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

Saint Elizabeths Hospital Compliance Report 5

April 9, 2010

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Chief Compliance Officer

V. Integrated Treatment Planning

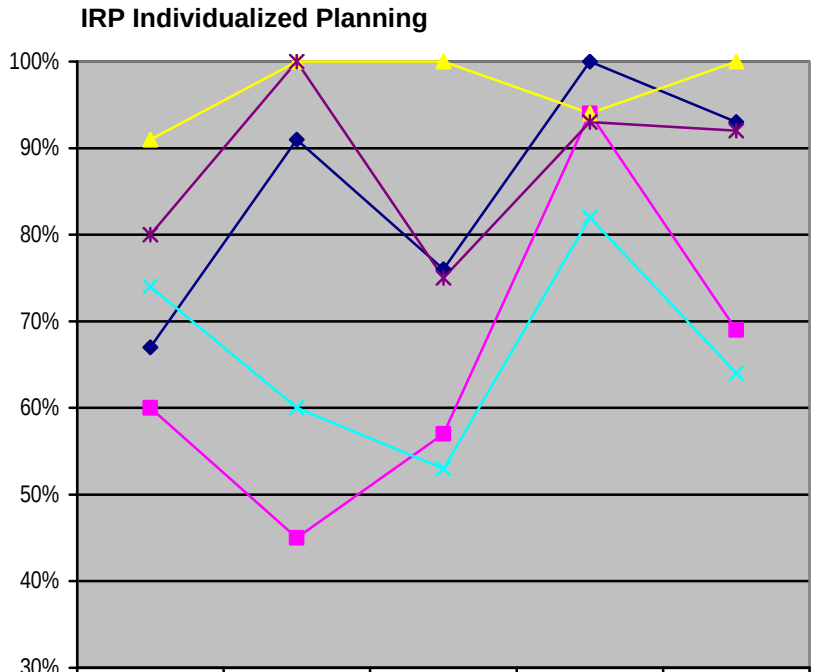
No	Requirement	Progress/Findings
	By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.	**Summary of Status/Progress:** 1. The Hospital continues to train staff and strengthen IRP development skills, although delays in executing a contract for additional training somewhat adversely affected progress. 2. During this review period, coaching in the process of development of the IRP occurred on five units (RMB 3, 4, 5, 6 and JHP 10). The coaching included observations of the IRP conferences on these units by the various coaches (who are the internal Hospital experts on IRP development) and then mentoring was targeted based upon observed needs. Coaching is complete on RMB 3 and 4 and continues on RMB 5, 6 and JHP 10. Staff have not yet been trained on writing the IRP - - that is the purpose of the recently awarded IRP training contract. 3. Additional training of the Clinical Administrators in development of the clinical formulation and clinical formulation update was completed, and included the actual joint development of a clinical formulation update. Additional training for Clinical Administrators was provided on positive behavioral support. 4. A contract for outside assistance in training on IRP development, including the writing of goals, objectives and interventions was recently finalized. The contractor is expected to be on site beginning late April or early May. The scope of the training includes targeted coaching around all aspects of IRP development. 5. Existing IRP forms were modified to address issues raised by DOJ reviewers in their last visit, including removing duplication within the form. As of the middle of March, 2010, IRPs (all types) are being completed in Avatar. 6. The IRP Manual has been revised to reflect modifications in various forms and to provide model clinical formulation/updates and IRPs. Additionally, examples of objectives and interventions have been improved. The policy section was also updated, and the checklist, tips sheets and instructions were modified to reflect some efficiencies in the Phase I presentations, 7. The Hospital continues to make progress in the conduct of IRP conferences. The conferences overall are more efficient, and attendance of nursing and psychology is much improved. IRP conferences are functioning in an organized manner. 8. Changes in the treatment programs will be implemented in May, 2010, when most of the individuals move to the new hospital building. (This is discussed in more detail in Chapter VIII.) The Hospital now is able to track scheduled active treatment hours through Avatar for its individuals, although it is aware that staff are still not inputting all data around treatment scheduled or attended and therefore the data is not yet accurate.

No	Requirement	Progress/Findings
		9. The Hospital continues to monitor IRP conferences through observations. It modified the IPR process observation tool in November, 2009 (no observations were conducted during that month as a result), to address inter-rater reliability issues and to better capture the type of data it found most useful in identifying training needs or quality issues. While this makes trending difficult at this point for some indicators, ultimately is should assist clinical leadership in developing quality improvement strategies. This will be discussed in more detail below. 10. The Hospital's therapeutic monthly progress note will be completed in Avatar beginning in May, 2010. Both the written form and Avatar form require staff to relate provided interventions and progress to IRP objectives. An audit tool and instructions for the therapeutic progress note were finalized, and audits began in mid March, 2010. Data are expected to be available during DOJ visit. 11. Clinical chart audits have not begun, though a new strategy was developed which targets improvement in the clinical formulation and clinical formulation update. The Hospital revised significantly its clinical chart audit tool based upon a phased implementation of clinical chart audits, with the initial focus on the clinical formulation/ clinical formulation update. This strategy may be reconsidered as the new IRP consultation contract was recently finalized. 12. All disciplines are conducting self audits of initial assessments and the monthly updates. Psychiatry, Social Work, Nursing, Psychology and Rehabilitation Services audit their initial assessments, and psychiatry, and social work audit the monthly updates as well. Psychology completed audit tools for its remaining assessments and is beginning audit in August 2010. Nursing is evaluating the update audit tool. 13. Transfer audits are continuing.
	A. Interdisciplinary Teams	
	By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	
V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Findings:** See findings in V.A.2 to V.A.5, V.B, V.C, V.D and V.E for additional information. Overall, the Hospital continues to perfect its IRP training using a combination of internal

No	Requirement	Progress/Findings
		experts/coaches, and recently contracting for outside consultant support. This training includes didactic, observational and mentoring components. Internal training over the past six months implemented two strategies. The first included targeted training of clinical administrators as the authors of the clinical formulation/update and the IRP document. Training included small group work in the actual writing of a clinical formulation update, and included how to use information from assessments in developing the update. This was followed by one training session in the development of an IRP, using the clinical formulation update the groups had developed. Staff were provided with a model IRP and focused on developing measurable and attainable individualized focus statements, objectives and interventions. Also, these staff received training by the PBS team leader on the goals of PBS and how it can be used to support individuals in care. *See Tab # 1, IRP training curricula and data.* In addition to this training, five units have received or are receiving IRP coaching. The units include RMB 3 (complete) and 4 (complete) and RMB 5, 6 and JHP 10 which is ongoing. Coaching includes review of the records, IRP observations, providing feedback to the team members and assisting with the revising of the clinical formulation/update and the IRP. (There will be some realignment of treatment team staff upon move to the new hospital as it moves from 15 units to 13 units, so training may need to be renewed for some units.) The IRP Manual was updated with model clinical formulations/updates and a model IRP, and new examples of statements of focus areas, objectives and interventions are included. *See IRP Manual*. In late November 2009, the Hospital announced a request for proposal for training around IRP development and a contract was awarded in mid March, 2010. The contract includes: • Training (to include coaching and mentoring) on 8 units, with 4 units completed by June 30, 2010 and the remaining 4 units completed by September 2010; • Dedicated training of psychiatrists; • Development of written tools and strategies for each discipline around IRP preparation and participation; • Training of clinical administrators around clinical formulation/update writing, including provision of examples to be included in the IRP manual; • Training IRP teams on developing and integrating individualized needs, focus statements, objectives, goals and interventions; • Training on writing the IRP and development of a comprehensive written set of

No	Requirement	Progress/Findings
		examples of focus statements, objectives, goals and interventions; • Review of and recommendations for further revision of the IRP manual • Assistance with development of clinical chart audit tool. Services under the contract are expected to begin in April, 2010 and continue through the remainder of the fiscal year. *See Tab # 2 IRP Training contract.* There continues to be improvement in the quality of the IRP conferences themselves, with better presentation of present symptoms and improvement in the content of clinical formulation/update in general. While there is some progress in some of the written IRP however, it continues to lag behind the progress in the IRP process. The above described training is expected to address those areas in which improvement is still needed. To improve the assessment of performance in the IRP conferences, the Hospital's Performance Improvement Department (PID) modified its IRP observation tool and instructions based upon the auditors experience with the tool. From April 2009 through September, 2009, the tool used was titled “”Integrated Treatment Planning – IRP Observation Tool”. That tool was modified for the October, 2009 observations (form is titled “IRP Meeting Observation Tool” dated 9/13/2009), but PID determined that additional modifications were required to address inter-rater reliability issues, and to capture data that would be more useful to treatment teams working to improve their performance. The tool was thus again modified in November (no observations were done in November, 2009) and a new “IRP Meeting Observation Tool” is now being used. *IRP Process Monitoring Tool/Instructions, Tab # 8*. The IRP Monitoring Observation tool used beginning in December was a significant modification from prior tools. The changes reflect more focus on the review of the clinical formulation/update, particularly with respect to presentation of the individual’s present status. The tool also captures the individual team member’s contributions to planning, especially around the interventions provided and their effectiveness. *Tab # 8, IRP Monitoring Observation Tools, dated 12.14.09 and 2.1.10* Data from the reviews show that teams are improving in reviewing and planning with involvement of the individual around the individual’s life goal, strengths and in engaging the individual in discharge planning. Improvement is still needed around reviewing the individual’s progress, and in developing interventions with the individual’s input. See Data below.

No	Requirement	Progress/Findings



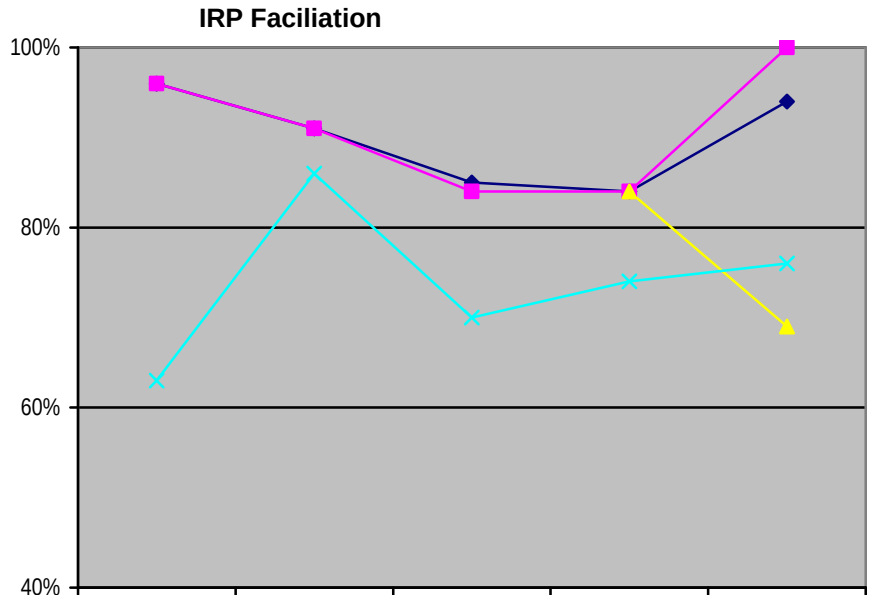
	Aug	Sept	Oct	Dec	Jan
Strengths reviewed	67%	91%	76%	100%	93%
Pt input into interventions	60%	45%	57%	94%	69%
Life goal discussed	91%	100%	100%	94%	100%
Review Pt Progress	74%	60%	53%	82%	64%
Engage Pt Discharge Planning	80%	100%	75%	93%	92%

See Tab # 8 IRP Monitoring Observation Forms/Instructions and Tab # 9, IRP Monitoring Observation Results for specific indicators and additional data.

The Compliance Office observed at least two IRP conferences on 10 of 15 units and progress continues on all units. While the team's performance in Phase I continues to be stronger, progress is being made in Phase II of the IRP conference, especially around engaging the individual in a more productive discussion of individual goals and in discussing progress on meeting objectives. In most IRPs observed, assessment was not occurring. However, additional improvement is needed in the development of objectives

No	Requirement	Progress/Findings
		that are more specific and realistic given the individual's symptomotology; the same is true of the development of interventions. This is expected to be addressed by the consultant who will provide coaching as well as training on writing IRPs. **Compliance: Partial**
V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Findings:** All treatment teams are led by a treating psychiatrist. At the time of the writing of this report, there are 15 treatment teams. Each admissions unit (RMB 6, RMB 4, JHP 6, JHP 7 and JHP 9) has two psychiatrists assigned, and each continuing care units (RMB 1, 2, 3, 5, 7, and JHP 1, 3, 8, 10, and 12) has at least one psychiatrist assigned. Upon move to the new hospital, there will be a total of 13 units, 11 in the new building and two in the RMB Annex. There will be one admissions unit that will serve civil admissions (capacity is 27 patients); it will have two treatment teams (each teams will consist of a psychiatrist, clinical administrator) as a well as two social workers and psychologists. The unit will be supported by one nurse manager. The remaining admissions units, presumably serving forensic admissions, will have two psychiatrists, one clinical administrator, one nurse manager, one social worker and one psychologist. Each continuing care unit will have psychiatric coverage that will meet the required caseload standards of 24:1. *List of ward based staff (current and post May 3, 2010), Tab # 43.* See also subcell V.A.4 regarding core team members. **Compliance: Substantial**
V.A.2.a	assume primary responsibility for the individual's treatment;	**Findings:** Each team's treating psychiatrist is primarily responsible for the individual's treatment, and is supported by the clinical administrator who coordinates the IRP scheduling and process. The team decides which team member will facilitate the conference. Data from the IRP observations show continued improvement in the facilitation and organization of the IRP conference. The checklist was revised to remove time targets for IRP conferences. *See IRP Manual.* On-going internal mentoring and anticipated coaching through the recently awarded contract is expected to continue improvements in the process around IRP conferences. Data from IRP conference observations is collected to assess the performance of the facilitator. Among the relevant indicators, the Hospital is collecting information includes an indicator to ensure all team members are encouraged to participate and to provide input on

No	Requirement	Progress/Findings
		the individual in care's present status. Data show:



	Aug	Sept	Oct	Dec	Jan
Facilitator encourage all participation	96%	91%	85%	84%	94%
Discipline updates present status	96%	91%	84%	84%	100%
Structure by focus area	n/a	n/a	n/a	84%	69%
Key focus for Phase II identified	63%	86%	70%	74%	76%

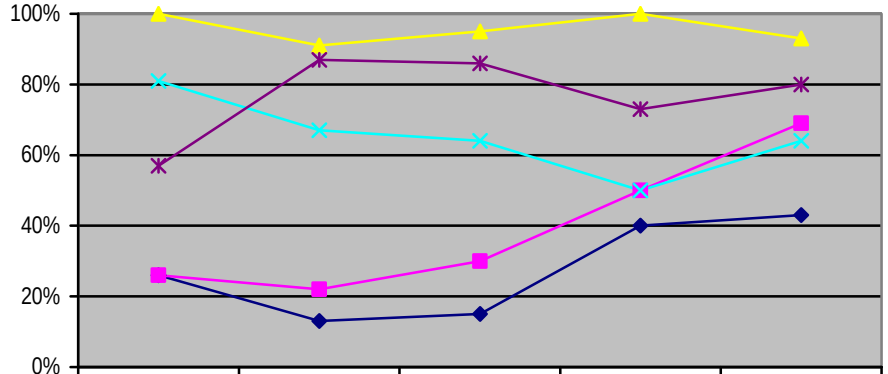
IRP Monitoring Observation Audit results, Tab # 9.

