binder X, Tab # 1 (S/R Policy revised)	PID
Complete			

X.C.8

Findings

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.

In general, patients in seclusion or restraint are supervised by a 1:1 staff member. The seclusion/restraint audit reviewed the episodes and attempted to track the use of seclusion or restraint. It appears from the audit that staff had completed or were current in the seclusion and restraint competency training in 100% of cases.

Compliance Status: Substantial

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications.*	***Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training Director to work with Civil and Forensic Directors on monitoring training hours and courses for staff, to include notification of managers when employee's training is to lapse or when competency not achieved	6/27/2008		Training Director, CNE
Complete - Status: Meeting held and procedure agreed upon			
2 See also V.B.1 recommendation 4			
3 Training data base to be implemented in February, 2009 will include competency results in database.	2/27/2009		Training director, CNE

1) Apr 2008	***2*** *Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.*	***CVC; JH; Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discuss process with Civil and Forensic Directors to ensure notice is sent when competence is not achieved or training expires	6/18/2008	Document previously provided.	Training director; Chief Nurse Executive
Complete - Status: See also X.C.1 recommendation 1			

1) Apr 2008	***3*** *Develop basic core competencies for all clinical disciplines consistent with their potential involvement in seclusion and restraint as well as less restrictive interventions.*	***Medical; Chief Nurse Executive; Discipline Directors***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Director of Nursing to develop standards for core competencies related to use of seclusion and restraint.	9/15/2008		CEO
- Status: Positions are posted and interviewing is in process. Feb 2009 Update: CNE hired mid-October, 2008			
2 Nurse education consolidated under CNE to ensure competencies evaluated through training	12/31/2008		CNE
Complete			
3 Not Identified			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *See VIII.D.1*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.D.1			

2) Dec 2008 ***3*** *Develop competency measures for all clinical disciplines based on the responsibilities articulated in the newly developed policy, and the monitoring results. These competencies should have core elements that are required by all disciplines, and discipline specific components related to specified responsibilities.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008 ***4*** *Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.* ***AS; CNE, CEO***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop draft procedure around limiting practice when competency not achieved.	4/1/2009		CNE
2 Discuss with labor management committee.	5/29/2009		CEO

X.D.

By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.

Findings

In February, 2008, a new system was put in place to improve accuracy of seclusion/restraint data. Under that system, seclusion and restraint data is collected each shift by the nursing supervisor's office. This system has substantially improved the data collection, but there remain some discrepancies. The recent seclusion and restraint audit checked to see if the seclusion and restraint episode was accurately reported on the log, and found it was accurately reported 91% of the time. Only in 13% of cases as a UI form completed. Binder X, tab # 3 (S/R Audit results)

Compliance Status: Partial

Recommendations	*Responsible Party*
1) Apr 2008 ***1*** *Explore and resolve barriers to accurate reporting.*	***PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to X.C.5 recommendation #1 and X.C.6			

2 Implement automated data tracking through AVATAR beginning with Phase 2	1/30/2009		COO

- Status: February 2009 Update: AVATAR Phase II is set for phased implementation over spring and summer, 2009. Seclusion and restraint orders and monitoring will be included in that phase.

1) Apr 2008 — ***2*** *Evaluate potential ways to embed reporting requirements within other documentation requirements.* — ***PID; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide technical assistance to program managers on how to avoid duplicative reporting requirements.	5/20/2009		PID; CVC; JH

- Status: February 2009 Update: Nurse Managers are reviewing adminstrative responsibilities to identify possible areas of duplicative reporting. Use of AVATAR management reports will also be explored.

2) Dec 2008 — ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 — ***2*** *Conduct full clinical case reviews on the individuals who have been high users of seclusion/restraint. Focus "upstream" to identify improvement opportunities rather than simply at the circumstances immediately surrounding the restraint/seclusion use.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

X.E.

By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or res

Findings

The Hospital policy meets this requirement. See Tab # 1 (Seclusion/restraint for behavioral reasons). However, there is little evidence that the IRP is modified to identify new objectives or interventions that would reduce likelihood of future use of seclusion or restraint. Data from the audit show that in 0% of cases was the IRP modified. Binder X, tab # 3 (Results of S/R Audit).

Compliance Status: Partial.

Recommendations — ***Responsible Party***

1) Apr 2008 — ***1*** *Explore and resolve barriers to adhering to this standard.* — ***CVC; JH; PID; BG; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize monitoring form for S/R with input from consultant	8/15/2008	Binder X, Tab # 2 (S/R Audit Tool)	PID; Chief of Staff

Complete - Status: Tool is in draft. Under review by consultant, but it is being used at this point. February 2009 Update: Monitoring tool revised

2 Monitor compliance with policy and report results.	10/1/2008	Binder X, tab # 3 (S/R audit results)	PID
Complete - Status: Audits using new tool underway			
3 Identify issues and implement corrective actions.	12/1/2008		PID, Medical Director, CNE,
- Status: Ongoing			

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *See X.C. and X. D.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See X.C and X.D			

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:

Findings

See sub cells for findings

Compliance Status: See sub cells for findings.

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;

Findings

The Hospital revised its Involuntary Administration of Medication policy as well its Seclusion and Restraint for Behavioral Reasons policy to improve clarity around this requirement. The seclusion and restraint audit results suggest that in 26% of cases, there was evidence that emergency involuntary medication was administered. Binder X, tab # 3.

The Hospital developed a report tracking use of PRN and Stat medications. The report does not yet fully track if the medication was administered on an involuntary basis, but it does track method of administration - oral or by injection. Binder X, tab # 12 (PRN/Stat report)

The Hospital continues to meet statutory requirements around the process for long term use of involuntary medications.

Compliance Status: Noncompliance.

Recommendations			***Responsible Party***
1) Apr 2008	***1*** *Develop policies that define pharmacologic restraint consistent with CMS definitions, that establish clear standards for use, and that also describe the use of prn and stat medication. Clearly differentiate the requirements and indications for each of these three categories.*		***CVC; JH; Medical; PID; BG; OGC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1	Incorporate CMS-defined definitions into Restraint/ Seclusion and Involuntary Medication policies to the extend consistent with DC law.	6/15/2008	Binder X, Tab # 1 Seclusion and Restraint for Behavioral Reasons Policy revised) Tab # 7 (Involuntary Medication Policy)	J Taylor

Complete - Status: Incorporated CMS-defined definitions into policies. Please note DC has a specific law which differs in part from CMS definition, so policies reflect both. February 2009 Update: S/R for Behavioral Reasons policy revised.

1) Apr 2008

2 *Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide.*

PID; AS; Discipline Directors

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create crystal reports through AVATAR that will track use and time frames for use of emergency involuntary medication, prn medication and stat medications by developing Crystal reports	4/30/2008		COO

- Status: Phase II prep sessions with Vendor began in October 2008; the kick-off was 11/19/2008. There will be staggered implementation beginning in 1/2009. February 2009 Update: AVATAR EMAR does not provide the method of adminstration as a mandatory field. We are considering making that mandatory.

2	Reports to be reviewed and monitored by discipline chiefs	11/28/2008		Medical Director; CVC; JH

- Status: Feb 2009 Update: A management report on PRN and STAT medications is available. Refinements needed however, to address purpose of medication (psychiatric or medical) for example. Data is available by unit and practioner.

3	Once developed, ensure capacity to run reports at least monthly to identify trends and provide data to Exec staff and P & T Committee	12/17/2008		

Complete - Status: Enhancement is needed and has been requested. In August 2008, 1 Crystal Developer was hired. The Management Report will be draft once the enhancement has been completed.

1) Apr 2008

3 *Explore alternatives to gathering data that do not involve nursing staff filling out reports, in addition to regular documentation. Paper technologies, such as NCR copies of orders, pharmacy records, as well as electronic technologies should be explored.*

AS; Chief Nurse Executive

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Successfully implement Phases One and Two for the Avatar application.	2/27/2009		Eric Strassman, Sharmaine Allen, Mark Larkins

- Status: The ability to update progress notes in the Avatar application is a part of Phase II of the implementation- tentatively scheduled to go live at Winter 2009.

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *Revise the definitions and "Drugs used as Restraint" part of the Involuntary Medication Administration policy to be aligned with the revisions in the restraint/seclusion policy.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise S/R policy to modify definition of drugs used as restraint.	2/27/2009	Binder X, Tab # 1 (S/R Policy, revised)	PID
Complete			

X.F.2

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

Findings

Data or other information on meeting this requirement is not available. No tool has been developed to collect this data. However, anecdotally, in appears that when involuntary emergency medication is administered as part of a restraint or seclusion episode, there is a physician assessment of the patient as part of the seclusion/restraint episode; information shows that the physicians are seeing patients if seclusion or restraint is ordered.

Compliance Status: Noncompliance.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See X.F.1*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See X.F.1			

2) Dec 2008 *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

X.F.3

the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.

Findings

No progress has been made. Data or other information on meeting this requirement is not available. No tool is available to collect this data.

Compliance Status: Noncompliance.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *See X.F.1.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See X.F.1.			

1) Apr 2008 ***1*** *Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide.* ***Medical; PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Crystal Report that captures emergency involuntary administration of medication so that trigger can be identified.	11/7/2008		COO
- Status: February Update: A management report is available that captures use of PRN and Stat medications by patient, date, ward and practitioner, but it does not yet reflect if medication was administered involuntarily. The AVATAR steering committee is considering this issue to determine if this information can be ascertained from the electronic system.			
2 Provide reports weekly to Medical Director and Civil and Forensic Directors to ensure treatment teams review cases as appropriate and tracks by practitioner, unit and system wide.	12/12/2008		COO
- Status: Feb 2009 Update: PRN/Stat medication reports are available daily to all staff through AVATAR			
3 Obtain technical assistance from consultant to review tools and data reports.	3/2/2009		
- Status: February 2009: No progress to report			

2) Dec 2008 *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Implement prior action steps not implemented or initiated.			

X.G.

By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based

Findings

See VIII.D. The nursing training was consolidated under the direction of the Director of Nursing. Training is done on in the involuntary administration of medication as well as seclusion and restraint.

Compliance Status: Noncompliance

Recommendations	*Responsible Party*
1) Apr 2008 ***1*** *Develop and implement a competency-based training curriculum to jointly train MDs and RNs on these policy requirements since most involve both disciplines and a collaborative effort will support success.*	***Medical; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1	Hire Director of Nursing to develop training on policy requirements.	9/15/2008	CEO

- Status: Position has been posted and interviews are in progress.
February 2009 Update: CNE began in October, 2008. Nursing education was consolidated under her. Medical Director hired December, 2008. They are working to develop training that is expected to be completed by July 15, 2009.