Compliance: Partial

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:** Data is also collected concerning the individual's participation in IRP conferences as well as participation by families and community members.

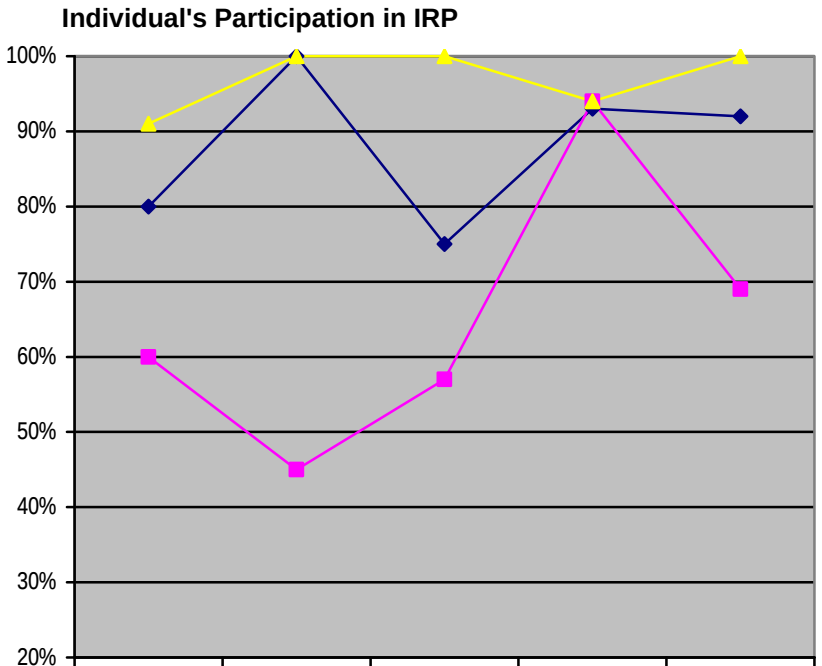
No	Requirement	Progress/Findings

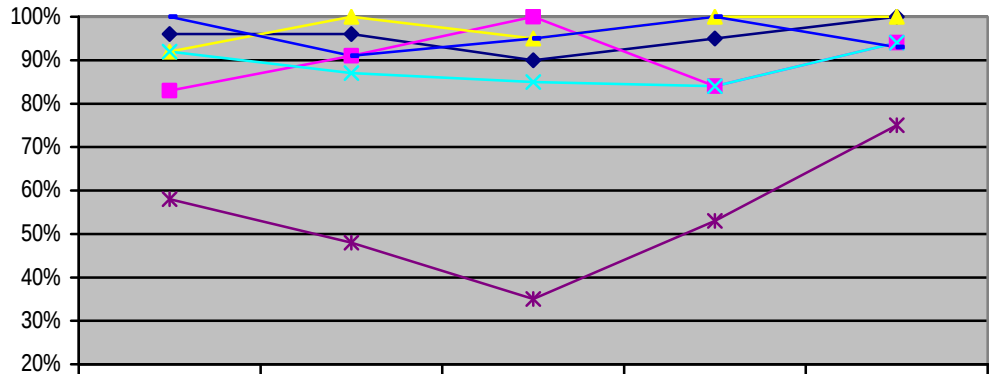
Non-hospital attendance at IRPs



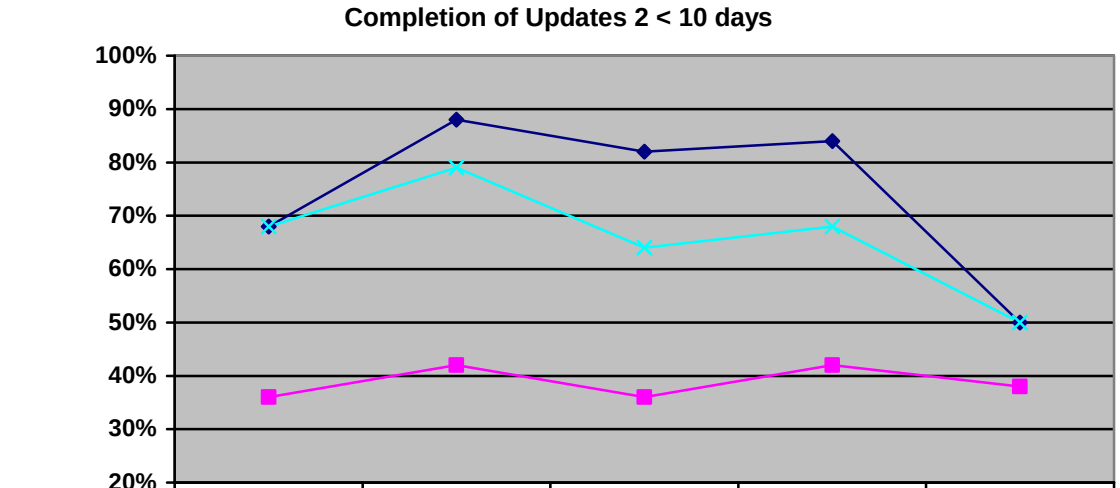
	Aug	Sept	Oct	Dec	Jan
Family attending	26%	13%	15%	40%	43%
Community attending	26%	22%	30%	50%	69%
Individual attending	100%	91%	95%	100%	93%
Family invited	81%	67%	64%	50%	64%
Community invited	57%	87%	86%	73%	80%

While the attendance of family and community is in general low, attendance is gradually increasing and they are being invited at a higher rate – family is invited to IRP conferences at a range of 50% to 81% of applicable cases (family member is known and individual consents), and community support workers at a range of 57% to 87% during the period of August 2009 through January, 2010. Observers also are monitoring the degree of the individual's participation in actual planning.

No	Requirement	Progress/Findings
		 Aug / Sept / Oct / Dec / Jan Indiv has input in d/c planning: 80% / 100% / 75% / 93% / 92% Indiv. Input Interventions: 60% / 45% / 57% / 94% / 69% Life goal: 91% / 100% / 100% / 94% / 100% While performance is generally trending up on these indicators, additional involvement of the individual in developing interventions is needed. *See IRP Monitoring Observation Results, Tab # 9.* Changes in how TLC groups are going to be selected upon move to the new building, as well as co-location are expected to impact this indicator positively. *See Tab # 69, Treatment Programming Summary.* **Compliance: Partial**
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	**Findings:** Each core member of the team, (psychiatrist, nurse and social worker) completes a monthly update, and treatment providers also complete a monthly therapeutic progress

No	Requirement	Progress/Findings
	treatments;	note. All disciplines are now conducting monthly audits of the initial assessments and assessment updates (nursing to begin in April or May) to assess timeliness and quality. Data are presented in Chapter VI below for each discipline. In addition, audits of therapeutic progress notes were conducted for the first time in March, 2010. This data will be available during the DOJ visit. IRP observers also review discipline attendance, completion of updates prior to the IRP conference and participation in the IRP conference. Data show core members (psychiatrist, nursing and social worker) are attending the conference in over 90% of the cases, and psychology's attendance is improving as well. See chart below for data of all disciplines. **IRP ATTENDANCE DATA**  Aug / Sept / Oct / Dec / Jan Psychiatry: 96% / 96% / 90% / 95% / 100% RNs: 83% / 91% / 100% / 84% / 94% Clin Ad: 92% / 100% / 95% / 100% / 100% SW: 92% / 87% / 85% / 84% / 94% Psychology: 58% / 48% / 35% / 53% / 75% Individual: 100% / 91% / 95% / 100% / 93% *See tab # 9 IRP Monitoring Observation audit results.* Data also show that core members are completing their updates at least two days but not longer than 10 days prior to IRP conferences at lower than expected levels. Observers report that in many cases, updates are completed, but not within the 2 – 10 day window set by policy (i.e. they are completed the day prior to the IRP conference). See chart below.

No	Requirement	Progress/Findings



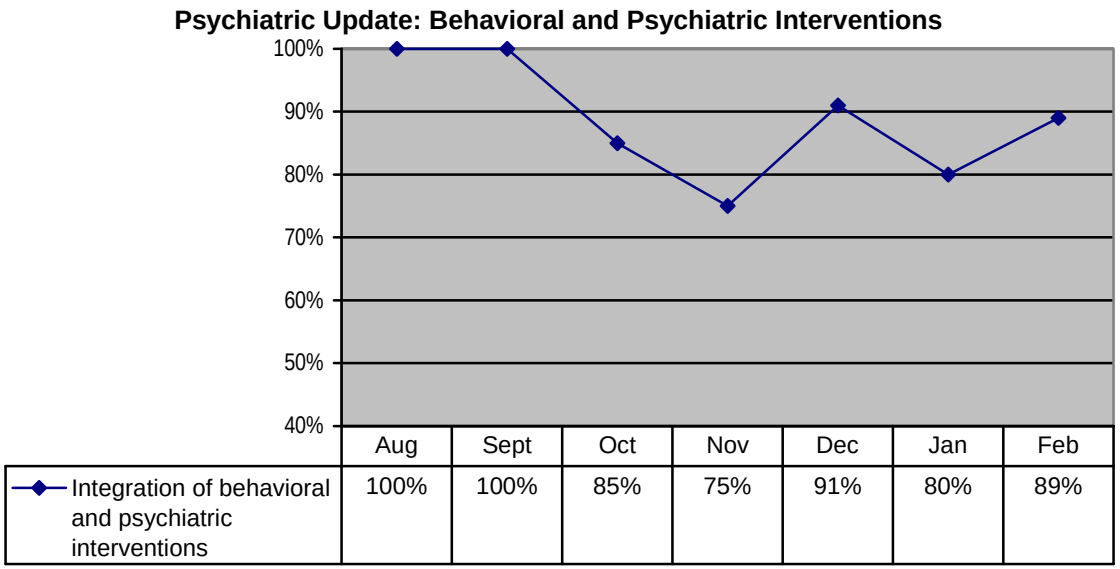
	Aug	Sept	Oct	Dec	Jan
Psychtry	68%	88%	82%	84%	50%
RNs	36%	42%	36%	42%	38%
SW	68%	79%	64%	68%	50%

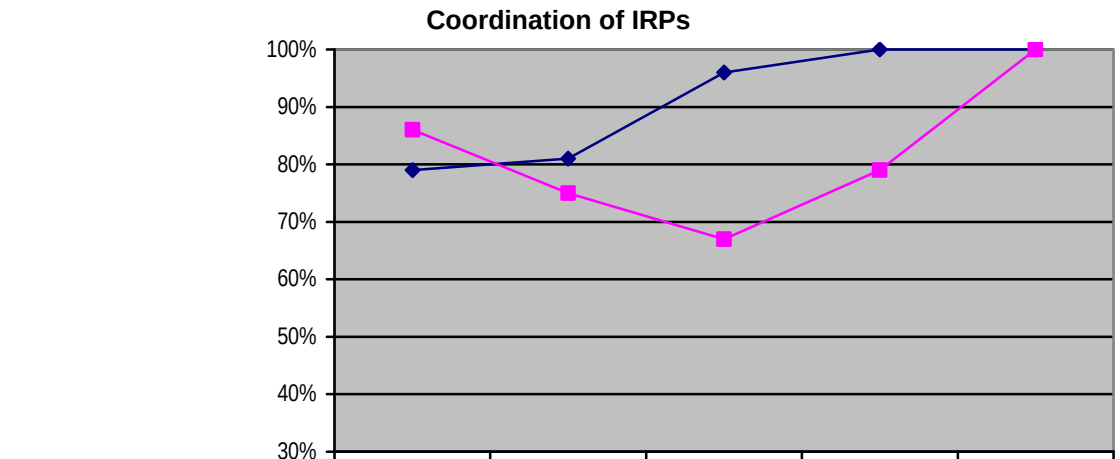
The most recent audit tool for IRP observations is tracking participation by discipline in presenting information about interventions they are providing. Data is only available for December and January, so no trends can yet be identified. The data show that staff are performing better at providing general descriptions of interventions but the performance of all disciplines is inadequate in discussing interventions with any degree of specificity and in suggesting alternative interventions that might be more effective in addressing outstanding issues.

Indicator	Dec 09	Jan 10
RN discussed in general interventions nursing providing	75%	75%
RN discussed specifics about interventions nursing is providing	58%	69%
RN discussed progress or lack thereof as a result of nursing interventions	58%	69%
Psychiatrist discussed in general interventions he/she is providing	95%	100%
Psychiatrist discussed specifics about interventions he/she is providing	88%	69%
Psychiatrist discussed progress or lack thereof as a result of psychiatric interventions	94%	94%
SW discussed in general interventions sw is providing	76%	80%
SW discussed specifics about interventions sw is providing	75%	62%
SW discussed progress or lack thereof as a result of social work interventions	33%	58%

No	Requirement	Progress/Findings
		Tab # 9, IRP Monitoring Observation results. The Assessment and Medical Records policies were reviewed and updated to ensure consistent time frames. The policies make clear the expectation is for monthly updates by psychiatry, nursing and social work after the first thirty days, and more frequent documentation during the first month of hospitalization. *Medical Records policy, Tab # 13, Assessment policy, Tab # 12.* **Compliance: Partial**
V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Findings:** See V.A.1 for update on IRP training activities and new IRP consultant contract. *See also Tab # 1 IRP Training summary.* The IRP Manual has been updated, and additional updates are expected as the IRP training and consultation contract is implemented. *See IRP Manual.* IRP observations are reviewing the interdisciplinary nature of the IRP conferences and performance continues to improve. A new method of measuring some aspects of the interdisciplinary nature of the conference was introduced in December 2009 around the discussion of the individual's progress so the data is not yet able to be trended. See V.A.2.c for the data. The Hospital continues to struggle with implementing clinical chart audits around the content of the IRP. Because in part the Hospital was soliciting for additional IRP training especially around the content of the IRP, the decision was to phase in clinical chart audits by first focusing on assessing the content and quality of the clinical formulation/update, and a new tool was developed and tested. *Tab # 10 Clinical chart audit tool/instructions.* Clinical chart audits are planned for May and the tool will continue to be reviewed and revised as needed. **Compliance: Partial**
V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Findings:** The Hospital continues to make slow progress in meeting this requirement. Psychology attendance at IRP conferences reached 75% in January, 2010, but it is too early to determine if that level of attendance will continue. Three new psychologists began work on March 29, 2010. The Hospital hired a new PBS team leader, as well as two PBS