2	Work with nurse educator on design and implementation of training.	7/15/2009	CNE

1) Apr 2008 ***2*** *Develop aggregate reports on the percent of staff that satisfactorily complete this training.* ***Medical; PID; Chief Nurse Executive***

Action Step and Status		Target Date	Relevant Document(s)	Responsible Staff
1	Formulate report on completion of related training.	11/30/2008		Medical Director, Chief Nurse, Training Director

- Status: Training module to be developed.
February 2009 Update: No progress to report

1) Apr 2008 ***3*** *Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.* ***Medical; Chief Nurse Executive,***

Action Step and Status		Target Date	Relevant Document(s)	Responsible Staff
1	Develop procedures to provide remedial training and when indicated, disciplinary actions when competence is not achieved.	11/15/2008		Medical Director, Director of Nursing

- Status: Procedure needs to be developed. May require negotiations with labor unions. Feb 2009 Update: Nurse education consolidated with Director of Nursing. She is working to establish a process to identify staff who have not met competencies. Will likely need to be discussed with labor.

2) Dec 2008 ***1*** *Take action on previous recommendations that are currently incomplete and monitor implementation.*

Action Step and Status		Target Date	Relevant Document(s)	Responsible Staff
	Implement prior action steps not implemented or initiated.			

2) Dec 2008 ***2*** *See VIII.D.1 and X.C.8.*

Action Step and Status		Target Date	Relevant Document(s)	Responsible Staff
	See VIII.D.1 and X.C.8			

XI. Protection from Harm

Summary of Progress

1. The Hospital revised its policy "Reporting of Suspected Abuse or Neglect" to clarify that only individuals in care can be subject to abuse or neglect.

2. The Hospital has provided competency based training to over 700 employees on reporting suspected patient abuse and neglect. Training included classroom and short skits as well as various scenarios.

3. The Hospital revised its unusual incident reporting policy and UI form.

4. The Hospital has fully implemented criminal background checks for unlicensed direct care staff employed after 2001 and new employees, the full extent permitted by DC Law. . The law excludes criminal checks of licensed employees, and it does not appear that DC licensing boards routinely complete criminal background checks prior to issuing licenses.

5. The Hospital conducted environmental surveys that showed improvement compared with the previous survey.

6. The Hospital has filled the position of Director of Consumer Affairs. A patient handbook has been drafted and is in final stages of review. A satisfaction survey has been developed and will be rolled out this spring.

XI. Protection from Harm.

By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.

Findings

See sub-cells in Sections XII, XIV, VIII.D and VIII.A.2.b.iv.

Compliance Status: See related sections

Recommendations		*Responsible Party*
1) Apr 2008	***1*** *For discrete recommendations to fulfill the obligations of this Section, please refer*	

to:

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related sections of action steps			

1) Apr 2008 ***1*** *The recommendations listed below in Section XII regarding incident management.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related action steps in section XII			

1) Apr 2008 ***2*** *The recommendations listed in Section XIV regarding environmental conditions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related actions steps in Section XIV			

1) Apr 2008 ***3*** *The recommendations listed in Section VIII.D regarding nursing services.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related action steps in Section VIII.D			

1) Apr 2008 ***4*** *Develop and implement a mortality review system that ensures that death reviews are timely, thorough and complete, contain specific recommendations for corrective action, and that such actions are implemented. (See Section VIII.A.2.b.iv. of SA and Report p. 110).* ***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.A.2.b		Binder XI, tab # (Patient Death review policy); Tab # (Sentinel event policy)	
- Status: Feb 2009 Update: Policy revised to include investigation by Risk Manager, interdisciplinary review and external review.			
2 Revise policy to provide for a system that includes 1) peer review; 2) investigation by Risk Manager; 3) interdisciplinary review process; 4) and external review	10/15/2008	Binder XI, tab # (Patient Death review policy); Tab # (Sentinel event policy)	Medical Director, J Taylor
- Status: Revised Policy is in draft form, and is expected to be finalized in fall, 2008 Feb 2009 Update: Policy revised to include investigation by Risk Manager, interdisciplinary review and external review.			
3 Enter into contract with external reviewer.	12/31/2008		DMH; COO
- Status: Feb 2009 Update: Policy revised to include investigation by Risk Manager, interdisciplinary review and external review. External review may be with MHA or other external person/body, depending on circumstances.			

XII. Incident Management

Summary of Progress

1. The Hospital revised its UI policy to incorporate additional recommendations by DOJ. An unusual incident form is to be submitted for all UIs. Further, the Hospital has now fully switched to the new UI form and the data base revised so that data is collected by patient and by staff, inter alia.

2. The Hospital hired a new Risk Manager with experience in working on behavioral units in a hospital setting.

3. The Hospital is conducting investigations into all reported allegations of abuse or neglect, suicide or suicide attempts, and elopements of dangerous patients.

4.. The Hospital has developed and implemented a training program governing suspected abuse and neglect. Over 700 staff have been trained.

5. The UI data is reported bi-monthly in the trend analysis. With full implementation of the new UI form reporting of additional factors will begin. Back up data is made available to managers.

7. The Hospital recognizes the need to track review of recommendations of the Risk Manager, QI Department and Mortality review committee and is considering options. QI is tracking implementation of recommendations.

8. A new patient death review policy and sentinel events policies have been finalized.

9. The Hospital identified three high risk indicators (repeated UIs, repeated s/r, and repeated medical emergencies). These will be discussed at the new PIC meeting to set goals and identify other indicators.

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.

Findings

See sub-cells for findings

Compliance Status: See sub cells for findings.

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 requir

Findings

The Hospital revised its UI policy and made slight modifications to the UI form based upon DOJ recommendations and feedback from staff. Binder XII, tab # 1 (UI Policy); tab # 2 (UI form). Further, modifications were made to the policy Reporting Suspected Patient Abuse and Neglect to clarify definition of abuse. Binder XII, tab # 3 (Reporting Abuse and Neglect Policy). Abuse or neglect definition has been clarified to only include abuse or neglect of a person in care. Additionally, the type of medication error that must be reported to DMH has been revised.

The Hospital conducted training on reporting abuse and neglect, which includes information about completing the UI as well as the patient grievance process and how they relate. Binder XII, tab # 4(Training curricula, reporting abuse and neglect). Training including presentations, skits and then group work with scenarios covering all types of employees. A post training test was required. To date, 720 staff have been trained. Binder XII, tab # 5 (Training data)

Compliance Status: Significant progress is being made toward the June, 2009 compliance date.

Recommendations			***Responsible Party***
1) Apr 2008	***1*** *Review and revise incident management policies.*		***PID; Risk manager***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discuss with the Mental Health Authority DOJ recommendations to reduce number of UI codes and other related recommendations.	4/30/2008		Acting PID director
Complete - Status: Agreement reached to reduce number of codes.			
2 Receive approval from DMH Office of Accountability	5/9/2008		CEO
Complete			
3 Revise UI policy to incorporate approved changes	6/30/2008	Binder XII, tab # 1 (UI Policy, revised)	Director, Policy; Risk Manager
- Status: Revised Policy is complete. February 2009 Update: UI Policy modified per DOJ recommendations			
4 Train staff from selected units in civil and forensic units on new policy and form, first piloting the form; pilot to last until August 31, 2008	8/29/2008	Binder XII, Tabs # 4, 5 (Reporting abuse and Neglect TrainingCurricula & Data)	Risk Manager
- Status: Training is being developed. February 2009 Update: Some training occurred with the Reporting Abuse and Neglect training.			
5 Train all staff on new policy and form	9/30/2008		Risk Manager
- Status: on-going			
1) Apr 2008	***2*** *Clarify the appropriate use of the grievance system and include the distinction between a grievance and an incident in incident training at orientation and during annual training.*		***BG; Trg;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop new policy governing allegations of abuse and neglect.	6/30/2008	Binder XII, Tab # 3 (Reporting Abuse and Neglect Policy revised)	Director, Policy
Complete - Status: February 2009 Update: Reporting abuse and neglect policy revised.			
2 Obtain approval by Exec staff..	7/17/2008		CEO
Complete			
3 Train all staff on new policy and incorporate into new employee orientation	9/30/2008	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula); Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)	Director, Policy; Risk Manager; Director, Training
- Status: February 2009 Update: Training of over 600 employees has been completed. Training will continue until all trained			

2) Dec 2008 *Revise the relevant definitions in Policies 301-01 and 305-03 to clarify to whom each applies.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Revise policies per DOJ recommendation		Binder XII, tab # 3 (Reporting Abuse and Neglect Policy), # (UI policy)	PID
Complete			

XII.A.1

identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;

Findings

The revised UI policy and form have substantially simplified the number and reporting of unusual incidents. The UI policy now requires that all incidents of seclusion or restraint result in the completion of a UI report. The new system is simplified for staff, as they are no longer required to determine if an incident is major or minor - - that is the responsibility of the Risk Manager who also assigns severity codes to each incident.

Over the Fall, 2008, the Hospital fully switched to use of the new form, although in some cases staff are still printing and handwriting the form and during the Months August to October, 2008, there were incidents in which the former code was used. That switch was made in November, 2008. In addition, there remain cases in which information is not provided in the form. The Risk Manager is developing a process to ensure all required information is completed on the form.

Data shows that incidents of seclusion and restraint are not yet been reported as a UI as required by policy. Binder XII, tab # 6. This was addressed in the reporting abuse and neglect training, but in most cases, an UI is not being completed. Risk management is working with nursing to address this issue.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Compress the number of incident types to reduce the likelihood of coding errors.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise incident type list and obtain approval of Authority	5/16/2008		Acting Director, PID
Complete			
2 Finalize policy with reduced codes	7/15/2008	Binder XII, Tab # 1 (UI Policy revised)	CEO
Complete - Status: Feb 2009 Update: UI policy revised per DOJ recommendations			

1) Apr 2008 ***2*** *Revise the incident policies to require the reporting of all uses of restraint and seclusion.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise seclusion and restraint policy and UI policy to require reporting of all incidents of seclusion and restraint as UI	6/30/2008		Director, Policy
Complete			
2 Approve restraint and seclusion policy and UI policy	7/15/2008		CEO

3 Track compliance with new policy		Binder XII, tab # 4 (Results of S/R audit)	PID
- Status: Ongoing			

2) Dec 2008 ***1*** *Revise the definitions of incident types in Policies 301-01 and 305-03 to identify clearly who may be a victim and who a perpetrator.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the definitions of incident types in Policies 301-01 and 305-03 to identify clearly who may be a victim and who a perpetrator.		Binder XII, Tab # 1 (UI policy), Tab # 3 (Reporting Abuse and Neglect Policy)	PID
Complete			

2) Dec 2008 ***2*** *Consider revising Policy 305-03 to limit the types of medication errors that the hospital must report to DMH.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Meet with MHA staff to determine if it is possible to reduce the type of medication errors that must be reported to MHA	2/27/2009	Binder XII, Tab # 1 (UI Policy)	PID; Risk Manager
Complete			

2) Dec 2008 ***3*** *Expedite training for staff members, so that incident data will reflect the use of the revised definitions.* ***PID; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train nurse managers on new UI Policy	2/27/2009		CNE
Complete - Status: Nurse managers trained.			
2 As UI policy is revised, update training and train nursing and other staff on new policy	5/1/2009		Training Director
- Status: Training not yet begun as policy was just revised.			