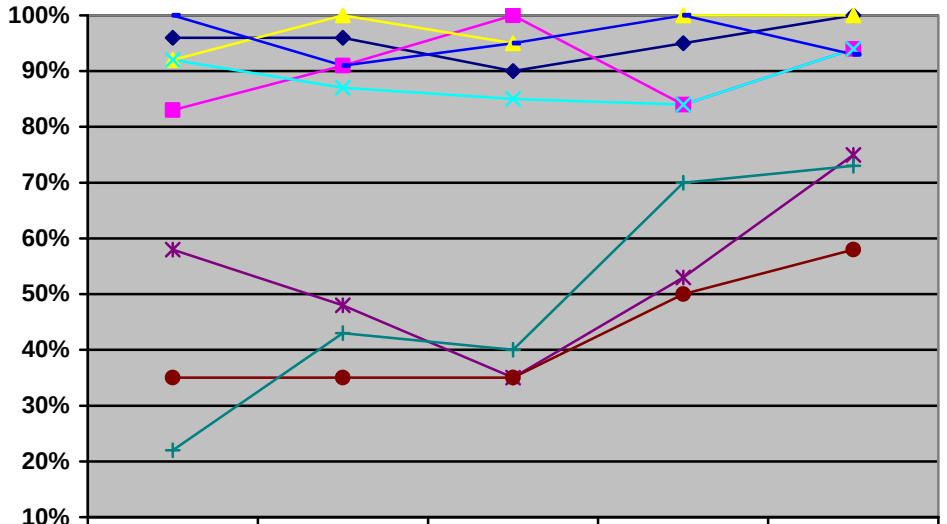
No	Requirement	Progress/Findings
		specialists. Recruitment is underway for a data specialist, and a nursing position will also be assigned to the team. Once the table of organization change is approved, recruitment for a PBS nurse to complete the team will begin. *Tab # 41, Vacancy Announcements, PBS Team.* The Hospital also announced a request for proposal for additional training of staff around positive behavioral support (PBS) principles in November, 2009 and a contract was awarded in March, 2010. The contract includes: • Training of all clinical staff in the PBS model; • Train the trainer trainings; • Coaching and mentoring of SEH trainers as they train SEH staff; • Ten days of on unit training of SEH unit staff; • Training PBS team; • Training unit-based psychologists in functional and structural assessments, behavior guidelines and PBS plans; • Support development of PBS tools. *See Tab # 89, PBS Contract.* There has been one PBS plan and two sets of behavioral guidelines completed since the last review. There are twenty individuals who have been referred to psychology for behavioral assessments. *Tab #18, Advanced Document request for Boggio.* The psychiatric update audits include an indicator to assess the integration of psychiatric and behavioral modalities. Data show:

No	Requirement	Progress/Findings
		 *See Tab # 11 Psychiatric Update audit results* **Compliance: Partial**
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 clinical administrator for each unit is charged with the scheduling and coordination of assessments, for completing the clinical formulation/update and for drafting IRPs. Data show:

No	Requirement	Progress/Findings
		 Aug | Sept | Oct | Dec | Jan Timely scheduling IRPs: 79% | 81% | 96% | 100% | 100% Held at time scheduled: 86% | 75% | 67% | 79% | 100% *Tab # 9, IRP Monitoring Observation audit results.* See V.A.2.c and V.A.4 for attendance data. Attendance of psychologists and rehabilitation specialists at all IRPs is not required by the Settlement Agreement as they are not defined as core member of the team under the Agreement. See V. A.4 Attendance of psychologists is tracked however. *Tab # 9, IRP Monitoring Observation audit results.* **Compliance: Substantial**
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:** See V.A.1. **Compliance: Partial**
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	**Findings:** Core team members as defined in the Settlement Agreement include the psychiatrist, nurse, social worker and clinical administrator, and each is attending at a rate above 90%. Neither psychology nor rehabilitation specialists are core members as defined in the Agreement, but the attendance of psychologists is tracked.

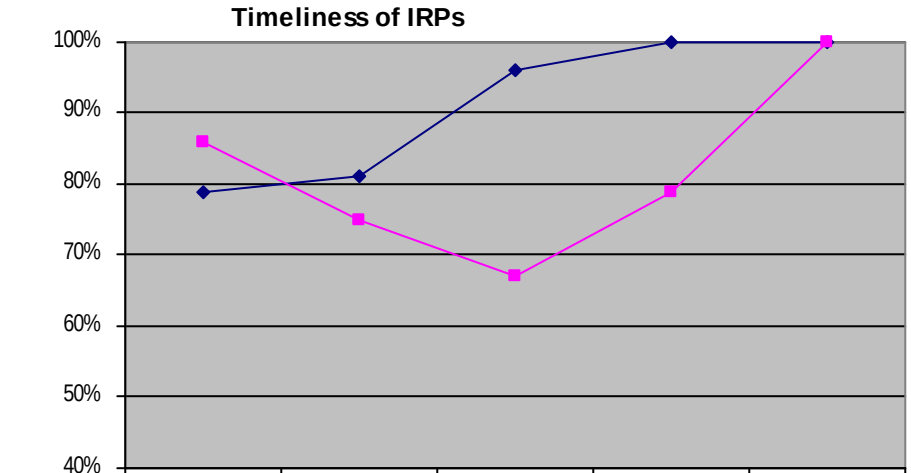
No	Requirement	Progress/Findings
	patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	Core members of the treatment team are attending IRP conferences in the significant majority of cases. Attendance by psychologists, GMOs, and other clinical staff who may be involved in treatment is improving.

IRP ATTENDANCE DATA



	Aug	Sept	Oct	Dec	Jan
Psychtry (core)	96%	96%	90%	95%	100%
RNs (core)	83%	91%	100%	84%	94%
Clin Ad (core)	92%	100%	95%	100%	100%
SW (core)	92%	87%	85%	84%	94%
Psychlgy	58%	48%	35%	53%	75%
GMO	35%	35%	35%	50%	58%
Other St.Es	22%	43%	40%	70%	73%
Individual	100%	91%	95%	100%	93%

Currently there are 15 units. All units have a dedicated clinical administrator and at least one psychiatrist. Some units have a part time psychologist and social worker, but that is expected to be resolved by the time of the move to the new hospital as the number of units will decrease from 15 to 13. *See Tab # 43, List of Ward Based Staff, Tab # 37, List of Psychiatrist by ward and board certification status.*

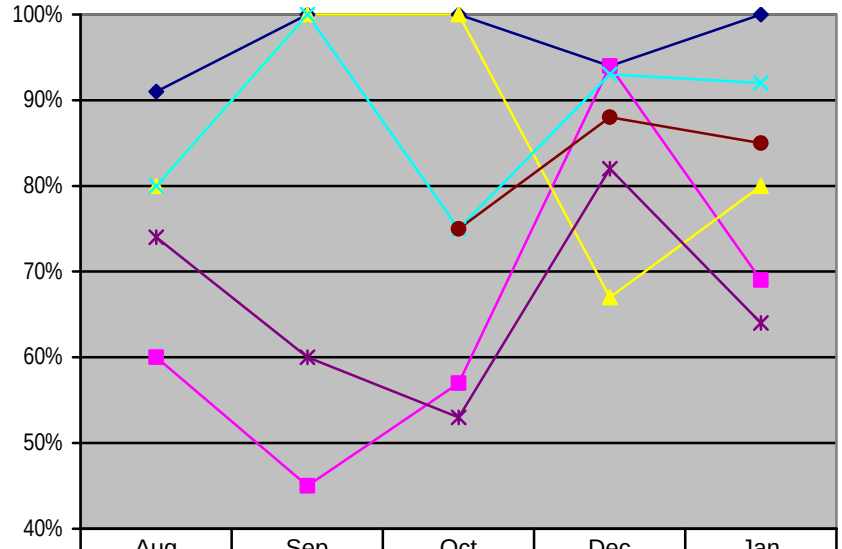
No	Requirement	Progress/Findings
		Compliance: Partial
V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Findings:** Review IRP conferences (30, 60 and every 60 days thereafter) are being held consistent with hospital policy in most cases, but there is not sufficient data to assess compliance with the 7 day conference requirement.  Most of the data available are for IRP reviews, either at the thirty day interval or at the sixty day interval. PID is working to develop a sampling mechanism for the 7 day IRP review and conference. It is also monitoring to ensure the IRP conferences begin as scheduled. Reasons for cancellation include psychiatric unavailability due to court or illness, the individual is unavailable due to clinic appointment or a recreational trip. The development of initial IRPs, comprehensive IRPs and IRP updates in Avatar was implemented in March, 2010. This should allow the monitoring of timeliness through an Avatar management report. Initial data should be available at the time of the visit. **Compliance: Partial for comprehensive IRPs, Substantial for Review IRPs.**

	Aug	Sept	Oct	Dec	Jan
Timely scheduling IRP reviews	79%	81%	96%	100%	100%
Held at time scheduled	86%	75%	67%	79%	100%

No	Requirement	Progress/Findings
	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:	
V.B.1	where possible, individuals have input into their treatment plans;	**Findings:** See V.A.1 around IRP training/mentoring information as well as the consultation contract that will support additional training around individual engagement. See also Section V.A.4 for data on individual attendance at IRP conferences. The Hospital updated the IRP manual. The revised IRP Manual includes a tip sheet regarding the engagement of individuals and coaches are providing guidance during their work with treatment teams. In addition to feedback from the coaching and mentoring teams, observers are also providing feedback to teams immediately following the conclusion of the IRP conferences. *Tab # 1, Training summary and guidelines for feedback and coaching.* The Hospital also made substantial modifications to the IRP Monitoring Observation Audit form and instructions to reduce inter-rater reliability issues and to obtain more useful data around the individual's participation in IRP planning. *See Tab # 8, IRP Monitoring Observation tools/instructions.* Indicator 7 (formerly indicator 8 in tool used in August, Sept and Oct) identifies a number of factors that measure whether the individual has meaningful input into the IRP. Data is collected as to whether the team discusses with the individual his or her life goal and gives it due consideration, reviews progress with the individual, and obtains input into objectives and interventions. Further, there is a specific indicator that addresses if the team addressed cultural preferences, such as cultural identification, involvement or preferences with the individual during the conference. *Tab # 8, IRP Monitoring Observation Tool/Instructions.* As indicated in the chart below, the Hospital is monitoring the individual's participation through a number of indicators. Areas of strength include the discussion of the individual's life goal, getting the individual's input into objectives and his or her participation in discharge planning and in incorporating cultural preferences. Improvement is needed in reviewing the individual's progress and in obtaining input into interventions.

No	Requirement	Progress/Findings

Individual's Participation

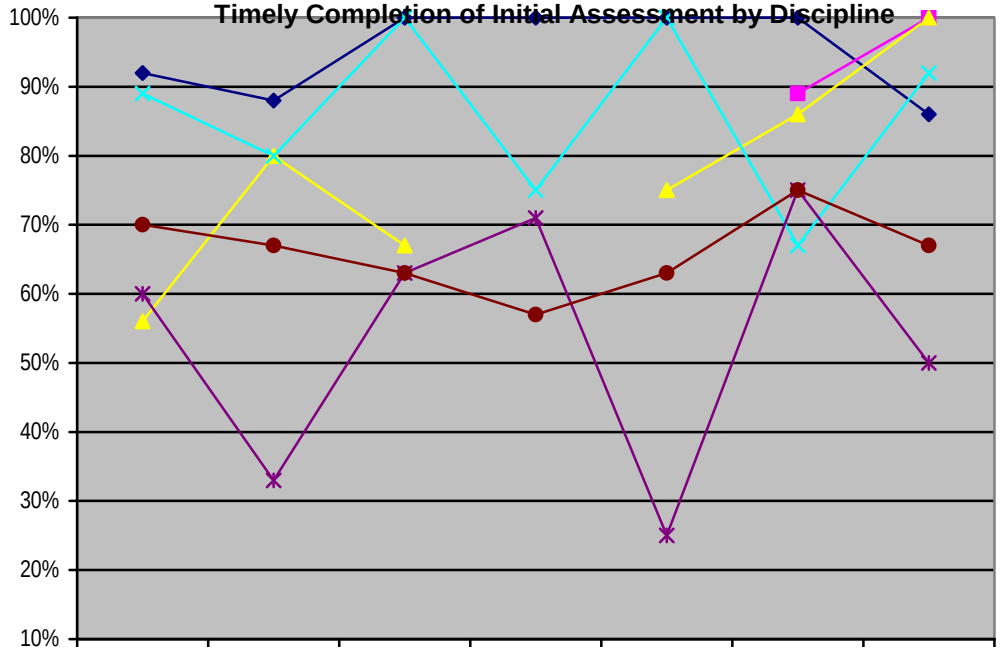


	Aug	Sep	Oct	Dec	Jan
Discuss Life goal	91%	100%	100%	94%	100%
Pt Input interventions	60%	45%	57%	94%	69%
Incorp cultural preferences	80%	100%	100%	67%	80%
Participates in Discharge planning	80%	100%	75%	93%	92%
Review progress	74%	60%	53%	82%	64%
Pt input objectives	n/a	n/a	75%	88%	85%

The Hospital modified the clinical formulation/clinical formulation update and the IRP conference protocols to address the presentation of present status and minimize repetitiveness in the conferences, and trained clinical administrators on the key components. In addition, beginning in December, 2009, the IRP Monitoring Observation tool was substantially modified to provide data concerning the presentation of present status. Under the new protocol, the clinical administrator presents an update of the individual's present status and is evaluated as to whether the following seven issues are addressed: present symptoms, functional status/level, current risk factors, current interventions, response to current interventions, results of any testing, evaluations etc, and finally individualized discharge criteria, if appropriate. The tool also evaluates whether the team members provided updates to or comments on the presentation. Finally, the tool in Indicator 5 was modified to evaluate whether the individual team members provided

No	Requirement	Progress/Findings
		updates on the interventions they are providing, as well as the individual's progress. Coaches work with the clinical administrators and the teams to address issues and identify techniques on presentation and working with the individual. See V.C. for additional information and results of observations. *Tab # 8, IRP Monitoring Observation Tool/Instructions. See also Training summary and Tips for Feedback from Observers, Tab # 1* Finally, each individual in care, before attending the TLC, participates in a week-long orientation that includes a focus on the individual's role in IRP planning. A new Wellness and Recovery Guide is given to all individuals in care, and the Consumer Affairs office (4 individuals) meet with individuals shortly after their admission to review their rights and role in the IRP process. *Wellness and Recovery Guide, tab # 47*. **Compliance: Partial**
V.B.2	treatment planning provides timely attention to the needs of each individual, in particular:	
V.B.2.a	initial assessments are completed within 24 hours of admission;	**Findings:** The Hospital Assessment and Medical Records policies establish the standards for completion of initial assessments by the various disciplines. Hospital policy requires initial assessment to be completed by nursing within 8 hours, by psychiatry within 24 hours, and by psychology (Part A), social work and rehabilitation services by the 5th calendar day of admission. *Assessment policy, Tab # 12; Medical Records policy, Tab # 13.* Data show all disciplines other than psychology are largely meeting this standard.

No	Requirement	Progress/Findings



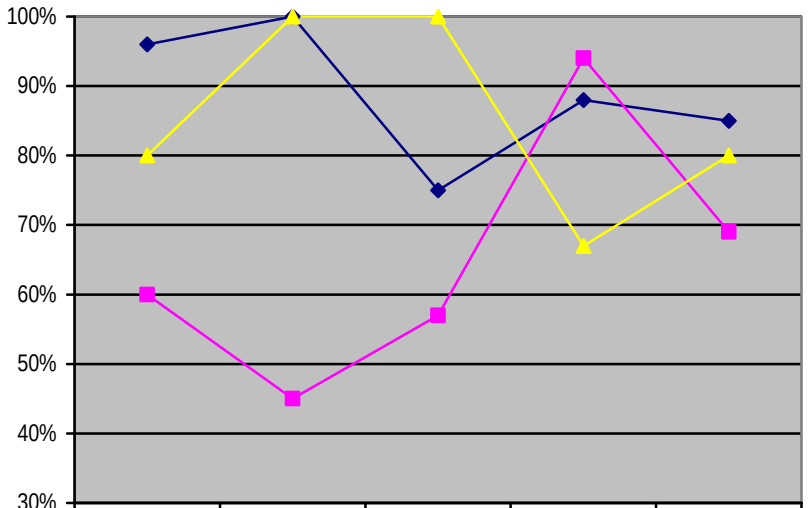
	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Psychry	92%	88%	100%	100%	100%	100%	86%
Nursing	n/a	n/a	n/a	n/a	n/a	89%	100%
SocWork	56%	80%	67%	n/a	75%	86%	100%
Rehab	89%	80%	100%	75%	100%	67%	92%
Psychgy (A)	60%	33%	63%	71%	25%	75%	50%
Psychgy (B)	70%	67%	63%	57%	63%	75%	67%

Hospital policy also requires that the Initial Individual Recovery plan (IIRP) be completed within 24 hours. It is completed by the psychiatrist with input from nursing and the general medical officer, and is due within 24 hours of admission. As of the writing of this report, there is no available data on compliance. The IIRP began to be completed in Avatar in March, 2010, so we expect a month or two of data to be available by the time of the visit. *Tab # 4, (IIRP form/instructions and screen shots)*

The initial assessment forms have been modified and all discipline initial assessments are now in Avatar. *See Tab #s 14 (CIPA form/instructions and screen shots); # 19 (IPA form/instructions and screen shots); # 23 (Initial Rehab Assessment form/instructions and screen shots); # 26 (Initial nursing assessment form/instructions and screen shots); # 31*

No	Requirement	Progress/Findings
		(SWIA form/instructions and screen shots). **Compliance: Partial**
V.B.2.b	initial treatment plans are completed within five days of admission; and	**Findings:** See V.B.2.a regarding IIRP (24 hour plans). With respect to the comprehensive treatment plans which, by policy are due by the 7th calendar day of admission, *See Tab # 3, IRP Policy,* the Hospital generally is not yet conducting observations of those conferences or reviewing the plans and does not have much data on their timeliness. In January, one seven day comprehensive plan was observed, and all time frames were met. The PID is now developing the methodology to pull a sample of comprehensive IRPs and expects to begin observations in Spring, 2010. In addition, as the Comprehensive IRP is now in Avatar, data may be available during the May, 2010 visit as to timeliness. During the last review, there was some confusion by the reviewers concerning the tools used by PID to observe the IRP conferences. Essentially, since August, 2009, there have been four versions of the audit tool. The tools include "IRP Process Observation Tool", dated 4/2/09 that was used from April, 2009 through August, 2009. It was replaced by the tool titled "IRP Meeting Observation Tool", dated 9/13/09, which was used for September and October, 2009 reviews. Based upon feedback from the reviewers as well as to improve inter-rater reliability, this tool was also modified and a revised tool, titled "IRP Monitoring Observation Tool dated", 12/14/2009 was used for the December, 2009 reviews. The revisions reflected recommendations made at the exit conference around 1) eliminating repetitiveness in Phase I of the IRP conference, 2) a renewed focus on presentation of present status at the IRP conference, 3) as well as assessing the content of the presentations of the present status and discipline discussion of interventions and progress of the individual. In addition, changes were made to the indicator around meaningful participation by the individual. A final modification (1 question deleted) was made for the January reviews and the tool used for observations in January and February, 2010 is titled "IRP Monitoring Observation Tool, dated 2/1/10. Please note that no observations occurred in November, 2009 as the tool was undergoing substantial revisions. **Compliance: Partial**
V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Findings:** The Clinical Administrator is charge with updating the IRPs to reflect discussions at the

No	Requirement	Progress/Findings
		conference. This is reflected in the position description for the position, and also in the IRP Manual where it describes roles of the participants. *See IRP Manual.* While previously the IRP observation tool included an indicator on this, it was removed as it was redundant and there is no doubt who must update the IRP. It should be noted that the content of the IRPs are not yet meeting expected standards. Clinical chart audits were deferred until training in writing IRPs occurred. Unfortunately delays in finalizing a contract for IRP training has affected progress in this area. The contract was recently awarded, and training is expected to begin in April or early May, 2010. *See Tab # 1 (IRP training information) and Tab # 2, IRP Contract.* **Compliance: Partial**
V.B.3	individuals are informed of the purposes and major side effects of medication;	**Findings:** The Office of Consumer Affairs developed a Medication Information Manual that contains information for individuals regarding psychotropic medications, including benefits and risks of use. *See tab # 49, Medication Information for Consumers.* In addition, each individual is now provided with a medication card that summarizes their medications and included allergy information. *See tab # 40 Medication Card sample* The physician is responsible for updating the card and providing each individual with a new one when changes are made to the medication regimen. Finally groups are held on the units and in the TLCs in which purposes and side effects of medication are discussed with the individuals. The Hospital will be making a few modifications to the psychiatric update as it is included in Avatar. It is anticipated that the Update form will include a prompt for information about medication education by the psychiatrist. The Hospital is completing its annual consumer satisfaction survey this Spring, 2010 so data is not yet available. However, as was the case last year, this survey will explore the individual's perception around the quality and comprehensiveness of information about medications. **Compliance: Partial**
V.B.4	each treatment plan specifically identifies the therapeutic means by which the treatment	**Findings:**

No	Requirement	Progress/Findings
	goals for the particular individual shall be addressed, monitored, reported, and documented;	See specific subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5) Overall, the Hospital is improving in working with the individual in establishing goals, objectives and interventions, including providing the individuals with input on objectives and options around interventions. Data from the IRP observations show: **Individual Input in IRP**  In addition, as of December, 2009, the IRP observers are assessing whether the team reviews, while the individual is present, the objectives and interventions that will happen during the review period that are designed to address the individual's needs and goals. Data shows that in December, 2009, in 84% of cases, observers concluded that the team reviewed with the individual the objectives and interventions for the upcoming review period; that number fell to 65% in January, 2010. There is no data that is now measuring if the written IRP meets standards around specificity and individualization as comprehensive training on writing an IRP has not yet begun.

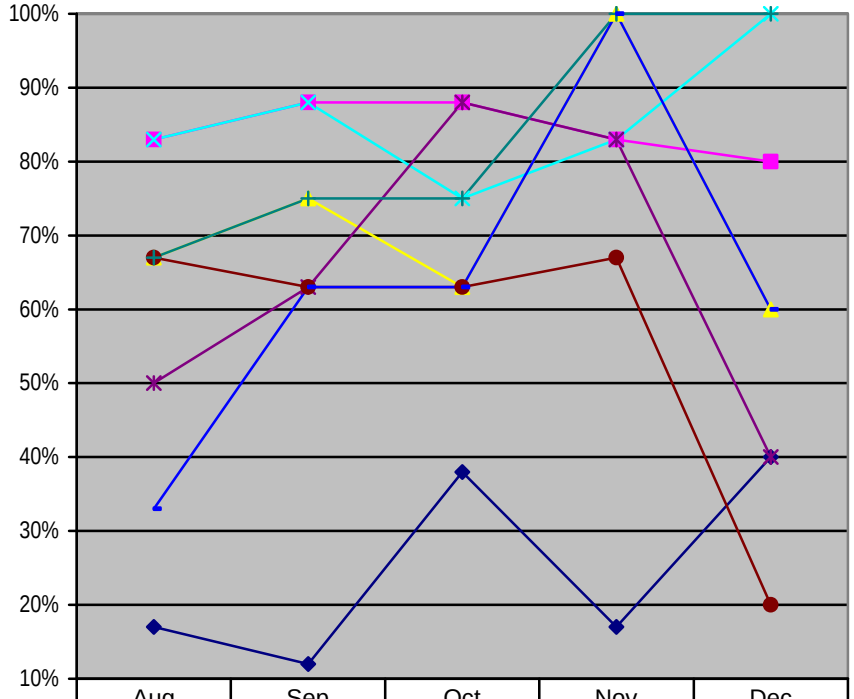
	Aug	Sept	Oct	Dec	Jan
Input into objectives	96%	100%	75%	88%	85%
Options of interventions	60%	45%	57%	94%	69%
Incorp cultural preferences	80%	100%	100%	67%	80%

No	Requirement	Progress/Findings
		Compliance: Partial
V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Findings:** The Hospital recently modified its procedure for review by the Medical Director of high risk cases. As of March, 2010, a new process was created. Rather than just focus on the repeated use of restraints or seclusion, particularly given the low incidence of their use in the Hospital *(see PRISM report,Ttab # 53)*, high risk has been redefined to capture any individual with three or more unusual incidents of *any* type, including but not limited to assaults, victim of assaults, unauthorized leaves, some types of medication refusals, restraint or seclusion, etc. Under the new process: ▪ Risk Management sends notification to the respective Medical Director. ▪ The Medical Directors/designee will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within three-business days of notification. ▪ The Medical Director/designee will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations into the next IRP. ▪ PID will track the recommendations. *See tab # 56, High risk indicator tracking processes and report.* Implementation of the new process will be monitored. **Compliance: Partial**
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 IRPs of individuals with a NGRI legal status are reviewed at the same intervals as others. Current practice continues, and the Review Board is monitoring cases to ensure each case is presented at least once per year. *Tab # 38, Review Board Reviews Summary List.* The Review Board is implementing the template for review board reports to include at the beginning of each report a list of 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. *Template for Review Board report, Tab # 57*. In addition, it implemented a system to document and track the implementation of review board recommendations. *Responses to FRB Recommendations Quarterly report, Tab # 58*.

No	Requirement	Progress/Findings
		The Chief, Post-trial Services continues working with clinical administrators so that the Review Board reports 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 during the period of September, 2009 to November 30, 2009 in 81% of the cases, the feasible Review Board recommendations were implemented; another 4% were in process, and 15% of feasible recommendations had not been addressed. *Summary of Responses to Review Board recommendations quarterly report,Tab # 58*. **Compliance: Substantial**
V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Findings:** See information provided in V.E.3, V.E.4 and V.E.5 and VIII. **Compliance: Partial**
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:** *See Transfer policy, Tab # 59, effective August 26, 2009.* The Hospital has undertaken several initiatives to improve the quality of a transfer of individuals both within units in the Hospital and between Saint Elizabeths and other hospitals. First, the Performance Improvement Committee developed and piloted a form that is to be used for emergency transfers to medical facilities. The form was designed to include critical information, but information also that can be quickly assembled while awaiting the ambulance. *See Tab # 59, Transfer policy and Transfer summary form for medical transfers.* The form is in queue to be added to Avatar. In the meantime it is available on the intranet, and its use will be expanded beyond the pilot. Audits of both inter-unit and inter-hospital transfers are continuing. Audits reveal that that there is little to no improvement in the documentation around transfers. The below two tables summarize data on some indicators measured during the transfer audits. However, in reviewing the data, it is important to note that the Hospital is monitoring through this audit only the presence or absence of documentation, not its quality, accuracy or comprehensiveness. Currently, there is no formal audit that tracks this latter information.

No	Requirement	Progress/Findings

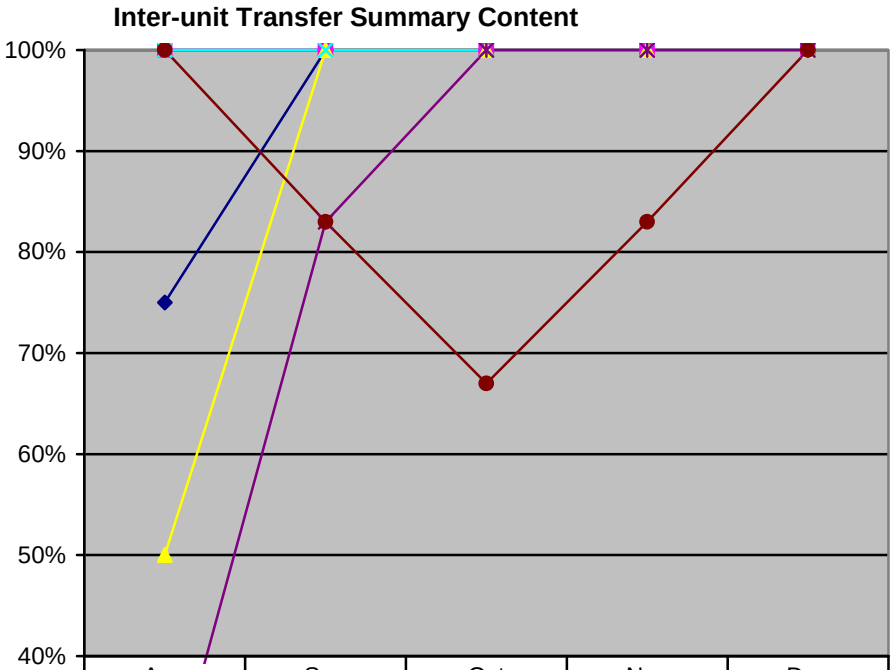
Inter-unit Transfer documentation



	Aug	Sep	Oct	Nov	Dec
Psy transfer note	17%	12%	38%	17%	40%
Nursing transfer note	83%	88%	88%	83%	80%
Psy acceptance note	67%	75%	63%	100%	60%
Nursing acceptance note	83%	88%	75%	83%	100%
GMO transfer note	50%	63%	88%	83%	40%
GMO acceptance note	67%	63%	63%	67%	20%
Transfer summary form completed	67%	75%	75%	100%	100%
IRPs Update 7 days	33%	63%	63%	100%	60%

One significant finding is that the presence of psychiatric transfer notes is low. The audits also suggest that the notes, when completed, are usually addressing the areas required by policy, but, as noted this audit only looks at if information is provided, not if it is complete or accurate, so data may be misleading. The Hospital is not currently auditing in a systematic fashion the content and quality of transfer notes and there is no plan yet on how that

No	Requirement	Progress/Findings
		information will be evaluated. Data show



	Aug	Sep	Oct	Nov	Dec
Rationale	75%	100%	100%	100%	100%
Current status	100%	100%	100%	100%	100%
Benefit transfer	50%	100%	100%	100%	100%
Review of risk factors	100%	100%	100%	100%	100%
Barriers to d/c	25%	83%	100%	100%	100%
Rec Care Plan	100%	83%	67%	83%	100%

Data on all indicators can be found in *Tab # 61, Transfer audit results.*

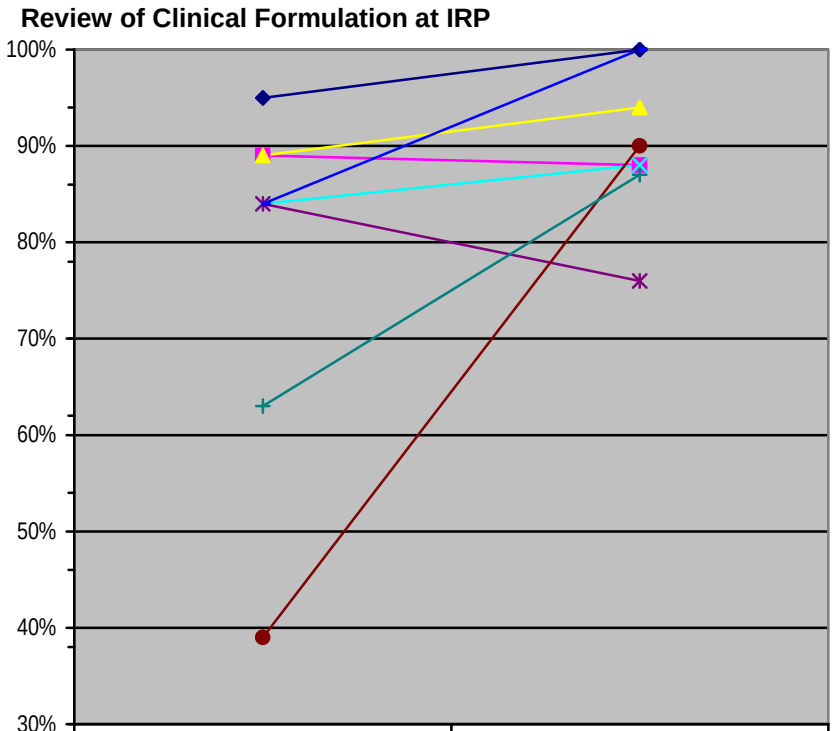
The Hospital is currently monitoring only non-emergency transfers to medical facility and data is found in Tab # 61. Audits are not yet conducted on the information in emergency medical transfers, which comprise the higher percentage of inter-hospital transfers, but should be forthcoming once the form that was in a pilot phase is finalized. *See Tab # 59, Transfer policy and emergency transfer form*

No	Requirement	Progress/Findings
		It should be noted that the Hospital is not considering the relocation of patients to the new hospital as transfers but IRPs will remain in place and the schedule will continue. **Compliance: Partial**
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 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.	**Findings:** The Hospital presented an audit sample plan to DOJ attorneys in February, 2010. The plan outlines the planned audits and the plan sample size. The audits include: • IRP observations and include 1 observation per unit for IRP reviews, 1 observation per admissions units for comprehensive IRPs and 1 per unit for any unit with a transfer onto the unit for transfer IRPs; • Clinical chart audit, one per unit per month (not yet occurring); • Audits of therapeutic progress notes, one note per group leader and individual therapist per month; • Audits of CIPA, 20% of prior month's admissions; • Psychiatric update audit, 2 per ward-based psychiatrist; • TD audits, 6 cases per month to review each person with TD diagnosis each six months; • IPA audits by psychology, 20% sample of prior month's admissions; • Psychology Risk Assessment, 1 per psychologist who completes risk assessment; • Psychology -Other, 1 per psychologist who conducts other type of assessment; • Psychology – PBS plans/guidelines, 100% sample • Rehab Initial Assessment audits, 20% sample of prior month's admissions; • SW initial assessment audits, 20% sample of prior month's admissions; • SW update, 2 per social worker per month; • SW discharge barriers audit,. 20% of persons on list; • Pharmacy medication audits – 30 cases per month, to review each individual case once per year; • Invol medication audit, 20% of persons given invol stat medications; • Nursing initial assessment audit, 20% sample of prior months admissions; • Nursing update audits, 2-4 per unit; • Seclusion and restraint audit – 100% of cases • Nursing side rail audit, 100% of cases where side rail is used regularly; • Discharge record audit, 20% of discharges; • Transfer audit, 20% of transfers; • Post-discharge follow up, at least 20% sample.