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;

Findings

The draft policy "Reporting Patient Abuse or Neglect" was modified to include an obligation to report suspected as well as known abuse and to limit definition to abuse or neglect of patient in care. The UI form has been modified for better tracking, to assign severity codes and to collect specific data about staff and patients; the UI data base was to capture the data reflected in the new form so now data by patient is available. Training of staff is largely complete, and includes training around reporting suspected abuse/neglect.

Currently, staff are using an electronic version of the form, and many are emailing the form. However, the system is not yet a fully electronic system. That system will be implemented through AVATAR but is not expected before summer, 2009.

Training on reporting abuse and neglect specifically included training on the timelines. Data about timeliness is included in the trend analysis, Binder XII, tab # 7 , and shows some improvement in the timeliness of reporting UIs but it still does comport with Hospital policy.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations			Responsible Party
1) Apr 2008	***1*** *Revise both DMH and SEH policies to require employees to report witnessed, discovered (suspicious injuries) or reported incidents and allegations of abuse and neglect.*		***PID; Risk Manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise reporting suspected abuse or neglect policy.	6/30/2008	Binder XII, Tab # 3 (Reporting Suspected Patient Abuse and Neglect Policy)	Acting director, Policy
Complete - Status: Feb 2009 Update: Policy revised.			
2 Train staff on new policy using competency based training.	10/31/2008	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)	Training director
Complete - Status: No action taken. New curriculum will need to be developed. February 2009 Update: Trained over 500 staff.			
1) Apr 2008	***2*** *Revise the incident reporting form to include an incident number.*		***PID; Risk Manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise UI form.	6/30/2008	Binder XII, Tab # 2 (UI form)	Director, Monitoring Systems; Risk Manager
Complete - Status: Revised UI form to reflect minor changes to policy			
1) Apr 2008	***3*** *Consider revising the "role" designation on the draft incident reporting form and including a severity of injury code.*		***PID; Risk manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise UI form relating to role designation and add a severityof injury code.	6/30/2008	Binder XII, Tab # 2 (UI form)	Director, Monitoring Systems; Risk Manager
Complete			
2 Obtain approval by Exec staff.	7/15/2008		
Complete			
1) Apr 2008	***4*** *Review and correct the July 2006 revision of the Investigation of Patient Abuse and Neglect policy before implementing it.*		***PID; Risk manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise reporting patient abuse and neglect policy.	6/30/2008	Binder XII, Tab # 3 (Reporting Abuse and Neglect Policy)	Director, Policy
Complete - Status: February 2009 Update: Revised policy			
2 Train staff on new policy.		Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)	Training Director
- Status: February 2009 Update: Trained over 500 staff.			

2) Dec 2008 *1 Provide guidance in Policy 305-03 for designating the severity of an incident.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise UI Policy	2/27/2009	Binder XII, tab # 1 (UI policy)	PID
Complete			

2) Dec 2008 *2 Ensure the A/N training being developed specifically addresses timely reporting, including also the possibility of disciplinary action for failure to report an incident as required by hospital policy.* ***Trg; CNE***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Train staff on reporting suspected abuse and neglect	3/27/2009	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)	Training. CNE
- Status: Feb 2009 Update: Over 500 staff trained			

2) Dec 2008 *3 Provide the necessary staff training to expedite on-line incident reporting.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise UI policy per recommendations	2/26/2009	Binder XII, Tab # 1 (UI Policy)	PID
Complete			
2 Train staff on electronic use of UI form	4/15/2009		Training
- Status: Use of electronic UI form is incorporated into reporting suspected abuse and neglect training. Additional training will be offered based upon revised policy.			
3 Develop UI module in Avatar that will provide for true electronic reporting	8/31/2009		COO

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;

Findings

The Hospital policy governing "Reporting Patient Abuse or Neglect" (which controls incidents at the Hospital) specifically requires an employee suspected of abuse and neglect to be reassigned to non-patient areas or to be placed on administrative leave pending the outcome of an investigation. Binder XII, tab # 3 (Reporting Abuse and Neglect Policy). It is the routine practice of the Hospital to do so when an allegation of abuse of neglect has been made.

The new Risk Manager will include in her reports the actions taken toward staff pending an investigation.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Revise the policies cited above so that they are consistent and clearly state that the named employee in allegations of abuse and neglect will be reassigned from direct support of individuals or will be placed on administrative leave, pending the conclusion of the investigation.* ***PID; Risk manager;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Revise allegation of patient abuse or neglect policy to address handling of suspect employee abuser.	6/30/2008	Binder XII, tab # 3 (Reporting Suspected Abuse and Neglect Policy)	Director, Policy
Complete			
2 Obtain approval by Exec staff.	7/15/2008		CEO
Complete			
3 Train managers on new policy at Senior staff meeting.	9/15/2008	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Curricula)	Director, Policy
- Status: Feb 2009 Update: Over 500 staff trained			

2) Dec 2008 *Document specifically in every investigation if and when the alleged perpetrator was removed from contact with the victim or, if the alleged perpetrator was a staff member, if and when he/she was removed from all contact with individuals in treatment.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure each investigation report involving patient abuse or neglect includes information about alleged perpetrator.	3/1/2009		PID
- Status: Ongoing for investigations after March 1, 2009			

XII.A.4

adequate training for all staff on recognizing and reporting incidents;

Findings

Competency based training on reporting suspected abuse and neglect is well underway. Binder XII, tab # 4 (Training curricula). Tab # 5 (training data). This revised training module is being incorporated into new employee orientation.

The Hospital hired a new training director who is revising new employee orientation training and evaluating how to implement an annual training program around employee's date of birth. She will be consulting with the nurse educators on the feasibility of implementing such a strategy.

Compliance Status: Significant progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Revise and expand training on the prevention and identification of abuse and neglect at both annual and orientation training, making it a discrete training course. Include in the title of the training the terms "abuse" and "neglect".* ***BG; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize new policy.	7/15/2008	Binder XII, Tab # 3 (Reporting Suspected Abuse and Neglect Policy)	CEO
- Status: Feb 2009 Update: Policy revised			

2 Develop training plan for competency based training on identifying and preventing abuse, with new curricula for current and new employees; begin training by Sept 30, 2008. Training will include component involving patient speakers.	9/30/2008	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Curricula)	Training Director
- Status: Training over 500 staff complete. Training will continue until all staff trained.			
3 Complete training of all staff and include in new employee orientation.	11/17/2008		Training Director
- Status: Ongoing. Current training module incorporated into new employee orientation.			

1) Apr 2008 ***2*** *Review and revise if necessary the practices in place when a prospective employee does not pass the competency test.* ***CVC; JH; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a system by which the Directors of Civil and Forensic Services are notified of an employee who fails competency based training. See also action steps to V.B.1 recommendation #4	9/30/2008		training Director, Director Civil Services and Forensic Services; Chief Nurse Executive
- Status: Memorandum completed, data base under development			

1) Apr 2008 ***3*** *Implement plans to have employees complete annual training around the time of their birthday month, so that training is completed prior to the employee's annual performance review and is considered during the performance review.* ***CVC; JH; Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a training data base that includes employee's date of birth and well as type and dates of training and results of competency based training.	8/31/2008		Director, Monitoring of Monitoring Systems; Training Director
- Status: Preliminary discussions on data base begun			
2 Ensure that employees' performance standards reflect requirements to complete annual training.	9/30/2008		All exec staff
- Status: Ongoing			

2) Dec 2008 ***1*** *Continue with plans for hiring a Training Director who will institute an Abuse/Neglect Identification and Reporting curriculum (by whatever name the hospital chooses) for orientation and annual training.* ***Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Hire Training director			CEO
Complete - Status: Training Director hired			

2	Develop curriculum around reporting abuse and neglect, and incorporate into new employee orientation	Training Director

Complete - Status: Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)

2) Dec 2008 *2 Begin competency-based orientation and annual A/N prevention, identification and reporting training.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

Complete

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;

Findings

See XII.A, A.2. A.4.. The Policy was revised to specifically require notification of suspected abuse and neglect. Training using a new curricula of reporting suspected abuse and neglect is well underway.

Compliance Status: Significant progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Revise policies as discussed above and expand and revise abuse and neglect prevention and identification training at annual and orientation training to ensure that employees understand their obligation to report.* ***CVC; JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above sections for action steps.			
2 Hire Training Director.	9/17/2008		CEO, COO
3 Develop curriculum that includes patients in training on abuse and neglect and reporting.	10/31/2008	Binder XII, Tab # 4 (Reporting Suspected Patient Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Patient Abuse and Neglect Training Data)	Training Director

Complete

1) Apr 2008 *2 Write guidelines to govern actions by instructors when employees fail the competency test at the conclusion of training.* ***CVC; JH; Trg; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Training director	9/17/2008		CEO; COO
- Status: Position is advertised. Offer was made and rejected. Recruitment continues			
2 Working with Directors of Civil Services and Forensic Services, Chief Nurse, develop process and provide guidance to instructors on procedures when employee fails competency.	4/8/2009		Training director

2) Dec 2008 *1 See recommendations in XII.A.4.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See action steps in XII.A.4			

2) Dec 2008 *2 Ensure that disciplinary measures are taken when employees fail to report suspected abuse or neglect.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monitor reporting of abuse and neglect, and take disciplinary measures as appropriate for failure to report.	3/27/2009		

- Status: Training of obligation is well underway. Expected to be completed by March 31, 2009.

XII.A.6

posting in each unit a brief and easily understood statement of how to report incidents;

Findings

Posters continue to be maintained on each unit.

Compliance Status: Substantial

Recommendations ***Responsible Party***

1) Apr 2008 *1 Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice.			

- Status: Practice continues.

2) Dec 2008 *Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice			

XII.A.7

procedures for referring incidents, as appropriate, to law enforcement; and

Findings

The UI policy has been revised to reduce the scope of unusual incidents that must be reported to the Police. See Binder XII, Tab # 1 (UI policy). The reporting of incidents to the Police is also covered in the reporting abuse and neglect training.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 *1 Revise the DMH policy to ensure that those incidents that require police notification are reported in a timely manner and those that do not require reporting are handled appropriately internally.* ***PID; Risk manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise policy accordingly.	6/30/2008	Binder XII, Tab # 1(UI Policy revised)	Director, Policy

Complete

2) Dec 2008	*Document in the investigation when an individual or staff member has been arrested.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in investigation report as appropriate	2/27/2009		PID, Risk Manager
Complete - Status: This is now included in reports, effective February 1st.			