No	Requirement	Progress/Findings
		The Hospital has increased the number of audit reports that include trends, and is now generally specifying both an N and n number in the data reports. The Hospital implemented the changes to the medication monitoring form to elicit data about whether the practice being audited is consistent with its medication guidelines. Data provided in Chapter VIII will show notable improvement in the use of polypharmacy and long term use of benzodiazepines in individuals in high risk categories. Information from audits conducted by MHA reflecting whether the recommended services post discharge were provided is available for January and February, 2010. These expanded audits were delayed due to delays in hiring a qualified individual who is charged with conducting the audits but are now occurring monthly. **Compliance: Substantial**
	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 individual. Specifically, the case formulation shall:	Please see sub-cells for findings and compliance.
V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Findings:** See V.A.1 for information relating to training and the recently awarded consultant contract. The clinical formulation/update and instructions were modified to provide additional clarity about completion of the formulation and to ensure it address the present status more appropriately. *Tab # 6 Clinical formulation/instructions and Tab # 7, clinical formulation update/instructions.* Staff now are expected to address seven components within present status, including symptoms, functional status, risk factors, current interventions, progress with interventions, results of any testing etc, and discharge barriers and progress toward discharge. Further, the separate needs list has been eliminated from the IRP. The Clinical Administrators, who draft the clinical formulation/update, have received intensive training around the development of the clinical formulation. Training included the

No	Requirement	Progress/Findings
		actual drafting of a "model" clinical formulation as a group. In addition, the instructions to the clinical formulation/update were modified to include more information about completing the present status section of the clinical formulation/update and they also now include prompts for addressing functional level and social skills. *Tab # 6 Clinical Formulation/instructions and Tab # 7, Clinical Formulation Update/instructions; IRP Manual.* The Hospital also updated the IRP manual to provide additional examples and more clarity in instructions. This will likely be further modified once the IRP consultants begin work as the scope of the contract includes review of and assistance with developing additional examples for inclusion in the IRP manual. While the Hospital is still developing its clinical chart audit tool and thus has not completed any clinical chart audits, it substantially modified its IRP Monitoring Observation tool in December, 2009 to capture more details about the presentation of the clinical formulation/update and to ensure the IRP conference adequately focuses on the present status of the individual. In addition, the tool measures the contributions of each core member plus the psychologist in discussing their interventions and the effect on the individual's progress. Data concerning this latter aspect is found in V.E. Data regarding the review of the clinical formulation at the IRP conference shows improvement in presentation of each component of the present status, particularly in including discharge criteria and the results of any testing or evaluation:

No	Requirement	Progress/Findings

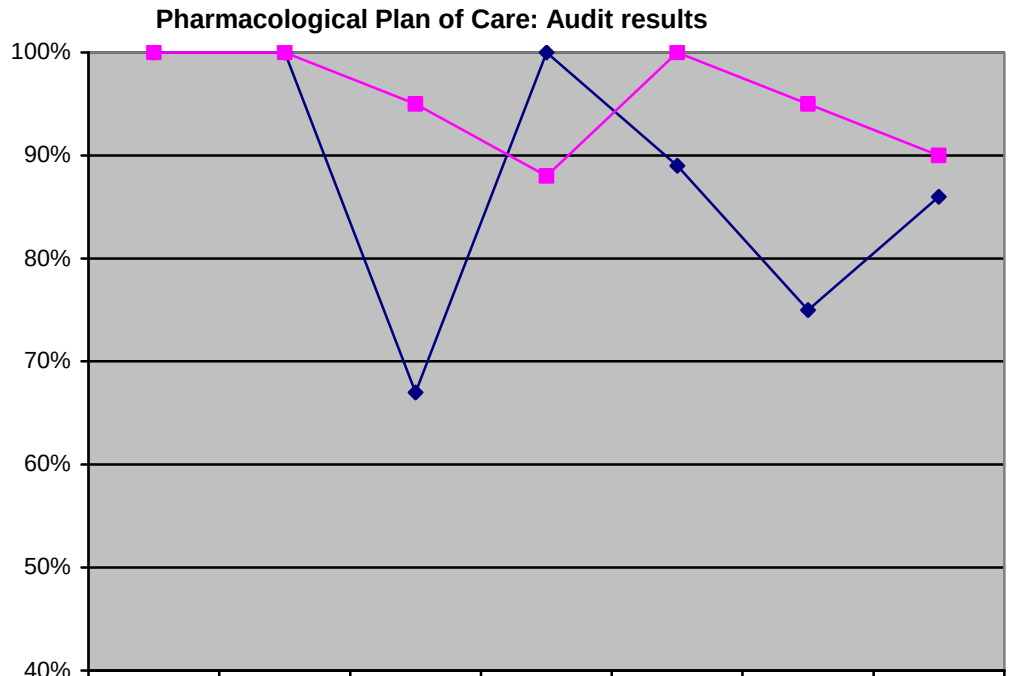


	Dec-09	Jan
Current symptoms presented	95%	100%
Functional status presented	89%	88%
Current risk factors identified	89%	94%
Current interventions presented	84%	88%
Response to intervention	84%	76%
Testing results	39%	90%
D/c criteria	63%	87%
Input from team	84%	100%

Tab # 9 IRP Monitoring Observation results.

Teams continue to assist in sharing strategies that are effective in addressing the presentation of the clinical formulation/update. Teams seem to be helping each other out

No	Requirement	Progress/Findings
		by identifying strategies that work in Phase II as well, and improvement is noted in Phase II as well. Clinical administrators meet every two weeks as a group, and issues identified by them are addressed and training is held often during these meetings. Despite these improvements, the written clinical formulations and IRPs are not yet at expected standards. **Compliance: Partial**
V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Findings:** Same as above. The Hospital is considering how best to complete the clinical chart audits and is likely to conduct the audits in two phases. The first phase will focus on the completion and quality of the clinical formulation/update. *See tab # 10.* Audits on Phase I will begin in May. **Compliance: Partial**
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**: See above. While clinical chart audits are not yet underway, the CIPA and Psychiatric Update audits include an indicator around completion of a pharmacological plan of care. Data show in general that doctors are completing an adequate pharmacological plan of care.

No	Requirement	Progress/Findings
		 Aug | Sep | Oct | Nov | Dec | Jan | Feb CIPA: 100% | 100% | 67% | 100% | 89% | 75% | 86% Psych Update: 100% | 100% | 95% | 88% | 100% | 95% | 90% *See Tab # 16, CIPA audit results (indicator 24) , and tab # 11 Psychiatric Update audit results (indicator 23 -26))* **Compliance: Partial**
V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Findings:** See V.C.1-3. **Compliance: Partial**
V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the	**Findings:** See V.C.1-3.

No	Requirement	Progress/Findings
	outcomes of treatment interventions;	**Compliance: Partial**
V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Findings:** See V.C.1-3. **Compliance: Partial**
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:** See V.C.1-3. **Compliance: Partial**
	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:	
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:** <u>Training:</u> See V.A.1 relating to additional training. The IRP consultant contract includes training around developing and writing focus statements, objectives and interventions. It is expected that training will begin in April or early May, 2010. *Tab #2, IRP contract.* <u>IRP Manual</u>: In addition, the Hospital updated parts of the IRP manual, although additional revisions are expected to be completed with the assistance of the contractor. Changes to the Manual included adding more examples on focus statements, objectives and interventions, among others. *IRP Manual*. Tip sheets were updated as was the IRP conference checklist. The IRP manual will also be reviewed by the IRP consultants for assistance in its refinement. The Manual also was updated to prompt clinical administrators to address functional levels and social skills in the clinical formulation/update and within the IRP itself. The Hospital considered the recommendation but elected not to include a specific focus statement around social skills, but rather to address that within the designated focus areas. As

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>previously noted, clinical chart audits of the written IRP have not yet begun so no data are available to assess improvement.

With the availability of additional groups addressing the needs of those with substance abuse disorders as well as cognitive disorders, the interventions for those individuals are more individualized.

Clinical chart audits: The Hospital is implementing a phased approach to the clinical chart audits. The first phase will focus on the completion and quality of the clinical formulation/update. That audit tool is completed, and audits will begin in May. See Tab # 10.

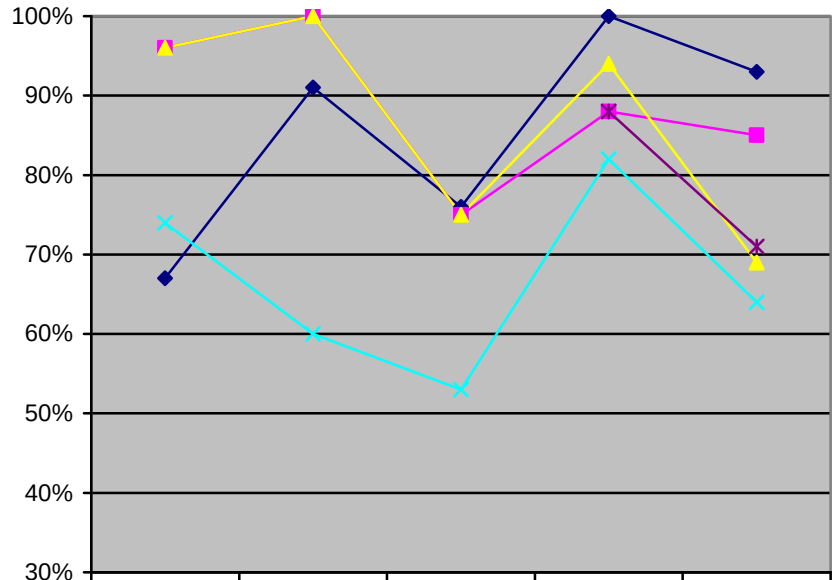
IRP Observations: The Hospital through the IRP observations began monitoring in December 2009 some aspects of individualization, although this does not capture the written content in the IRP. The observers are assessing if the disciplines are providing information about the interventions they are providing, whether the individual is making progress and if they recommend changes to the interventions. Tab # 9, IRP Monitoring Observation results. This information is important in updating the individual's objectives and interventions.

<table>
<tr><th>Discipline</th><th>Discuss Interventions generally</th><th>Discuss interventions specifically</th><th>Report on Individual Progress</th><th>Recommend alternative interventions</th></tr>
<tr><td>Psychiatry</td><td>Dec: 95%
Jan: 100%</td><td>Dec: 88%
Jan: 69%</td><td>Dec: 94%
Jan: 94%</td><td>Dec: 58%
Jan: 94%</td></tr>
<tr><td>Nursing</td><td>Dec: 75%
Jan: 75%</td><td>Dec: 58%
Jan: 69%</td><td>Dec: 58%
Jan: 69%</td><td>Dec: 38%
Jan: 69%</td></tr>
<tr><td>Social Work</td><td>Dec: 76%
Jan: 80%</td><td>Dec: 75%
Jan: 62%</td><td>Dec: 33%
Jan: 58%</td><td>Dec: 50%
Jan: 58%</td></tr>
<tr><td>Psychology</td><td>Dec: 80%
Jan: 92%</td><td>Dec: 88%
Jan: 70%</td><td>Dec: 88%
Jan: 70%</td><td>Dec: 60%
Jan: 70%</td></tr>
</table>

In addition, observers are assessing whether the objectives and interventions identified in the IRP conference are individualized and reflect the individual's progress or lack thereof. As is set out in the chart below, data show:</td></tr>
</table>

No	Requirement	Progress/Findings

IRP Planning: Individualized Factors



	Aug	Sep	Oct	Dec	Jan
Strengths identified with individual	67%	91%	76%	100%	93%
Input into objectives	96%	100%	75%	88%	85%
Input into interventions	96%	100%	75%	94%	69%
Review progress	74%	60%	53%	82%	64%
Objectives/interventions are individualized	N/A	N/A	N/A	88%	71%

Treatment Programming: Treatment programming at the Hospital is undergoing significant modification in anticipation of the move to the new hospital. Treatment will occur in three areas, the TLC in transitional services, the TLC in intensive treatment and ward-based programming. Psychologists provide therapies (group and individual) as well as assessing the cognitive functioning of individuals to ensure they are placed in groups appropriate to their functional levels. In addition, programming includes a number of co-occurring disorder interventions that focus on recovery for those with substance abuse and mental illness diagnoses. Such groups are led by specially trained therapists, and individuals are placed in groups consistent with their cognitive functioning and stage of change. *See Tab # 69 Treatment Programming summary.*

No	Requirement	Progress/Findings
		Specialized programming is provided for individuals with cognitive impairment, demonstrating problems with concentration, limited attention span, and poor social skills/ impulse control; diagnoses of Dementia, Borderline Intellectual Functioning, and Mental Retardation. The core groups for those with Dementia include cognitive stimulation, reality orientation, multi-sensory stimulation, exercise, and reminiscence groups. The core groups for those with Mental Retardation include money management, social skills, and basic life skills along with behavior management groups. Cognitive remediation/accommodation groups are provided for individuals who demonstrate cognitive impairment, poor concentration, and distraction by psychosis. The clinical profile of individuals expected to come to the TLCs include approximately 41 individuals with cognitive disorder diagnoses who will attend the transitional services TLC and 16 will attend the intensive treatment TLC. *See Tab # 69 Treatment Programming summary.* See attachment 2 to Tab # 69 for a description of the clinical profile of individuals who are expected to attend the mall. *See also Tab # 74 for clinical profile for individuals in care.* Medical Care: The Hospital has revised its Medical Response policy incorporating those recommendations with which it agreed and also developed separate policies for Medical Services and Seizure Management. *See Tab # 70, Medical Response, Medical Services and Seizure Management policies.* The Hospital appointed a supervisory general medical officer who supervises all general medical officers. The Hospital policy also provides for a history and physical examination within 24 hours of admission which is now completed in Avatar. Further, the Initial IRP and the IRP (comprehensive and update) each include a focus area around physical health. Under the leadership of the Performance Improvement Committee, a form to be used in emergency medical transfers was piloted and recently finalized. The form is intended to ensure the necessary information is provided when the individual is transferred to a medical facility and to ensure the reason for the transfer is specified. *Tab # 59 Transfer Policy and form for medical evaluation form/instructions.* The form is in the queue for inclusion into Avatar. *Tab # 156 Avatar issues list* Laboratory results are available, usually within 24 hours, and results are available to staff through Avatar. Laboratory staff notify doctors of any abnormal results and documents the notice. With respect to persons with seizure disorders, new guidelines for assessment and treatment were recently developed and presented to the medical staff. *Tab # 70 Seizure disorder management policy.* These guidelines should help the development of more

No	Requirement	Progress/Findings
		realistic and individualized objectives and interventions. **Compliance: Partial**
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 above. The IRP format provides for both treatment and enrichment interventions. Treatment teams are expected to ensure each individual's IRP includes both types of interventions. *See Tab # 5 IRP Form and Instructions.* **Compliance: Partial**
V.D.3	write the objectives in behavioral and measurable terms;	**Findings:** Same as above. The clinical administrators have received some training around writing objectives in behavioral and measurable terms, but training by the IRP consultant is expected to target writing all aspects of the IRP. **Compliance: Partial**
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 above. As IRPs are now being completed in Avatar, the intervention, person responsible and time frames are now mandatory fields and should be completed in all IRPs subsequent to mid March, 2010. Further, the revised IRP form includes information regarding interventions that align with each objective, the type of intervention, its frequency and duration and responsible staff as well as delineation of treatment and skill building interventions. Therapeutic progress notes will be completed in Avatar beginning in May, and audits began in March, 2010. **Compliance: Partial**
V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate	**Findings** The Hospital is in the initial stages of using the treatment scheduler module in Avatar to

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td>treatment/rehabilitation per week; and</td><td>track hours scheduled and hours attended. Not surprisingly, some staff are having adjustment issues in posting the hours, but we expect those to be resolved by the time of the visit. Current data shows for week of 3/28/10:

<table>
<tr><th>Hours</th><th>Scheduled</th><th>Attended</th></tr>
<tr><td>0.1-10</td><td>92</td><td>191</td></tr>
<tr><td>11-15</td><td>108</td><td>10</td></tr>
<tr><td>16-20</td><td>28</td><td>0</td></tr>
<tr><td>>20</td><td>11</td><td>0</td></tr>
<tr><td>No schedule</td><td>54</td><td></td></tr>
</table>

Tab # 46, Treatment Mall Attendance data. The data suggests that staff are not recording all groups attended. The numbers do not include individuals on leave or who have been at the hospital less than 14 days. Updated data will be provided during the site visit.

Compliance: Partial</td></tr>
<tr><td>V.D.6</td><td>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.</td><td>**Findings:**

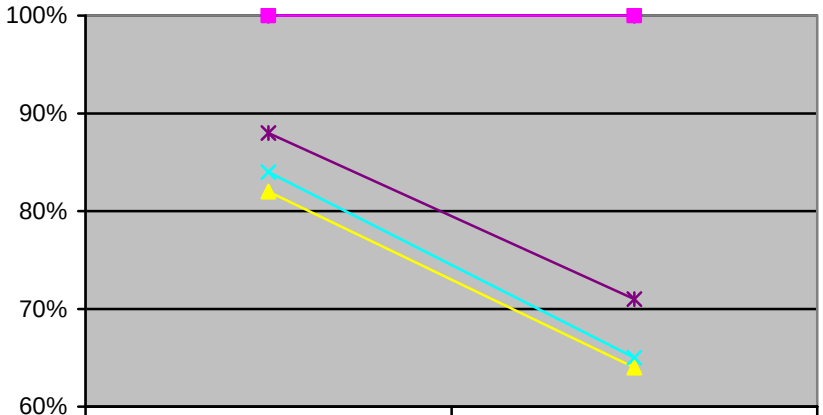
Same as in V.D. 1 through 6.

Compliance: Partial</td></tr>
<tr><td></td><td>**E. Outcome-Driven Treatment Planning**</td><td></td></tr>
<tr><td></td><td>By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:</td><td></td></tr>
<tr><td>V.E.1</td><td>revise the objectives, as appropriate, to reflect the individual's changing needs;</td><td>**Findings:**

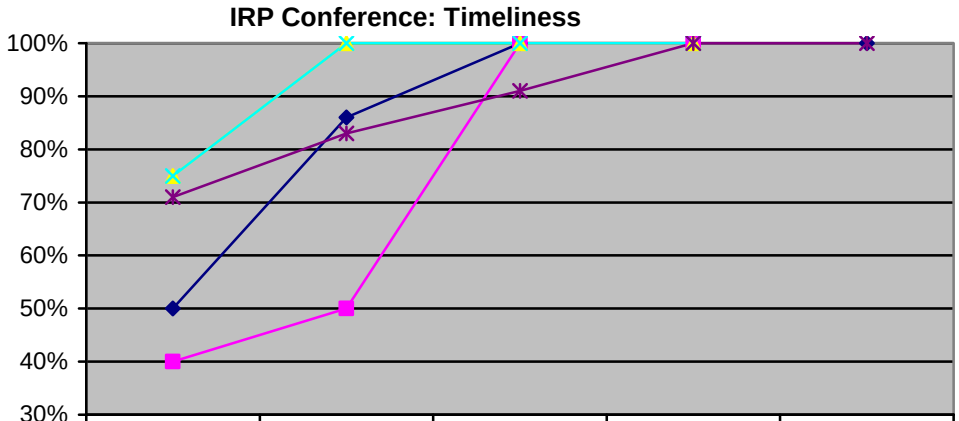
See V.A.1 regarding training on IRP development. *See also tab # 2 re IRP training contract*

<u>Clinical chart audits</u>: The Hospital will be completed in two phases. The first phase will focus on the completion and quality of the clinical formulation/update. The audit tool is</td></tr>
</table>

No	Requirement	Progress/Findings
		completed for this phase and audits by designated clinical managers will begin in May, 2010. This will give an opportunity for the IRP consultant to provide comments on the tool. Thus, at this time, the Hospital does not have any data reflecting the written content of the IRP. The IRP observation tool was modified in December, 2009, to monitor whether the treatment teams were focusing in the IRP conferences on the individual's progress or lack thereof, whether the objectives and interventions were tailored to the individual's strengths, functioning, needs and goals and whether they were modified based upon the individual's course over the prior IRP period. Data suggest that the Hospital is improving in focusing on progress or lack thereof in IRP conferences and revising objectives and interventions to reflect the individual's present status. However, the statements of objectives and interventions in the written IRP in many cases still do not include specific and realistic written objectives of what the individual is targeted to accomplish in the review period. There is improvement among some treatment teams in recognizing the plan is a 30 or 60 day plan and in therefore tailoring objectives in more of a step by step approach that will progress the individual toward discharge but at the same time are more realistic and achievable. However, as the data suggest, additional progress is needed.

No	Requirement	Progress/Findings
		IRP Planning: Individualized Factors  Dec / Jan Discussion if individual benefiting from therapies? — 100% / 100% If not benefiting from therapies, revise the related intervention? — 100% / 100% Did team review progress in meeting objectives — 82% / 64% Explain what will occur to support individual's needs — 84% / 65% **Compliance: Partial**
V.E.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Findings:** Same as in V.E.1. See also V.A.2.c. The Hospital policy requires an initial IRP (IIRP) within 24 hours, a comprehensive treatment plan within 7 days, and updates within 14 days, 30 days, 60 days and every 60 days thereafter. *See IRP policy, Tab # 3.* Policy also requires an IRP within 7 days of a transfer to a new unit. Some data is available on timeliness, but additional data on the timeliness of IRPs should be available at the time of the visit, as IRPs are now completed in Avatar. In reviewing the data below, it should be noted that except for the every 60 day IRP review the sample sizes were very small (and n/a means no cases in that category were sampled). However, upon development of a management report, timeliness data will be available for all categories.

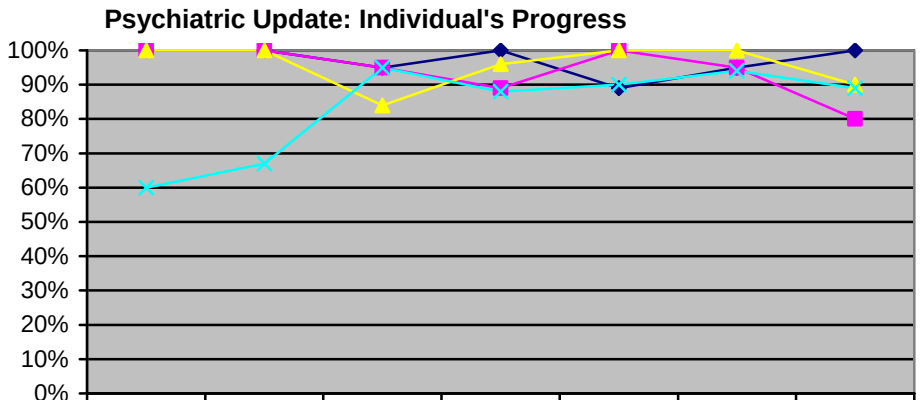
No	Requirement	Progress/Findings



	Aug	Sept	Oct	Dec	Jan
7 day	50%	86%	100%	n/a	100%
7 day transfer	40%	50%	100%	100%	n/a
30 day	75%	100%	100%	100%	n/a
Day 60	75%	100%	100%	100%	n/a
every 60 days	71%	83%	91%	100%	100%

In addition, the Assessment policy also requires psychiatry, nursing and social work to complete a monthly update that include specific assessments of the individual's progress. *See Assessment Policy, tab # 12.* For example, the Psychiatric Update that is completed monthly requires the doctor to address the individual's response to medication, psychiatric condition generally (including changes to condition) and whether the individual is progressing toward his or her treatment goals. *Tab # 17 Psychiatric Update and instructions.* The Nursing Update includes an evaluation of the individual's response to nursing interventions, and the social work update also requires social workers to assess progress toward objectives, discharge and overall service needs. *Tab # 28, Nursing Update form/instructions, Tab # 34 Social Work Update form/instructions.*

Audits of each of the disciplines update forms were conducted.
The psychiatric update audit form expressly assesses whether the psychiatrist is monitoring the treatment goals, objectives and interventions at least monthly. Data show:

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>


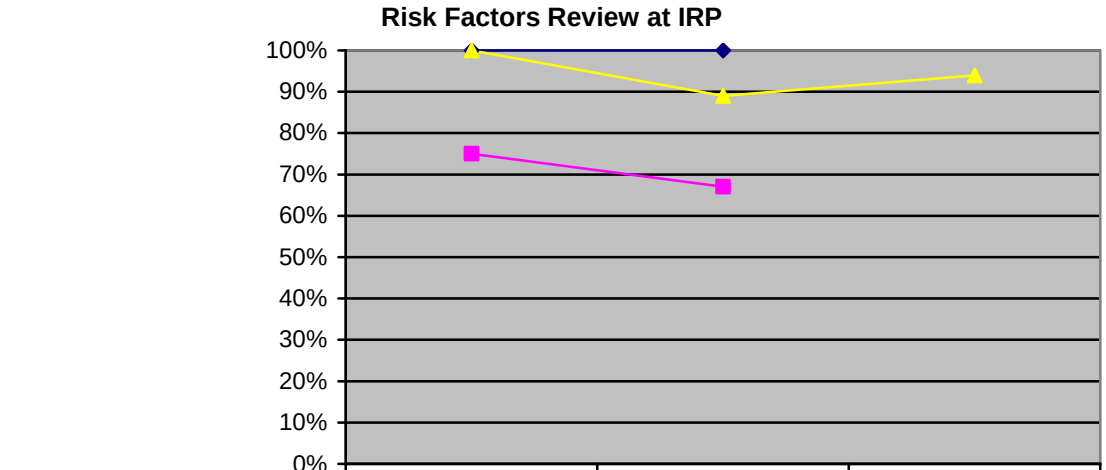
<table>
<tr><th></th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th></tr>
<tr><td>Response to med addressed</td><td>100%</td><td>100%</td><td>95%</td><td>100%</td><td>89%</td><td>95%</td><td>100%</td></tr>
<tr><td>Progress updated</td><td>100%</td><td>100%</td><td>95%</td><td>89%</td><td>100%</td><td>95%</td><td>80%</td></tr>
<tr><td>DX completed</td><td>100%</td><td>100%</td><td>84%</td><td>96%</td><td>100%</td><td>100%</td><td>90%</td></tr>
<tr><td>Barriers to d/c</td><td>60%</td><td>67%</td><td>95%</td><td>88%</td><td>90%</td><td>94%</td><td>89%</td></tr>
</table>
If an event occurs prior to the next scheduled treatment plan, the IRP policy provides that a IRP conference should be held to address the individual’s needs. Tab # 3 IRP Policy. Data is not available to assess progress.

Compliance: Partial
</td></tr>
<tr><td>V.E.3</td><td>review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;</td><td>Findings:

Same as in V.E.1 and E.2.

The revised IRP policy, the revised IRP Manual, the clinical formulation update and the psychiatric update template include prompts that facilitate implementation of this requirement. See Tab # 3 IRP Policy and IRP Manual.

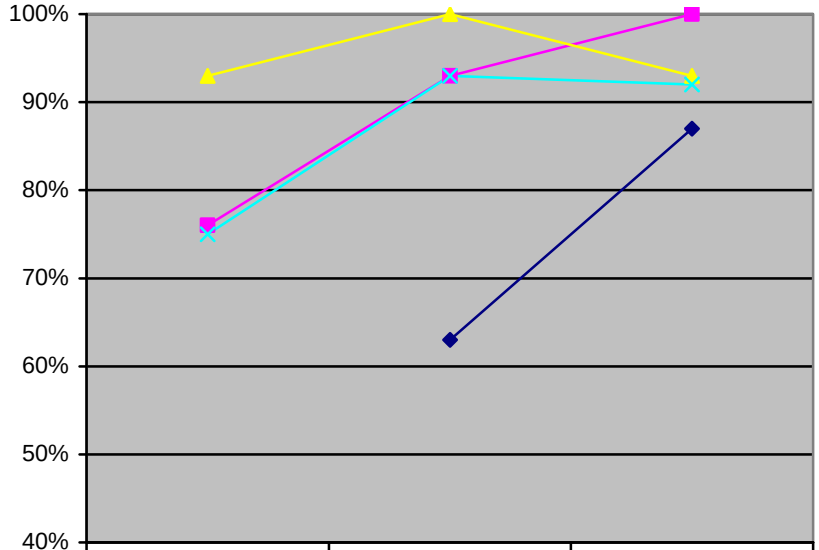
In addition, the Hospital revised its process around alerts involving high risk triggers. Now, when an individual is involved in three or more unusual incidents of any type within a 30 day period, the Medical Director/designee is notified by the Risk Manager. The Medical Director/designee will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within three-business days of notification.</td></tr>
</table>

No	Requirement	Progress/Findings
		The Medical Director/designee will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. The Clinical Administrators will capture/consider the recommendations into the next IRP. PID will track the recommendations. *See Tab # 56, Process for and Tracking of High Risk Indicators.* In addition, beginning in October, 2009, the IRP observers began tracking if teams addressed 1) use of seclusion/restraint or 2) STAT/PRN medications and 3) risk factors (including UIs). Please note that in January, none of the cases in the sample included individuals who had been administered STAT medications or who had been secluded or restrained. Data shows:  This data only reflects when the treatment teams are meeting. There is some data (see Chapter X) concerning the treatment team meetings following a restraint or seclusion episode that suggest teams are not holding special IRP conferences between regularly scheduled conferences as often as appropriate, but to date there is not a systemic way to capture this. **Compliance: Partial**
V.E.4	provide that the review process includes an	**Findings:**

	Oct	Dec	Jan
S/R episodes addressed	100%	100%	n/a
STAT Meds addressed	75%	67%	n/a
Risk Factors (Uis)	100%	89%	94%

No	Requirement	Progress/Findings
	assessment of progress related to discharge; and	See V.E.2 and E.5. See also V.A.1 regarding IRP training contract, *Tab # 2.* The IRP Monitoring Observation tool, modified in December 2009, includes several indicators that monitor the team's review of the individual's progress toward discharge during the IRP conference. Currently there are four indicators that address this requirement, and involve both Phase I and Phase II of the IRP conferences. Data suggest meaningful progress both in the team's focus on individualized discharge planning as well in involving the individual in discharge planning. Training by the IRP consultant around the role discharge planning has in IRP development should strengthen performance as well.