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 censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.

Findings

The Hospital policy titled "Reporting Patient Abuse and Neglect" includes a specific statement that a reporter shall be free from retaliation. See Tab # 3 (Reporting abuse and neglect policy). Language in DC regulations governing consumer rights similarly protects patients who may seek to file a grievance. This issue was also covered in the training.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008	***1*** *Ensure that in the revisions to the relevant policies specific mention is made of the right for all persons to be free of retaliation or threats of retaliation for reporting an allegation of abuse or neglect in good faith. Include also the statement that staff members found to have engaged in threats or retaliation will be subject to disciplinary action.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise policy around reporting suspected abuse or neglect.	6/30/2008	Binder XII, Tab # 3 (Reporting Suspected Abuse and Neglect Policy)	Director, Policy
Complete - Status: Feb 2009 Update: Policy revised			
2 Exec staff to approve policy	7/15/2008	Binder XII, Tab # 3 (Reporting Suspected Abuse and Neglect Policy)	
Complete			

2) Dec 2008	*Remind staff members who report abuse/neglect of their right to be free of retaliation and their recourse should they be threatened or retaliated against.*	***PID; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure policy makes clear that staff are free from retaliation for reporting suspected abuse and neglect	2/5/2009	Binder XII, tab # 3 (Reporting Suspected Abuse and Neglect Policy)	PID
Complete			

2 Ensure curriculum reflects requirement.	2/27/2009	Binder XII, Tab # 4 (Reporting Suspected Abuse and Neglect Training Curricula), Tab # 5 (Reporting Suspected Abuse and Neglect Policy Training Data)	training Director

Complete

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.

Findings

The Hospital's Risk Manager resigned unexpectedly in October, 2008, and a new Risk Manager began in January 2009. Binder XII, tab # 8 (CV of Martha Pontes). The new Risk Manager has experience in a hospital behavioral health setting and is certified and trained. She has expanded investigations and now reviews cases of abuse and neglect, deaths, attempted suicide and serious assaults, long term medical hospitalizations.

The Risk Manager is developing protocols for the review of UI forms to ensure all information is reported. Monitoring the implementation of recommendations continues to be an issue, although the recent changes to the UI form and anticipated changes to the database should allow for better tracking of recommendations. Presently, there is no systemic tracking of recommendations or follow up to ensure that recommendations are considered by Executive staff, approved and implemented. The Risk Manager and PID is working to develop a tracking method for recommendations in her investigations.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1) Apr 2008 — *1 Ensure the review of incident investigations with approval indicated by the signature of an appropriate staff member other than the staff completing the investigation.* — ***CVC; JH; Medical; PID; BG; Risk manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure investigative reports are reviewed and approved by supervisor	9/30/2008		Director, Policy; Risk Manager; Director, Monitoring Systems

Complete

2 Not Identified

2) Dec 2008 — *Expand the investigational responsibilities of the Risk Manager to meet the requirements of the Enhancement Plan and provide any additional supports necessary to enable the completion of investigations in a timely manner.* — ***PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review availability of part time FTE to assist with investigations.	2/27/2009	Binder XII, Tab # 9 (Position Description for Performance Improvement Coordinator)	PID, COO

Complete - Status: Position identifed to work approximately 60% of time on investigations and remaining time on other quality improvement activities.

XII.B.1

require that such investigations be comprehensive, include consideration of staff's adherence to

Findings

Investigations are completed by either the Hospital Risk Manager, who is assigned to PID, or at times by the Mental Health Authority's Office of Accountability. The Hospital Risk Manager is trained in investigations. A new system of

programmatic requirements, and be performed by independent investigators;

presenting recommendations to PIC and to Executive staff, review by Executive staff, and tracking implementation of approved recommendations was recently finalized. Binder XII, tab # 10 (Sentinel event policy). PID also will be creating an education plan about changes in policy.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Identify why recommendations are not being reviewed, approved or revised as needed and take measures to correct the problem. Identify persons/offices for monitoring implementation of the corrective measures and reporting back to the appropriate body.*	***CVC; JH; Medical; PID; Risk manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Establish a short term work group led by QID Director to assess why recommendations of Risk Manager or other committees are not implemented and to make recommendations on new process for review, approval and tracking.	8/29/2008		Director, QID, Policy Director
- Status: Review has begun but only relating to Mortality Review Committee			
2 Exec staff to approve new process	3/31/2009	Binder XII, Tab # 11 (New Quality Improvement Process)	CEO
- Status: February 2009 Update: New process approved by Exec relating to mortality reviews, sentinel events and other QI recommendations. Implementation to be led by PID director.			
Not Identified			

2) Dec 2008	*Expedite the work of the Serious Incident Follow-up Work Group and expand its composition, if necessary, to address this systemic issue.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

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;

Findings

See findings in XII.B. 1. The Safety Officer is the former Risk Manager, and also has completed investigations training.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Ensure that all staff members who investigate serious incidents have investigation training.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff

1 Training provided as needed to Risk Manager.		Binder XII, Tab # 8 (Risk Manager CV)	Risk Manager

Complete - Status: New Risk Manager has completed State Farm Insurance training program. Also, Safety Officer (former risk Manager) completed training as provided previously. February 2009 Update: New Risk Manager has training in completing investigations.

2) Dec 2008 *Expand the investigatory responsibilities of the Risk Manager to include all serious injuries. Provide necessary supports to enable the timely completion of this work.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps XII B.			

XII.B.3

include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and

Findings

The Risk Manager's reports are reviewed and approved by Director, Performance Improvement Division. Mortality reports are provided to the Executive staff of the Hospital, including the Medical Director, as well as to the Medical Staff Executive Committee. Binder XII, tab # 12 (Patient Death review policy); tab # 10 (Sentinel Event Policy). The Director, PID is working with PIC and Executive Staff to establish a feedback loop. Binder XII, tab # 11 (chart of mortality process). Reports since the September 2008 visit indicate date investigation opened and closed, date of interviews, date report received and other key dates.

Reports beginning March 1, 2009 will include a cover sheet.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1 Develop and implement procedures for the review of death reports completed by Risk Management by the appropriate member of the hospital's medical leadership.*** ***Medical; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise death review policy to provide for review of death reports by appropriate hospital medical leadership	2/27/2009	Binder XII, Tab # 12 (Patient Death Review Policy); Tab # 10 (Sentinel Event Policy)	PID

Complete

2) Dec 2008 ***1 Provide the date and time of all interviews in the investigation report. When an investigation is completed and then when it is approved, sign and date it.*** ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide the date and time of all interviews in the investigation report. When an investigation is completed and then when it is approved, sign and date it.			PID risk Manager

Complete - Status: This will now be included in all reports

2) Dec 2008 ***2 Initiate the use of a face sheet with the identifying information discussed above.***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Hospital is considering this recommendation.	3/31/2009		PID

- Status: This will now be included in all reports

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.

Findings

See XII.B.3. The Risk Manager and Director PID, will work with the PIC, Risk Management and Safety Committee to establish a format for presenting investigation material to it and to track implementation of recommendations.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	***1*** *Identify the source of the problem in failing to give timely consideration and approval to recommendations made at the close of a death investigation by the Risk Manager.*	***PID; EXEC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps related to XII.B.1 and revised policies around patient deaths and sentinel events.			

1) Apr 2008	***2*** *Ensure the Risk Management and Safety Committee reviews all serious incident investigations in addition to reports on incidents prepared by the Risk Manager.*	***PID; Medsec***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager and Safety Officer will present information about all investigations to Risk Management and Safety Committee in month following completion of investigation.	7/31/2008		Safety Officer; Risk Manager

- Status: Ongoing,

1) Apr 2008	***3*** *Identify a method for reviewing the effective implementation of corrective and preventive actions identified by the incident review process.*	***CVC; JH; PID; Risk Manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to XII.B.1			

2) Dec 2008	*Expedite the work of the Serious Incident Follow-up Work Group and expand its composition, if necessary.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See section XII. B 1.			PID

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

Findings

See XII.B.3

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations		Responsible Party
1) Apr 2008	***1*** *Revise the review of deaths and the operations of the Mortality Review Committee*	***Medical; PID;***

to meet current practice standards.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Mortality Review Committee will review the policy to assess how deaths are reviewed and make necessary changes to ensure reviews meet appropriate standards	7/31/2008	Binder XII, Tab # 12 (Patient Death Review Policy), Tab # 10 (Sentinel Event Policy)	Director, Medical Affairs, Director, Policy
Complete - Status: Policy is under review. Feb. 2009 Update: Policy revised			
2 Exec staff will review and modify as needed and submit to DMH Authority	9/30/2008		CEO
Complete			
3 Risk Manager will reinstitute sentinel event/root cause analyses for deaths	8/29/2008	Binder XII, Tab # 12 (Patient Death Review Policy), Tab # 10 (Sentinel Event Policy)	Risk Manager
- Status: Feb. 2009 Update: Policy revised			

1) Apr 2008 ***2*** *Review the role of the Office of Quality Improvement and expectations around response to its reports.* ***PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII B. 1			

2) Dec 2008 ***1*** *Expedite the work of the Serious Incident Follow-up Work Group to determine the source of the hospital's inability to act on its own recommendations in a timely fashion and offer solutions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See XII. B.1			

2) Dec 2008 ***2*** *The Executive Director should actively monitor and/or participate in the workgroup.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
The hospital is not agreeing to this recommendation. The Director, PID will participate as the CEO designee.			