Discharge Planning: IRP Conference



	Oct	Dec	Jan
Present status includes individualized d/c criteria	n/a	63%	87%
Discuss d/c plans as team	76%	93%	100%
Review d/c criteria with individual	93%	100%	93%
D/c planning with individual	75%	93%	92%

See Tab # 9 for IRP Monitoring Observation audit results.

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>Review of this requirement may also be included in the clinical chart audit tool (Phase II) once it is finalized.

Compliance: Partial</td></tr>
<tr><td>V.E.5</td><td>base progress reviews and revision recommendations on clinical observations and data collected.</td><td>Findings:

See Section V.A.1 to V.A.1.5., V.B.1., and V.E.4.

The monthly therapeutic progress note will be completed in Avatar in May, 2010. See Monthly Therapeutic Progress note/instructions, Tab # 44. An audit was conducted for the first time in March, 2010 but no results are yet available. See Tab # 45, Monthly Therapeutic Progress Note Audit and Instructions. The notes should relate the provided interventions to the IRP objective, and the audit tool assess the quality of information provided to the team.
.
During the review period, prior to the IRP conference, the clinical administrators from most teams will contact the TLC to obtain information about the individual’s progress. Beginning in December, 2009, the IRP observations included several relevant indicators:

<table>
<tr><th>Indicator</th><th>Dec</th><th>Jan</th></tr>
<tr><td>Did team discuss treatment therapies and if individual was progressing?</td><td>100%</td><td>100%</td></tr>
<tr><td>If team determined not progressing, did it revise interventions</td><td>100%</td><td>100%</td></tr>
</table>

The TLCs on the civil side are conducting weekly rounds with treatment teams to give them information about individuals’ progress toward treatment objectives and discharge criteria. These will be expanded to all TLCs upon move to the new building.

Compliance: Partial</td></tr>
</table>

VI. Mental Health Assessments

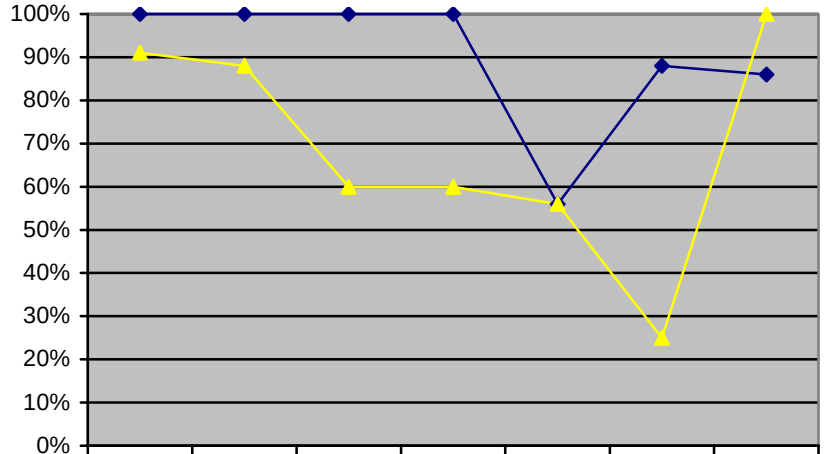
No	Requirement	Progress/Findings
	By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	**Summary of Progress:** 1. The Hospital's Medical Director continues to undertake various reviews and analyses designed to improve compliance with requirements of this Agreement. The number of individuals with Rule Out diagnoses for longer than 90 days continues to drop and all individuals now have a diagnosis reflected on Axis I. 2. The Hospital continues to improve high risk medication practices, with notable progress in reducing the number of individuals with polypharmacy. Progress is also noted in the number of individuals prescribed benzodiazepines over 90 days who have substance abuse, cognitive disorder diagnoses or who are elderly. Drug use evaluations are underway to review the remaining cases in each of these categories. 3. Medication audits are continuing and the audits include a review of 1) medication prescribing practices, 2) use of PRN/STAT medications, 3) use of benzodiazepines over 90 days who have substance abuse, cognitive disorder diagnoses or who are elderly, 4) use of anti-cholinergics in individuals with cognitive disorders, and 5) those with a tardive dyskinesia diagnosis, as well as several other categories. 4. The initial assessments for nursing, psychiatry, psychology, social work and rehabilitation services are all now completed using Avatar. The social work update is also completed using Avatar, and the other discipline's updates are in the queue for completion over the next 4-6 months. 5. The Hospital implemented audits of the initial assessments by each discipline, as well as audits of the discipline update tools. Some audit tools have been revised (per DOJ recommendations or Hospital experience) and implemented, some were revised and are scheduled for implementation in April, and some are still being revised. 6. The Hospital hired a PBS team leader (clinical psychologist) and two PBS technicians. Recruitment is underway for a PBS data analyst; recruitment for a nurse for the PBS team will be announced following an approved table of organization change. The PBS team leader reviewed and updated the PBS policy and procedure and several PBS plans or guidelines were completed and are being implemented. Staff training is underway. In addition, DMH recently finalized a contract for additional training and consultation around the development of PBS plans/guidelines and training of the PBS team. 7. The three Psychology vacancies have been filled as were several rehabilitation services vacancies, but five rehabilitation services staff vacancies remain, four of which are in recruitment and one is pending a table of organization change.

No	Requirement	Progress/Findings
	A. Psychiatric Assessments and Diagnoses	
VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Findings:** The Assessment and Medical Records policies have been revised and reconciled. *See Tab # 12 Assessment policy, Tab # 13 Medical records policy.* The policies now establish the following documentation requirements for psychiatry: • Initial assessments within 24 hours; • Weekly progress notes for the first 60 days (content specified in the Medical records policy); • Psychiatric updates (reassessments) monthly; the 30 day and 60 day updates will take the place of that week's progress note. The comprehensive initial psychiatric assessment (CIPA) is now completed using the Avatar system. *See tab # 14 for the Avatar report and screen shots and instructions.* The psychiatric update is not yet in Avatar but is in the queue for development. However, doctors are using the paper Psychiatric Update template to complete their monthly reassessments. Both the CIPA and Psychiatric Updates include sections relating to the pharmacological plan of care as well as review of the medication regimen (with rationales), and these sections are audited in both the CIPA and Psychiatric Update audits. *See Tab # 15 CIPA audit, tab # 16 CIPA audit results, tab # 18 Psychiatric Update Audit tool and tab # 11 Psychiatric Update audit results.* Audits of both CIPA and the Psychiatric Update are occurring, and are being implemented in accordance with the Audit sample plan submitted to DOJ in February, 2010. *Tab # 36, Audit Sample Plan.* The CIPA audits began in June 2009 and have occurred monthly since that time, and the Psychiatric Update audits began in August, 2009. *Tab # 16, CIPA Audit results, Tab # 11, Psychiatric Reassessment (Update) audit results.* Data from the audits will be referred to in the specific related subsections. Effective April 2010, the Psychiatric Update audit tool will include a specific indicator assessing if diagnosis was updated based upon information that became available during the hospitalization. See *Tab # 18, Psychiatric Update Audit Tools (tool dated 7/7/2009 and tool dated 4/1/2010).* However, the data available at this time from the psychiatric update audits does not reflect this indicator. The instructions to the clinical formulation update form, however, specify that the clinical formulation update should include an update

No	Requirement	Progress/Findings
		of information relating to any of the "six Ps" which was learned subsequent to hospitalization and thus this is incorporated into ongoing IRP planning. *Tab #7 Clinical formulation update/instructions. See also IRP Manual.* The CIPA data shows sustained high performance in nine areas (timeliness, correct legal status, review of psychiatric history, history of presenting illness, medical history, stage of change in substance abuse assessment, completion of social and developmental history, completion of mental status examination and consistency between diagnosis and clinical presentation.) Areas in need of improvement include the completion of information from prior treatment settings, addressing adverse reactions to medications in psychiatric history, completing the family history section, identifying precautions where appropriate, identifying strengths appropriately and addressing risks associated with a particular medication regimen. *See CIPA audit results Tab # 16.* The Psychiatric Update Reassessment audit shows high performance in accurate completion of medication regimen section, the appropriateness of a pharmacological plan of care, justification for using anti-cholinergics, response to treatment, completion of risk assessment section and updating the barriers to discharge. However, improvement is needed in completion of annual AIMS test, in specifically addressing the rationale for completion of various types of pharmacological plans and review of assessments if completed by the trainee, for example. *See Tab # 11, Psychiatric Update Reassessment audit results.* **Compliance: Partial**
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 Hospital is implementing this requirement in phases - - a risk screening is completed by nursing, followed by the psychiatrist within 24 hours as part of the CIPA, followed by the completion of a risk screening by a psychologist by day five. Then, as part of the clinical formulation and comprehensive individual recovery plan completed by day seven, any areas of confusion are addressed. Audit data on completion of the admission risk assessment shows improvement is needed in the identification of precautions by psychiatrists when a risk is noted. In general, a 20% sample of monthly admissions was reviewed and data shows compliance in completion of the risk assessment section ranging from a low of 56% to a high of 100%. Data suggest significant improvement is needed in development of precautions when a risk is noted. Psychology audits results show high rates of compliance generally.

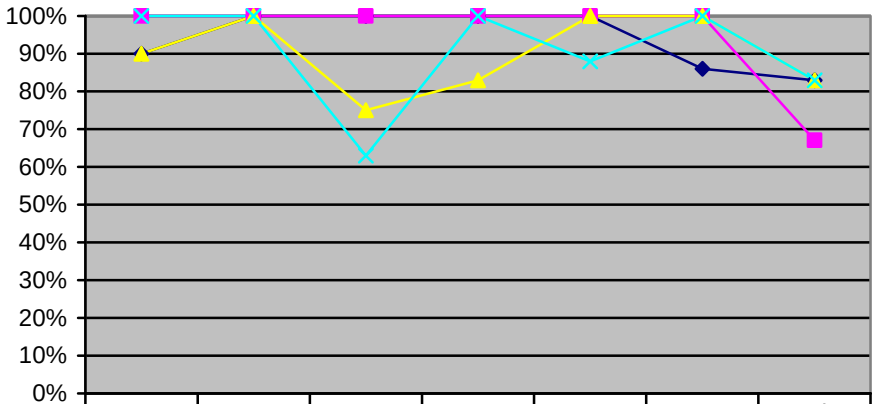
No	Requirement	Progress/Findings

Risk Assessment - CIPA



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Risk Assessed -CIPA	100%	100%	100%	100%	56%	88%	86%
Precautions identified-CIPA	91%	88%	60%	60%	56%	25%	100%

Risk Screening: Psychology

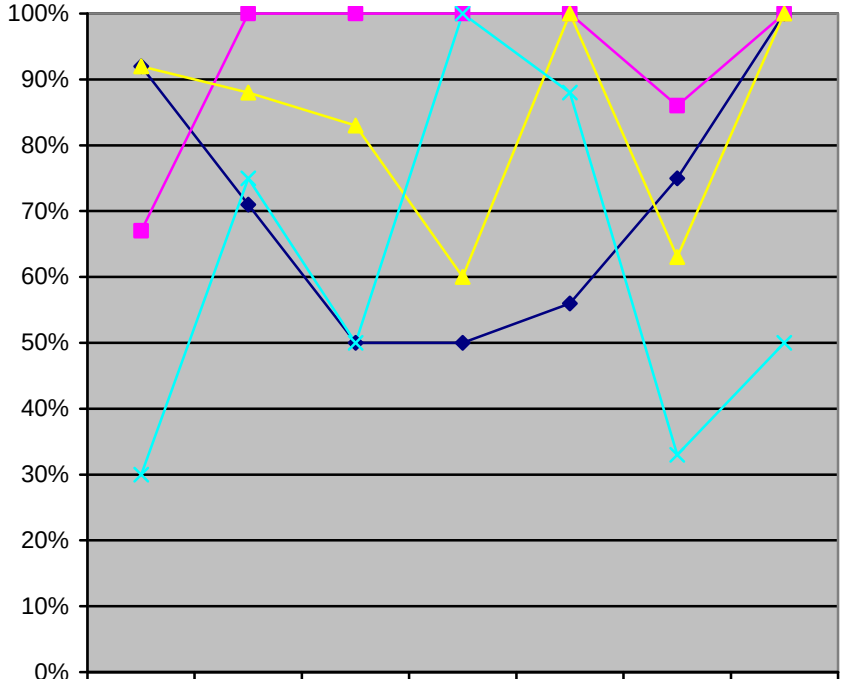


	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Assess-Violence Risk	90%	100%	100%	100%	100%	86%	83%
Assess-Suicide Risk	100%	100%	100%	100%	100%	100%	67%
Findings-Violence	90%	100%	75%	83%	100%	100%	83%
Finding-Suicide	100%	100%	63%	100%	88%	100%	83%

No	Requirement	Progress/Findings
		Reviewers expressed concern during their last visit about the potential for conflicting findings by the current process outlined above. The Hospital considered the recommendation but believes the system is appropriate. The CIPA screen is completed within 24 hours, and the psychology screen up to five days later. This staging allows for additional information to be obtained and more opportunity to observe the individual. Then, at the comprehensive IRP conference, and at the following conferences, (14 day, 30 day, 60 day etc), the information is discussed and any confusion is resolved. **Compliance: Partial**
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:** Both the CIPA and the Psychiatric Update include sections relating to diagnosis, and the Psychiatric Update specifically includes in the Assessment section prompts for diagnosis (including updating as needed), specific behavioral or psychodynamic issues that are affecting the individual's lack of progress, justifications for deferment of Axis II diagnoses and justification for continued NOS diagnoses. The current Psychiatric Update audit tool assesses whether the diagnosis section is accurately updated and completed. *See Tab # 18, Psychiatric Update audit tools (current version and that to be used beginning April 1, 2010).* A revised Psychiatric Update audit tool was finalized in March, 2010 for use beginning with the April audits. The revised psychiatric update audit will specifically address if the diagnoses reflect current clinical data and if it was changed or updated based upon changes in current clinical data. *See Tab # 18, Psychiatric Update audit tools (dated 7/09 and 4/10).* The CIPA audits assess two aspects of diagnosis - - first, item 20 evaluates whether all axes were completed and item 21 evaluates whether the diagnosis accurately reflects the results of the mental status examination, psychiatric and medical history, family and social history, risk assessment, substance abuse assessment and stage of change and prior treatment. *Tab # 15 CIPA audit tool/instructions.* While the data around whether all axes are completed shows a decline in performance, the data suggests improvement in the indicator of whether the diagnoses reflect the individual's clinical presentation. *See Tab # 16 CIPA audit results.*