2) Dec 2008 ***3*** *Revise the review of deaths and the operations of the Mortality Review Committee to meet current practice standards.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Policy	2/27/2009	Binder XII, Tab # 12 (Patient Death Review Policy), Tab # 12 (Sentinel Event Policy)	PID
Complete			
2 Implement policy for all deaths after its effective date			PID
- Status: Ongoing			

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 investigatio

Findings

The UI form has been revised to capture information about patients, staff involved, and witnesses. The form is now in use hospital wide, and data is available that reflects staff and patient involvement. There are still some cases in which key data is omitted in the form; the Risk Manager is finalizing a process to ensure UI reports contain all mandated data. A plan to track implementation of recommendations will be finalized in March, 2009.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations			***Responsible Party***
1) Apr 2008	***1*** *Include the names of individuals in the incident management database.*		***PID; Risk Manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise UI form and process.	7/15/2008	Binder XII, tab # 2 (UI Form)	Exec staff; Director of Monitoring Systems; Risk Manager
Complete - Status: Revised UI form and policy have been drafted and scheduled for review by Exec staff. Feb 2009 Update: Revise UI form			
2 Train staff on new process	9/26/2008		Risk Manager
Complete - Status: ongoing			
3 Modify data base	7/31/2008		Director of Monitoring Systems
Complete - Status: February 2009 update: Data base now includes patient and staff names.			
4 Ensure information can be captured in AVATAR (Phase II) database and reports	3/18/2009		COO
1) Apr 2008	***2*** *Revise the incident management information system when appropriate to reflect the changes made in the incident definitions and codes and on the incident reporting form.*		***PID; Risk manager***
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See XII D 1.			
2) Dec 2008	*Continue with plans to institute the on-line reporting of incidents using the revised reporting form.*		
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Electronic reporting now available			
2 Implement electronic reporting through AVATAR by Sept 2009	9/30/2009		COO

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.

Findings

See XII.D. See also revised UI form. Binder XII Tab # 2 The database permits tracking and trending of each field of the UI form. See also Binder XII, tab # 7 (Trend analysis).

Such a system shall:

Training of over 700 staff on obligation to report suspected abuse and neglect is expected to improve the reporting of suspected abuse and neglect.

The modified UI form allows for the collection of information by patient and staff and by role; witnesses are identified, as is location, date and time, type and cause of incident.

A system of monitoring the implementation of recommendations is being developed and should be finalized before the March, 2009, visit.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Redesign the incident information systems so that the hospital can produce periodic reports on the characteristics of incidents specified in the Settlement Agreement.*	***PID; Risk Manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII D 1.		Binder XII, Tab #7 (Trend Analysis)	Director, Monitoring Systems
- Status: Currently, bi-monthly trend analysis captures some data, which will be revised subsequent to Exec staff approval			
2 Implement automated system through Phase II of AVATAR	12/31/2008	Binder XII, tab # 7 (Trend Analysis)	COO
Complete - Status: Staff are working with AVATAR to ensure that it can capture key data to generate reports and capture data. February 2009 Update: Avatar implementation expected by Sept, 2009 Reviewing current database to determine capacity to report on all categories in SA. Feb 2009 Update: Updated UI database. Information reflecting Agreement categories will be reported, but note since it was not collected under prior system, comparisons will not be able to be made.			

1) Apr 2008	***2*** *Identify and correct whatever made the death tracking inaccurate and be sure it did not infect other counts as well.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review data around deaths in CY 2007.	6/2/2008		
Complete - Status: Reviewed data around deaths, clarifying that some reports of death include death of JHP outpatients as well as Hospital inpatients which accounts for discrepancy.			

2) Dec 2008	*Identify procedures for sharing significant incident trending and pattern data with treatment teams with the expectation that the team will consider the information in directing treatment. See the recommendation in XII.E.1.c for a suggestion on how to begin.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Share data from trend anaylsis with clincial adminstrators on each unit, as well as CNE and other key administrators.	12/31/2008		PID
Complete - Status: Trend analysis is on intranet and provided to clinical administrators as published.			

XII.E.1 **Findings**

Track trends by at least the following categories: See XII.E

Compliance Status: See XII.E

XII.E.1.a

Findings

type of incident; See XII.E

Compliance Status: See XII.E

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Produce reports on incidents on a more frequent basis—initially on a quarterly basis.*	***PID; Risk Manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Produce Trend Analysis every two months.	5/31/2008	Binder XII, Tab # 7(Trend Analysis) Trend Analysis (April/May) Tab # 8	Director of Monitoring Systems
Complete - Status: Trend analysis will become monthly once AVATAR (Phase 1 and 2) are fully functional			

2) Dec 2008	***1*** *Identify expectations on how the data will be used to improve the quality of care at the hospital. Write guidelines/policies around these expectations.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID with PIC to develop guidelines around use of data to improve performance.	5/29/2009		PID

2) Dec 2008	***2*** *Clean the incident management database at regular intervals.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Clean the incident management database at regular intervals.	5/15/2009		Risk Manager

XII.E.1.b

Findings

staff involved and staff present; See XII.E

Compliance Status: See XII.E

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Consider changing the incident reporting form to identify aggressor, victim, witness and otherwise involved making it possible to report on staff members involved.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain approval from DMH and revise form	4/30/2008	Binder XII, tab # 2 (UI Form)	Acting PID Director
Complete			
2 Obtain Exec staff approval	7/15/2008		CEO
Complete			

2) Dec 2008 ***1*** *Continue training for staff on the use of the on-line incident reporting system.* ***Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue training			Training Director

2) Dec 2008 ***2*** *Ensure that a monitoring system is in place to review the completeness and accuracy of the information in the incident reports.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Risk Manager to review UI reports and database to ensure completeness and accuracy of reports, and will work with CNE as needed.	4/1/2009		Risk Manager; PID

- Status: Ongoing

XII.E.1.c

individuals involved and witnesses identified;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Consider revising the incident reporting form so that a single reporting form identifies aggressor, victim, witness and persons otherwise involved.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain approval from DMH and revise form	4/30/2008	Binder XII, tab # 2 (UI Form)	Director, Monitoring System
Complete			
2 Obtain Exec staff approval	7/15/2008		CEO
Complete			

1) Apr 2008 ***2*** *Once this information is available in an information system, provide reports on individuals and staff members frequently involved in incident so that further inquiry can begin and corrective measures taken as indicated.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Track data and issue reports.	8/29/2008	Binder XII, Tab #7 (Trend Analysis)	Director, Monitoring System; Risk Manager
- Status: Current system does not capture this data yet. Training underway for pilot of new form. Information will be captured in Revised UI database, but will not be available until Fall after all staff are trained. Feb 2009 Update: Information is provided to staff in a comprehensive way bi-monthly			
2 Hire Crystal Report developers to ensure capacity to report once AVATAR is fully functional.	8/29/2008		COO
- Status: Avatar is not yet functional so system reports are not yet available. Plan is to have reports available on weekly to monthly basis.			
3 Develop reports to elicit staff and patient data relating to UIs	12/10/2008		COO

2) Dec 2008 *1 Take measures to ensure that every incident report is complete, accurate and legible as required by Policy 305-03. Do not enter incomplete information into the incident database.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Review of UI forms by Risk Manager before data entered into database			PID; Risk manager
- Status: Ongoing			
2 Train staff and encourage use of electronic submission of UI form.			PID; Risk Manager
- Status: Ongoing			

2) Dec 2008 *2 As a first step, in using incident data for the benefit of the individuals in care, produce reports on a periodic basis of individuals who are repeat victims and repeat aggressors and forward this information to the respective treatment teams for a treatment response.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include in trend analysis information about individuals who are repeat aggressors or victims	2/27/2009	Binder XII, Tab # 7 (Trend Analysis)	PID
- Status: Included for first time in Trend Analysis, (Nov/Dec)			

XII.E.1.d

location of incident;

Findings

See XII.E.

Compliance Status: See XII.E

Recommendations — ***Responsible Party***

1) Apr 2008 *1 Identify the location of incidents more precisely down to the unit level.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify data base to collect data based upon new form.	7/31/2008	Binder XII, Tab # 7 (Trend Analysis)	Director, Monitoring Systems
- Status: ongoing			
2 Modify form	5/30/2008	Binder XII, Tab # 2 (UI Form)	Director, Monitoring systems
Complete			
3 Produce reports.	9/30/2008	Binder XII, Tab # 7 (Trend Analysis)	Director, Monitoring Systems, Risk Manager
- Status: See Trend analysis page 36 to end.			

1) Apr 2008 *2 See also the recommendation below.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See also the action steps recommendation below.			

2) Dec 2008 *Document in the appropriate forum, the review of this data, recommendations for addressing patterns and trends and follow-up implementation strategies.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID to work with PIC to develop protocol for addressing trends and patterns illuminated by analysis	4/30/2009		PID

XII.E.1.e

date and time of incident;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations ***Responsible Party***

1) Apr 2008 *1 Provide a report of the high-risk times of day and location to the Risk Management and Safety Committee for review and action.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include information in Trend Analysis.	6/30/2008	Binder XII, Tab # 7 (Trend Analysis)	Monitoring Systems Director
Complete			
2 Report data and discuss at Risk Management Committee every other month.	8/21/2008		Risk manager

2) Dec 2008 *1 Attach all reports referenced in the minutes of the Risk Management and Safety Committee to the minutes.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Attach all reports referenced in the minutes of the Risk Management and Safety Committee to the minutes.			PID

2) Dec 2008 *2 Document in the minutes the important points of discussion and recommendations for actions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include reommendation and points of discussion in minutes of RM committee meeting	3/19/2009		PID

XII.E.1.f

cause(s) of incident; and

Findings

See XII.E

Compliance Status: See XII.E.

Recommendations		Responsible Party
1) Apr 2008	***1*** *Invest in the Risk Management and Safety Committee the responsibility to identify and review factors that have been identified in serious incidents and make recommendations for corrective measures.*	***Medical; Med Sec; Risk Manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure Risk Manager's PD reflects responsibility.	6/11/2008		HR; PID
Complete			
2 Ensure Hospital Bylaws establish this as responsibility of Risk Management Committee			
Complete			
3 Implement this recommendation	3/31/2009		PID

2) Dec 2008	***1*** *If not already in place, write a policy or guideline explicitly directing the work responsibilities of the Risk Management and Safety Committee to include discussion of factors contributing to incidents.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

2) Dec 2008	***2*** *Identify in investigation any environmental, staffing or other factors that may have caused or contributed to an incident.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure investigation reports address environmental, staffing or other issues that may have contributed to incident.	3/31/2009		Risk Manager

XII.E.1.g

actions taken.

Findings

See XII.E

Compliance Status: See XII.E

Recommendations		Responsible Party
1) Apr 2008	***1*** *Identify the source of the problem in the failure to approve or revise recommendations for corrective actions and take action to remedy the problem.*	***Medical; Risk Manager, QID Director***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2 Create capacity in database for follow up monitoring.	8/29/2008		Director, Monitoring Systems
- Status: Database will need to be updated as new UI form is implemented. Feb 2009 Update: database modified			
3 Monitor follow up and report same to Exec staff and Risk Management and Safety Committee	8/29/2008		Risk manager
- Status: Ongoing			

	1 Create capacity for follow up on UI form.	6/30/2008		
	Complete - Status: UI form includes capacity for follow up			
1) Apr 2008	*2 When the incident management database is expanded and improved, collect and report on corrective measures.*			***PID;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 See XII.E.1, recommendation 1			
2) Dec 2008	*Expedite the work of the Serious Incident Follow-up Work Group and expand its membership, if necessary, in order to develop a functioning system for the collection, review, approval, implementation and monitoring of recommendations.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	See prior action step.			

XII.E.2

Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.

Findings

The Hospital is beginning to implement this recommendations. Three indicators have been identified to date (Persons with 2 or more restraint or seclusion episodes in 30 days, 3 or more UIs in 30 days, and two or more hospitalizations in a medical hospital within 30 days). See Binder XII, tab # 13 (High Risk indicator data). The data will be shared with PIC in March, and additional indicators will be selected by the Committee. Performance goals will be set for the indicators, and PID with PIC will establish monitoring system.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				***Responsible Party***
1) Apr 2008	*1 Include both behavioral and medical issues when determining the hospital's quality indicators and triggers that will require a specific clinical response.*			***Medical; PIC; Risk manager***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	1 Work with consultant to assist with developing Hospital's quality indicators and triggers, that can be tracked given the lack of automated information system.	11/28/2008	Binder XII, Tab # 13 (High Risk Indicator Data)	
	- Status: Consultation initiated June 2008. February 2009 Update: Several quality indicators recommended to PIC by PID. Pending approval of PIC			
2) Dec 2008	*Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents.*			
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			

XII.E.3

Findings

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.

Risk assessment for suicide is included in psychiatric, nursing and psychological assessments. Binder XII, tab # 14(Comprehensive Initial Psychiatric Assessment), tab # 15 (Psychiatric Update), tab # 16 (Initial Psychological Assessment (A & B))\. Doctors order precautions which nursing staff must implement.

Compliance Status: Some progress is being made toward the June, 2009 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Refine the incident management system so that it identifies the type of incidents in which individuals are involved and run reports that will identify repeat aggressors, repeat victims and those individuals demonstrating suicidal gestures or attempts.*	***PID; Risk manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise UI form and policy to capture such information.	7/15/2008	Binder XII, Tab # 2 (UI form); Tab # 7 (Trend Analysis) UI form Tab # 128	CEO, Director of Monitoring Systems
Complete			
2 Monitor data and produce relevant reports to Senior staff.	8/29/2008		Risk Manager
- Status: On-going			

2) Dec 2008	*Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

XIII. Quality Improvement

Summary of Progress

1. The Hospital produces a Trend Analysis bi-monthly to monitor key data and performance indicators. .

2. The Hospital is conducting IRP observations of 20% of scheduled IRPs and is reporting the results. Specific results are embedded in the related sub-cells of this report.

3. The Hospital is reviewing 20% of closed records to evaluate discharge planning, and is reporting the results. Specific results are embedded in the related sub-cells of this report.

4. The Hospital conducted a medication review of 50 charts and is reporting the results.

5. The Hospital conducted an audit of inter-unit transfers and is reporting the results.

6. The Hospital conducted an audit of substance abuse assessments and is reporting the results.

7. The Hospital completed two Environmental Surveys of all patient care areas.

8. The Hospital's Performance Improvement Department has identified three high risk indicators that will be presented to Performance Improvement Committee to review, set goals and identify other indicators.

9. The Hospital has finalized a patient death review policy and a sentinel event policy.

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.

Findings

See sub-cells for findings.

Compliance Status: See sub cells for findings

XIII.A.

Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.

Findings

The Hospital continues to publish its bi-monthly Trend Analysis which is now based in part upon AVATAR and in part on manual data The Hospital monitors ADRs and medication variances in the Trend Analysis, as well as Seclusion and Restraint use, IRPs and mall group cancellations as performance indicators. Data is manually collected for some topics as there remains no information system, so the reliability of the data is at times questionable and makes trending challenging. The Hospital is continuing reviews of discharge records, seclusion and restraint usage, medication usage, interunit transfers and is observing about 20% of treatment plans. See Binder XIII, Tab # 1, 2,3,4, 5, 6, 7.

Three indicators have been identified and data collected. Binder XIII, tab # 11 (High risk indicators). PID continues to work with PIC to identify other indicators, settle on goals, and begin monitoring. Other quality efforts include the IRP process observations, Binder XII, tab # 2(IRP Process results, July to Sept and February, 2009), seclusion and restraint audit, tab # 3 (S/R audit results), tab # 4 (Medication Monitoring Audit results), discharge record reviews, tab # 5 (Discharge Record reviews), interunit transfer audit, tab # 6 (interunit transfer audit results) and substance abuse audit, tab # 7. Disciplines are beginning peer review.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Continue with plans to identify other quality indicators and include both physical and behavioral triggers.*	***Medical; PID; BG; PIC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Receive technical assistance from consultant to identify quality indicators which include both physical and behavioral triggers.	10/31/2008		Chief of Staff; QID director
- Status: Given lack of comprehensive information system, selected indicators will have to reflect areas in which reliable data is available. Feb 2009 Update: PID director working with PIC to develop quality indicators.			
2 Evaluate capacity of Phase 1 Avatar to be used to assist in collecting data that will assist in identifying triggers	11/20/2008		COO; Chief of Staff
- Status: Will need to consider AVATAR capacity in identifying triggers and quality indicators. February 2009 Update: Avatar reports are in development.			
3 Collect data and assess trends and identify issues relating to indicators. Provide reports to Managers	3/31/2009		PID

2) Dec 2008	*1 Ensure the operation s of the Performance Improvement Committee to include making specific recommendations for improving care based on studies completed, incident and other data presented.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 New President of Medsec to appoint members to PIC	3/31/2009		Med Sec
2 PID director to support PIC on identifying quality indicators and making recommendations on improving care	4/30/2009		

2) Dec 2008	*2 Track recommendations faithfully through the approval and implementation phases.*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID to establish tracking system to track recommendations, including approval, modification and implementation	4/30/2009		PID

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:

Findings

See XIII.A

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		Responsible Party
1) Apr 2008	*1 Select additional quality indicators and begin collecting baseline data that includes the identification of individuals who reach an indicator or trigger. For example, identify individuals who have been the victim of an assault that required more than first aid.*	***Medical; PID; PIC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps related to XIII.A			
2 Modify UI process to ensure more specific data is collected to assist in identifying trends.	6/30/2008	Binder XII, tab # 8 (UI Form) UI form Tab # 128	PID
Complete			
3 PID and PIC to develop quality indicators and track	5/29/2009		PID

1) Apr 2008	*2 Identify corrective measures for priority quality indicators and measure performance.*	***Medical; PID; PIC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in XIII.A			
- Status: No action yet taken			

2) Dec 2008	*Continue implementation of plans to identify additional quality indicators and monitor performance. Consider both behavioral and clinical indicators.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action step above.			

XIII.B.1

the action steps recommended to remedy and/or prevent the reoccurrence of problems;

Findings

See XIII. A. and B.

Compliance Status: See XIII.A and B

Recommendations		Responsible Party
1) Apr 2008	*1 Select quality indicators and begin collecting baseline data.*	***Medical; PID; EXEC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in XIII.A			

1) Apr 2008	*2 Begin the conversation on the policies and procedures that will govern quality indicators and triggers (those events under each quality indicator which require a specific response by the IRT).*	***PID; EXEC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Work with consultant and educate Senior staff about identifying quality indicators	9/30/2008		
2 Research quality indicators used by CMS, JCAHO and other certifying bodies.	9/30/2008		Director, Policy

3 PID to work with PIC and identify quality indicators by May, 2009	Binder XIII, Tab # 11 (Suggested quality indicators)	PID

- Status: PID has identified several quality indicators and will present to PIC at its March meeting.

2) Dec 2008 *Expedite plans to identify quality indicators through the use of consultant services and the review of indicators recommended by accrediting bodies.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

XIII.B.2

the anticipated outcome of each step; and

Findings

See XIII. A. and B

Compliance Status: See XIII.A and B

Recommendations	*Responsible Party*
1) Apr 2008 ***1*** *See above findings and recommendations for XIII.B.1.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above action steps for XIII.B.1.			

2) Dec 2008 *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

XIII.B.3

the person(s) responsible and the time frame anticipated for each action step.

Findings

See XIII. A. and B

Compliance Status: See XIII. A. and B

Recommendations	*Responsible Party*
1) Apr 2008 ***1*** *See above findings and recommendations for XIII.B.1.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above action steps for XIII.B.1.			

2) Dec 2008 *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

XIII.C.

Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:

Findings

Corrective action plans of all types are distributed to senior staff and some are available on the intranet. The DOJ report is available on the intranet, and there is an Access data base available to all senior staff. Binder XIII, tab # 12 (Grid of Recommendations)

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Begin the conversation on the policies and procedures that will govern quality indicators and triggers.*	***EXEC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XIII.B.1			
2 Consultant to meet with Exec staff to begin focused discussion on identification of indicators.	9/30/2008		
3 Executive staff and Medical Staff Executive Committee to identify key policy issues	4/23/2009	Binder XIII, Tab # 9 (Patient Death Reviews policy), Tab # 10 (Sentinel Event policy)	CEO; Medical Director
- Status: February 2009 Update: Medical Staff Executive Committee and PID are working to identify quality indicators and triggers. They jointly developed mortality process and sentinel event process. Are working to identify quality indicators. PID has proposed several and will be focus of PIC meeting.			
4 Research quality indicators used by CMS or other certifying bodies and consider applicability to Hospital	9/30/2008		J Taylor, Exec staff

2) Dec 2008	***1*** *Expedite plans to identify quality indicators.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008	***2*** *Expedite the work of the Serious Incident Follow-up Work Group*	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
PID director to review work of serious incident follow up work group and develop structure for monitoring recommendation approval and implementation process.	4/30/2009		PID

XIII.C.1

disseminating corrective action plans to all persons responsible for their implementation;

Findings

See XIII.C.

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *See findings and recommendations above for XIII.C.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for XIII.C.			

2) Dec 2008 *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations in this section.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
see prior action steps			

XIII.C.2

monitoring and documenting the outcomes achieved; and

Findings

See XIII.C

Compliance Status: Minimal progress toward compliance date of June, 2010.

Recommendations	Responsible Party
1) Apr 2008 *1 See findings and recommendations above for XIII.C.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for XIII.C.			

2) Dec 2008 *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations in this section.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

XIII.C.3

modifying corrective action plans, as necessary.

Findings

See XIII.C.

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations	Responsible Party
1) Apr 2008 *1 See findings and recommendations above for XIII.C.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for XIII.C.			

2) Dec 2008 *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations in this section.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

XIII.D.

Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.

Findings

See XIII.A. and B. The Director, Performance Improvement Division, is working with the Performance Improvement Committee to set performance goals. Goals may be available at the time of the March, 2009 visit.

Compliance Status: Minimal progress is being made toward the June, 2010 compliance date.

Recommendations	Responsible Party
1) Apr 2008 *1 Select a limited number of performance goals and take steps to ensure that the*	**PID; EXEC**

entire hospital is aware of these goals and that the administration is counting on each staff member and individual to move the hospital toward achieving them.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Medical Staff Exec Committee and Exec staff to identify 4-5 performance goals for remainder of FY 2009. Goals should be in areas for which data is available.	4/30/2009		CEO
	- Status: February 2009 Update: PIC is working with PID to develop a limited number of performance goals which will reflect critidal areas in which data is available.			
2	Data will be collected on goals and will be incorporated into Trend Analysis.	11/20/2008		PID
	- Status: Feb 2009 Update: Data tracking progress in meeting performance goals will be included in trend analysis within 60 days of goals being identified.			
3	Performance goals and progress will be routinely reported at "All staff" meetings, senior staff meetings and will be posted on internet.	6/30/2008		

2) Dec 2008 ***1*** *Identify performance indicators and set performance goals.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008 ***2*** *Promulgate these indicators and performance goals hospital-wide.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008 ***3*** *Trend performance.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action step			

XIV. Environmental Conditions

Summary of Progress

1. The Hospital's Safety Officer led two environmental surveys for 4th Quarter, 2008 and 1st Quarter, 2009. The overall average rating for each indicator Hospital wide improved from 3.7 to 3.8. JHP 1 received the highest rating. Laundry room and storage rooms showed improvements and yet further improvement is needed.

2. The Hospital is modifying the environmental checklist to include identification of potential suicide hazards.

3. The Hospital is on target to move most patients into the new Hospital by Spring, 2010.

4. DCFD approved the fire plan.

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:

Findings

See sub cells for specific findings.

Compliance Status: See sub cells for compliance update.

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.

Findings

The Hospital's Safety Officer charged with assessing the environment of care and patient and employee safety. See Binder XIV, Tab # 1 (PD for Safety Officer). The Safety Officer conducts a monthly walk-through of the hospital to look for potential hazards and is refining the environmental checklist. The Infection Control Coordinator also conducted reviews of the wards and patient areas until her resignation. The Safety Officer is to work with the Risk Manager to revise the current checklist of safety items to guide the walk-through. Finally, nursing has developed a checklist as well to conduct regular environmental checks on the units. A new Infection Control Officer has been hired and is set to start work March 23, 2009. Tab #s 4 and 5.

In addition, the Hospital continues to conduct a periodic environmental surveys using staff and outsiders as review teams. See Binder XIV, tab # 2 for most recent environmental surveys.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Identify a list of possible suicide hazards, paying particular attention to bathrooms and bedrooms where most suicides in institutions occur. Prioritize the correction of these hazards, determining timelines and cost.*	***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Safety officer will conduct monthly walk through of all patient units to identify potential suicide hazards, using instrument he develops.	8/7/2008	Binder XIV, tab # 3 (Hospital Safety Inspection and Reporting Schedule: August to December 2008); Tab # 4 (Update safety inspection list), Tab # 2 (Environmental surveys)	Bob Winfrey

- Status: The Safety Officer began inspections of all patient occupied areas in September 2008. The 1st Quarter 2009 Environmental Survey data collection kicked-off the week of 12/8/08 and was completed January 30, 2009. A draft report is expected to be completed in mid-March 2009.

2	Continue process of quarterly Environmental survey and report same.	9/30/2008	Binder XIV, tab # 3 (Hospital Safety Inspection and Reporting Schedule: August to December 2008); Tab # 4 (Update safety inspection list), Tab # 2 (Environmental surveys)	Bob Winfrey

- Status: The Safety Officer began inspections of all patient occupied areas in September 2008. These findings were distributed to responsible department heads on 10/29/08. Findings from the most recent monthly inspection will be distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by 12/19/08. The 1st Quarter 2009 Feb 2009 Status: The Safety Officer continued inspections of all patient occupied areas in November, 2008. Results of inspections were distributed to responsible department heads on 12/9/08. Findings from the January monthly inspection were distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by 2/11/09. The 1st Quarter 2009 Environmental Survey data collection kicked-off the week of 12/8/08 and was completed January 30, 2009. A draft report is expected to be completed in mid-March 2009.Environmental Survey data collection is kicking-off the week of 12/8/08.Feb 2009 Status: The Safety Officer continued inspections of all patient occupied areas in November, 2008. Results of inspections were distributed to responsible department heads on 12/9/08. Findings from the January monthly inspection were distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by 2/11/09. The 1st Quarter 2009 Environmental Survey data collection kicked-off the week of 12/8/08 and was completed January 30, 2009. A draft report is expected to be completed in mid-March 2009.

1) Apr 2008 ***2*** *Include this list of suicide hazards on the environmental checklist or identify another method for the periodic and systematic review of each of the areas to which individuals have access.* ***PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify the environmental survey checklist to include the identification of areas that may pose a suicide hazard risk.	7/28/2008	Binder XIV, tab # 5 (Monthly Safety Inspections checklist)	Bob Winfrey, Jacquelyn Ehrlich

- Status: The monthly safety inspection tool has been modified to assess potential safety hazards, infection control risks and other occupational safety hazards (see attached document Behavioral Health Patient Safety Assessment Tool).

2	See action steps in XIV.A recommendation 1			

1) Apr 2008 ***3*** *Alert staff to the presence of suicide hazards on their units.* ***PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct a public awareness campaign to sensitize nursing staff of areas that are at risk of posing suicide hazards.	7/15/2008		Bob Winfrey, Risk Manager

- Status: The safety officer began on 8/1/08 working with the Administrative Officers and Nursing at both the Forensic and Civil hospitals to address potential suicide hazards, including purchasing and installing break-away shower curtain rods and transparent shower curtains. The Risk Manager and Safety Officer will review the current Nursing Orientation and Annual Training. curricula to determine whether suicide risks are adequately addressed during these trainings and make recommendations to the Hospital training Director by 1/31/09. The Safety Officer and the Hospital Risk Manager will also initiate a public awareness campaign in early 2009. The campaign will include the creation of a flyer identifying potential suicide hazards to be posted in all nursing stations and conducting a presentation regarding suicide hazards at the combined Forensic and Civil Nursing Managers and Senior Staff Meetings in January 2009. . Feb 2009 Status: The break-away shower curtain rods and transparent shower curtains have been purchased and installed in all Forensic Units as of 9/15/08.The Hospital's Risk Manager resigned on October 15, 2008 and at that time, this project was placed on hold. The new Risk Manager reported to duty on January 5, 2009. The new Risk Manager completes her orientation. In addition a new Director of Training was hired in January, 2009 and the new Risk Manager and Safety Officer will revisit this project in March 2009

2 Share results of Environmental Survey.	8/7/2008	Binder XIV, tab # 2 (Environmental survey reports)	Bob Winfrey

- Status: The Safety Officer began inspections of all patient occupied areas in September 2008. These findings were distributed to responsible department heads on 10/29/08. Findings from the most recent monthly inspection will be distributed to the COO, Medical Director, Chief Nurse Executive and Civil and Forensic Directors by 12/19/08. The 1st Quarter 2009 Feb 2009 Status: The Safety Officer distributed the 4th Qtr.FY-08 Environmental Survey Report to the Hospital's Executive Staff on December 19, 2008. The 1st Qtr. FY-09 Environmental Survey Report Data has been collected and is currently being analyzed. The draft report will be completed by mid-March 2009.Environmental Survey data collection is kicking-off the week of 12/8/08.

3 See XIV.A. recommendation 1 for additional steps

2) Dec 2008 ***1*** *Implement the use of the Safety Inspection Checklist and advise units of the findings.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps			

2) Dec 2008 ***2*** *Develop a plan for addressing the safety/suicide hazards found considering the level of risk associated with each.* ***PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Safety Officer, Risk Manager and Director, PID to meet to develop plan	4/30/2009		Robert Winfrey; Risk Manager

XIV.B.

By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.

Findings

DMH no longer requires the Hospital to report incidents of patients found with cigarettes. The Hospital completed a policy governing patient searches and contraband. Binder XIV, tab # 14, 15. The safety office checklist includes an item to report signs of contraband. Binder XIV, tab # 5

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations ***Responsible Party***

1) Apr 2008 ***1*** *Enter into conversations with DMH regarding its expectation that the hospital report incidents that involve finding only cigarettes.* ***PID; PJC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discuss with DMH need to notify them of incidents involving cigarettes with no injury	6/30/2008		Risk Manager

Complete - Status: DMH agrees that it will not need to be notified.

1) Apr 2008 *2 Revise the building inspection checklist to include evidence of contraband or find an alternate method that would meet the same objective.* ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Security will develop a draft Contraband Form to be used as a guide by security and nursing staff to screen more thoroughly for contraband. The first draft of this form will be submitted to the COO for review by July 15, 2008.	8/1/2008	Binder XIV, tab # 15 Contraband policy; Tab # 14 (Patient Search policy) tab # 5 (Monthly Safety checklist)	Savannis Peoples
- Status: Draft procedures and contraband form will be submitted to COO for review on 12/12/08. Feb 2009 Update: The draft contraband policy was submitted for Executive Review in February 2009.			
2 ES form requires reviewers to note if there was evidence of contraband such as cigarettes.	6/30/2008	Binder XIV, Tab # 5 (Monthly Safety checklist)	
Complete			

1) Apr 2008 *3 Reorganize and revise the draft "Patient Search" policy.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Patient Searches Policy.	9/15/2008	Binder XIV Tab # 15 (Contraband policy); #14 Search Policy	J Taylor
- Status: Policy currently under revision. Feb 2009 Update: Patient search policy finalized Contraband policy approved			

2) Dec 2008 *1 Add contraband issues to the Safety Inspection checklist.* ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Revise safety checklist to include contraband items	2/13/2009	Binder XIV, Tab # 5	COO
Complete - Status: Feb 2009 Status: The monthly safety inspection checklist has been modified to include a check for contraband items.			

2) Dec 2008 *2 Revise the Patient Search policy as planned.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See prior action steps		Binder XIV, tab #14	PID
Complete			

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 saf

Findings

The Trend Analysis includes data on incidents involving assaults/altercations, elopements and injuries that could be attributable to supervision issues. Binder XIV, Tab # 8 (Trend Analysis)

The Hospital's UI revised policy requires that the Risk Manager conduct investigations into all incidents involving serious injury to patients or staff, elopements of potentially dangerous individuals, deaths, suicides or attempted suicides, and allegations of patient abuse and neglect. As of the writing of this report, the Risk Manager is conducting investigations into these categories of cases, although as previously noted, the number of reports of patient abuse or neglect is lower than one would anticipate.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	***Responsible Party***
1) Apr 2008 *1 Conduct an investigation into all incidents that result in serious injury, looking to*	***PID; BG; Risk Manager***

make findings on the adequacy of staffing levels, staffing assignments, and neglect in the form of failure to provide adequate supervision.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager or MHA will conduct investigations into all such incidents and will address factors that led to incident, as reflected in UI policy	7/31/2008	Binder XIV, Tab # 10 (UI policy)	Risk Manager
Complete - Status: Ongoing.			
2 Sentinel event policy will be reviewed and updated as necessary.	8/29/2008	Binder XIV, tab # 17 (Sentinel Event policy)	Risk manager
Complete			
3 RM or MHA will conduct investigations into all incidents involving serious injury and reports will consider staffing, supervision and assignments.			Risk Manager
- Status: Ongoing			

1) Apr 2008 ***2*** *Conduct investigations into the unauthorized leaves of potentially dangerous individuals and those who are at risk because of their disability to determine the contributing factors, including those related to staffing levels and assignment.* ***PID; Risk manager***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Action steps for XIV.C 1			
2 Modify UI policy to clarify type of UI that is a major incident.	6/11/2008	Binder XIV, tab # 10 (UI Policy)	J Taylor
Complete			
3 RM to conduct investigations into UIs reporting elopements that involve forensic inpatients or other patients who may be at risk due to disability	7/31/2008		

2) Dec 2008 ***1*** *Continue efforts to reduce elopements.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Efforts to reduce elopements continue			

2) Dec 2008 ***2*** *Comment in the investigation reports on staffing levels at the time an incident occurred in order to identify staffing issues that may be contributing factors.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
RM to include staffing information in investigations, and will address if it may have impacted the incident	3/26/2009		PID

XIV.D. **Findings**

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 a

The elevators at JHP continue to have repair issues. Facilities is developing a tracking system to determine the nature of repairs and the length of time an elevator may be out of service. Binder XIV, tab # 13.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Include in the Facilities and Environment Monthly Status Report the date elevator problems were reported and the date they were fixed. Also include the date of any elevator inspections by local authorities.*	***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Begin tracking data regarding the breakdown and subsequent date of repair of elevators in the monthly Trouble Desk report to PID.	8/14/2008	Binder XIV, tab # 13 (trouble desk report)	Gilbert Taylor Tim Coefield Trouble Desk Analyst
- Status: FED continues to track data regarding the breakdown and subsequent date of repair of elevators in the monthly Trouble Desk Report to PID.			
2 Revise the Trouble Desk report to capture the dates on which repairs were completed and the dates of all DCRA and third party inspections.	8/14/2008		Gilbert Taylor
Complete - Status: Monthly trouble desk reports have been revised to capture the dates on which repairs were completed and the dates of all DCRA and third party inspections of all elevators			
3 Work with Facilities in developing report that includes analysis of environmental issues.	9/8/2008		OMS

1) Apr 2008	***2*** *Inventory the residential units of individuals using wheel chairs to ensure that whenever possible, these individuals are housed on the first-floor.*	***CVC; JH; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 RMB and Civil to assess patient mobility issues.	8/7/2008		
- Status: JHP layout will not permit wheelchair patients all to be on first floor. December 2008 Update: Forensic Services has a fully operational unit (Ward 2) for frail elderly and medically compromised post trial patients. The unit is on the second floor and patients/staff have direct access to the large courtyard by one flight of stairs. The unit is staffed by a psychiatrist who is board certified in gerontology and nursing staff with expertise in this area. The unit has been retrofitted with handrails on all corridors and other equipment to facilitate care and treatment of these patients with special needs.			

2) Dec 2008	***1*** *Implement an elevator service log that includes the date of the dysfunction and the date of the repair.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			
- Status: Feb 2009 Status: FED continues to track data regarding elevator status and records in the monthly trouble desk report. Reports for the month of September, October, November, and December 2008 were not submitted to PID. Report for January will be completed by 2/28/09			

2) Dec 2008 *2 Inventory the residential units of individuals using wheelchairs to ensure that whenever possible, these individuals are housed on the first floor.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

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.

Findings

DCFD approved the fire plan.

Compliance Status: Partial

Recommendations ***Responsible Party***

1) Apr 2008 *1 Take whatever steps are necessary to have the fire safety and evacuation plans approved by local authorities.* ***AS; Robert Winfrey***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update the existing Fire Prevention and Emergency Life Safety Plan and submit to the COO for review and approval.	7/1/2008	Draft Fire Prevention and Emergency Life Safety Plan Tab # 138	Robert Winfrey, Bridget Peterson, Bernard Phipps

Complete - Status: The draft Fire Plan was submitted to the DMH Risk Manager in July 2008.
The DMH Risk Manager submitted the plan to the Fire Marshall in July 2008 and copies of the final plan were distributed to all units in November 2008.

2 Update all floor plan diagrams for all occupied buildings to highlight all exits, areas to shelter in place, fire alarm pulls, fire extinguishers and areas of rescue.	8/7/2008		Robert Winfrey

Complete - Status: The floor plans for all occupied buildings were updated to highlight all exits, areas to shelter in place, fire alarm pulls, fire extinguishers and areas of rescue were approved by the Hospital Fire Inspector and submitted for review to the DMH Risk Manager on 7/2/2008. Upon approval by the Risk Manager, the plans will be submitted along with the Fire and Evacuation Plan to the Fire Marshall by July 31, 2008. Signs will be posted in all Shelter in Place locations in all floors beginning 8/7/08 and will be completed by 8/29/2008

3 Submit the approved Fire Plan along with Floor Plan Diagrams to the DMH Risk Manager who, upon approval, will submit it to the DC Fire Marshall.	7/31/2008		Robert Winfrey, Bridget Peterson, Bernard Phipps

Complete - Status: The draft Fire Plan was submitted to the DMH Risk Manager in July 2008.
The DMH Risk Manager submitted the plan to the Fire Marshall in July 2008 and copies of the final plan were distributed to all units in November 2008.

2) Dec 2008 *Ensure the Fire Prevention and Emergency Life Safety Evacuation Management Plan is approved as often as required by local ordinances.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Not Identified			

Complete - Status: Plan approved

XIV.F.

Findings

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 conditions in all living units and kitchen areas.

The Hospital completed environmental surveys for both 4th quarter 2008 and first quarter, 2009. Binder XIV, tab # 2. It is also conducting monthly inspections by the Safety Officer and the Risk Manager. Binder XIV, tab # 4, 5.

In July, due to issues with the fire hydrants experienced city wide, the Hospital began a fire watch for JHP, which continues.

Compliance Status: Progress is being made toward the June, 2010 compliance date.

Recommendations		***Responsible Party***
1) Apr 2008	***1*** *Revise the system of staff assigned to particular individuals to clarify the staff member's responsibility. At least weekly, the staff member should be responsible for documenting that he/she has ensured that the individual has personal hygiene items and clothes.*	***Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assigned nursing staff ensure patients have access to laundry and clean clothes			

- Status: Ongoing

1) Apr 2008	***2*** *Determine how best to solve the problem of laundering clothes with sufficient frequency that individuals have clean clothes.*	***AS; Chief Nurse Executive***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Evaluate the number and condition of washers and dryers on units.	8/29/2008		JH; CVC; AS; Donna Moran; Gilbert Taylor

Complete - Status: FED conducted an assessment of all washers and dryer on the units has been completed and reveals that washers and dryers are installed on all patient wards with the exception of JHP 5. There are 4 washers and 4 dryers in the RMB building, 10 washers and 10 dryers in JHP and 6 washers and 4 dryers in CT2 and 3. There are an additional 2 washers and 1 dryer in CT-7. A copy of the Washer/Dryer Inspection report is attached. Feb 2009 Status: The frequency of reports received by FED of malfunctioning and inoperability of unit washers and dryers is recorded in the monthly trouble desk report. This equipment continues to be maintained through contracted repair services. At this time, it has been determined that there is no need to purchase additional washers or dryers.

2 If needed, purchase additional washers and dryers or laundry supplies for patient use.	Donna Moran, Gilbert Taylor

Complete - Status: FED will continue to maintain washers and dryers utilizing contractor maintenance and repair services. There are no washers and dryers in CT2 because the building is vacant. At this time there is no requirement to purchase new washers and dryers. Laundry supplies, mainly laundry detergent are deemed critical and continue to be purchased through Materials Management. The Supervisor, Materials Management maintains the stock level to ensure that the stock does not fall below a minimal level. Nursing staff continue to use a 1509 form to request laundry supplies from Materials Management when needed throughout patient areas to wash patient clothing.

3	Establish procedures to ensure each patient has an assigned nursing staff member to assist with laundering clothes.	12/31/2008	Binder XIV, tab # 11 (Document called "Laundry List" used on the units to track patient use of laundry.)	CVC; JH

Complete - Status: February, 2009 2008 Update: Civil has procedures in which nursing staff "escort" patients to complete their laundry or complete the laundry for the patients who are unable. Patient laundry is tracked on units through the "Laundry List" document. The respective unit schedules also allocate specific times of the day for patients to compelete their laundry and address other personal hygiene issues. For example on RMB 3 Laundry is completed from 6 am to 8 am. For Forensic Services each unit has a posted "Laundry Schedule" and each patient has atleast 2 days a week to complete their laundry. Normally FPT's are involved in this activity but at times RN's may supervise. For some Forensic patients who have a need for additional laundry services due to their medical or paychiatric needs, nursing staff provide laundry services daily.

4	Ensure each ward has schedule to provide sufficient time for each patient to launder clothes at least every 5 days.	12/31/2008	Binder XIV, tab # 12 (Unit Schedules for RMB 3 and 5 as an example of Laundry times on unit schedules)	JH, CVC

Complete - Status: Both Civil and Forensic has laundry schedules with a mininum of two days a week and at times 2 hours a day for laundry to be completed.

1) Apr 2008 ***3*** *Determine whether the lack of clothing (particularly for men) and personal hygiene supplies is a matter of insufficient supply or a distribution problem and take appropriate action.* ***AS; Chief Nurse Executive***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Determine issues associated with lack of personal hygiene supplies.	7/25/2008		Clinical Function
2	Clinical staff are responsible for submitting request form 1509 to Materials Management Stock Rooms (RMB & JHP) whenever personal hygiene supplies are needed for patients			Donna Moran; Renee Bivins

- Status: There have been no backorders on file for 1509 request for patient personal hygiene supplies. Materials Management has been able to fill all requests submitted. A new Purchase Order for FY 09 is in place in the amount of $5,000.00 to order personal hygiene supplies.

2) Dec 2008 *Initiate the planned nursing reviews of unit safety and cleanliness with particular emphasis on clothing storage and bathroom cleanliness and supplies.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			