No	Requirement	Progress/Findings

CIPA Diagnoses Indicators

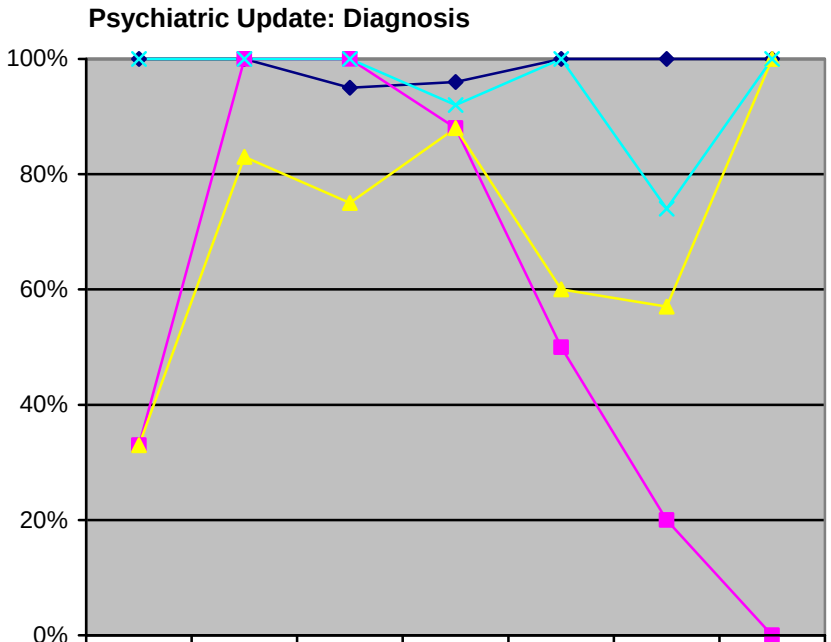


	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Diagnosis Section completed	92%	71%	50%	50%	56%	75%	100%
Diagnosis reflects clinical presentation	67%	100%	100%	100%	100%	86%	100%
Substance abuse evaluation completed	92%	88%	83%	60%	100%	63%	100%
Stage of change for s/a reflects assessment	30%	75%	50%	100%	88%	33%	50%

See Tab # 16, CIPA audit results. Because of the apparent decline in performance around the completion of all Axes in the diagnostic section of the CIPA, the Medical Director now runs a report periodically to evaluate if all Axes are completed.

The psychiatric update (reassessment) audit includes indicators regarding diagnostic accuracy. However, for the audits completed to date, this audit does not yet include a specific indicator to assess if diagnosis is properly updated in response to a review of

No	Requirement	Progress/Findings
		current clinical data. That indicator has been added to the tool for the April, 2010 audits. Data however shows the need for continued improvement in refining r/o, NOS and deferred diagnoses.



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Diagnosis section completed	100%	100%	95%	96%	100%	100%	100%
Justification for deferred Axis II	33%	100%	100%	88%	50%	20%	0%
Justification for R/O or NOS	33%	83%	75%	88%	60%	57%	100%
Justification for continued hospitalization	100%	100%	100%	92%	100%	74%	100%

I

Tab # 11 Psychiatric Update audit results.

While rationales are not yet routinely and adequately stated in the psychiatric assessments (initial or update), the Hospital continues to make progress in addressing diagnostic issues, including the use of R/O and NOS diagnoses. As of March 18, 2010, all 333 individuals at the Hospital have an Axis I diagnosis including the use of no Axis I diagnosis. Of the 333,

No	Requirement	Progress/Findings

there are 27 individuals with an R/O diagnosis, but of those, only 7 have the diagnosis for more than 90 days. There are also 100 individuals with an NOS diagnosis, and of those, 46 have had the diagnosis for longer than 90 days. Finally, there are only 7 individuals with a Deferred diagnosis for more than 90 days. Other diagnostic data show as follows:

Diagnosis Type	Number of Individuals (N = 333)
Mood Disorder	41
Depressive Disorder	13
Psychotic Disorder	305
Dementia	38
Impulse Control Disorder	8
Cognitive Disorder	54
Substance Abuse	145
Personality Disorder	93
Mental Retardation	27

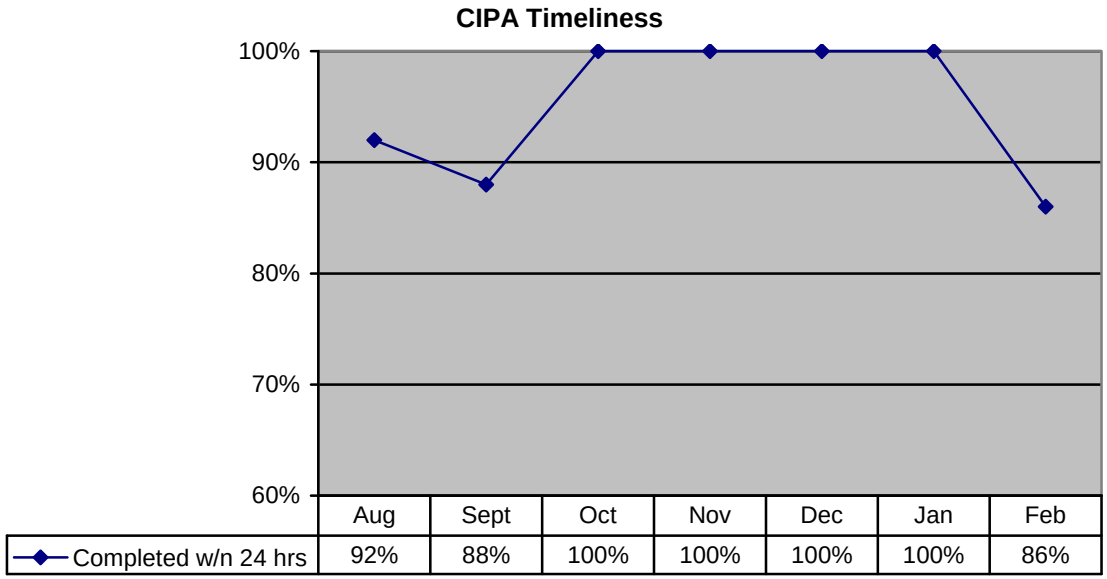
See tab # 74, Clinical Profile for individuals in care.

The Medical Director is also implementing a number of initiatives to address diagnostic and quality of care issues. He continues to regularly monitor the diagnosis of "Psychotic Disorder NOS" or "Mood Disorder NOS" and other "NOS" diagnoses, asking clinicians after several months to document if the individual meets specific criteria for those diagnoses, or whether we now know more about the individual and a different diagnosis might be more appropriate. Similarly, he regularly reviews any "Diagnosis Deferred" on Axis II in the diagnoses and after 3 months we expect that this will be changed to either a specific personality disorder or no diagnosis on Axis II. Finally, as noted, he runs reports to see if any of the Axes are left blank, and notify clinicians to be sure they are completed. As noted, now, all individuals have an Axis I diagnosis.

The Medical Director also requested and obtained a report on anyone with a PSA test (prostate specific antigen) that was high. This was followed by a quick "mini-audit" to see if they were receiving appropriate follow up, had a digital rectal exam (DRE), had been referred to an urologist, etc. He is working with the physician to establish the accepted standard of care, since there are varying opinions about how aggressively to follow up on increased Spa's, depending on a person's age and willingness to consent to a DRE.

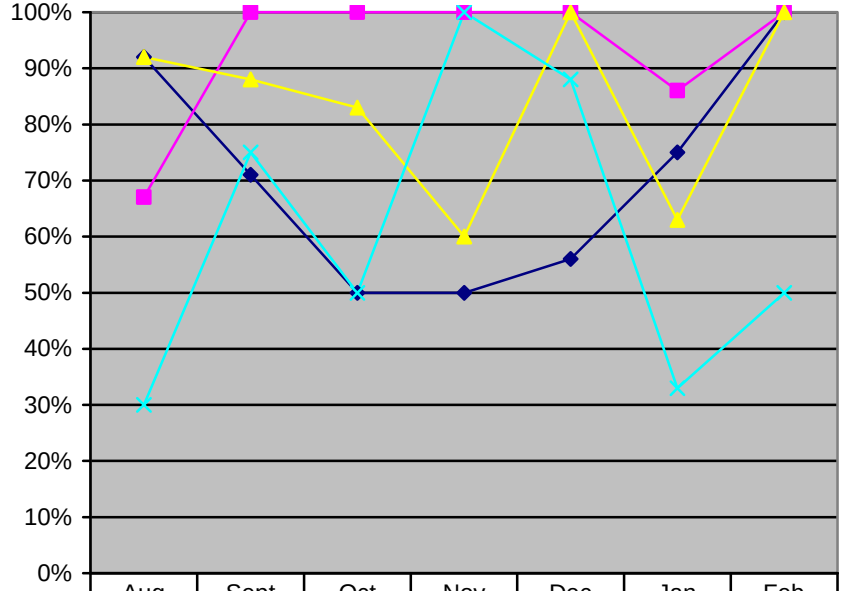
The Hospital also undertook a series of activities related to treatment of individuals with Hepatitis C. Upon obtaining a report of those in the hospital who are positive for Hep C, medical staff reviewed the latest protocols for follow up assessment and treatment. One of

No	Requirement	Progress/Findings
		the pharmacists presented to medical staff information about the various hepatotoxic medications that are used in psychiatry. Additionally, Pharmacy now notifies the physicians for individuals positive for hepatitis C of any medication that they are being prescribed that may be hepatotoxic and asks them to consider using other medications or justifying the continued use of the medication in light of the person's Hep C status. The Hospital is also using IRP observation audits to assess if during Phase I of the IRP conference, the treatment teams are reviewing the current diagnoses and discuss if diagnoses need to be updated. During this discussion, the team refers to any new evaluations or testing completed since the last IRP conference. Auditing of this was incorporated into the IRP Monitoring observation audit tool in December, 2010 and data shows compliance at 39% for December and at 90% in January. *IRP Monitoring Observation Audit results, Tab # 9.* **Compliance: Partial**
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:** See VI.A.3
		Compliance: Partial
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:** See VI.A.1, VI.A.2 and VI.A.3. The Hospital audits the timeliness of the completion of the CIPA through the CIPA audits. *Tab # 16, CIPA Audit results.* Data from the period August 2009 through February, 2010 show:

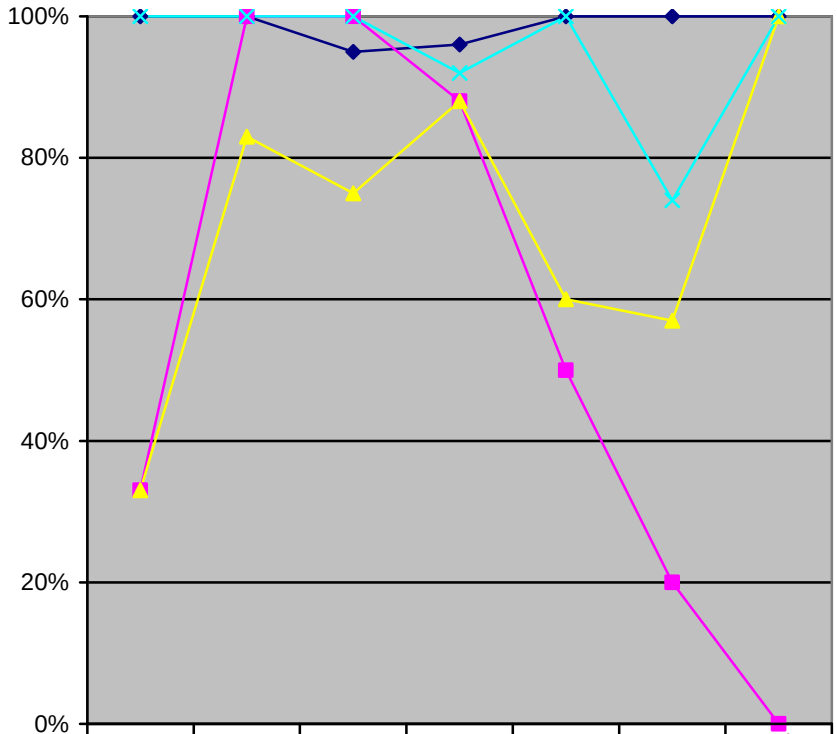
No	Requirement	Progress/Findings
		 *See Tab # 16, CIPA audit results.* The Hospital began completing the CIPA in Avatar during the review period, and screen shots and a sample report are included in *Tab # 14.* The CIPA audits continue to evaluate whether all fields are completed as well as the accuracy of diagnosis, development of precautions when risks are identified, the appropriate identification of strengths and needs and the completion of all sections of the mental status examination section. *See VI.A.2 and VI.A.3 for data summary.* Changes were made to the CIPA Avatar report to correct DOJ identified issues around the substance abuse assessment portion of CIPA. Further, an audit tool was recently created, and is to be implemented in April, 2010, that will assess whether IRP objectives and interventions reflect the results of the assessment and are appropriate given the individual's stage of change. *Tab # 52 Substance abuse audit tool/instructions.* **Compliance: Partial**
VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Findings:** See VI.A.1, VI.A.3, and VI.A.5. Data from both the CIPA and Psychiatric Update Audits

No	Requirement	Progress/Findings
		show progress in ensuring diagnoses are supported by the individual's clinical presentation, although data from the psychiatric update audit also suggest that documentation for deferred Axis II diagnosis needs improvement. *Tab # 11 (Psychiatric Update), Tab # 16 (CIPA audit results)*

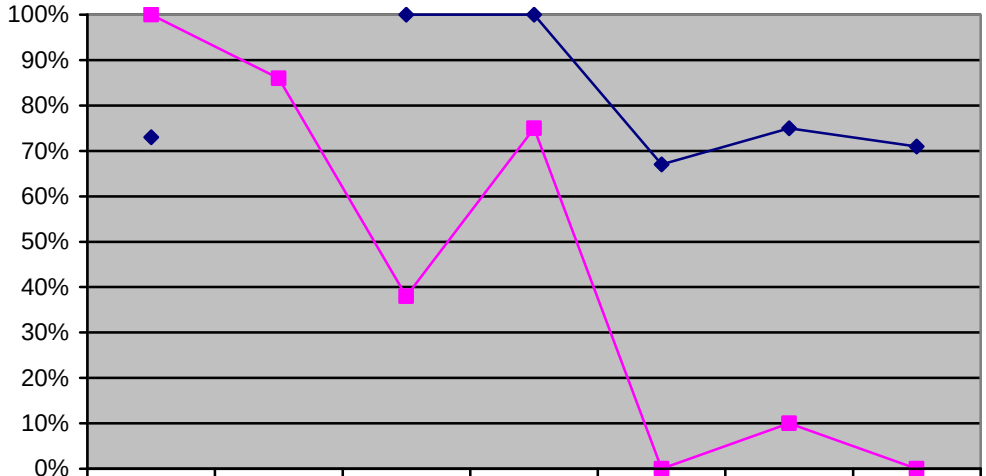
CIPA Diagnoses Indicators



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Diagnosis Section completed	92%	71%	50%	50%	56%	75%	100%
Diagnosis reflects clinical presentation	67%	100%	100%	100%	100%	86%	100%
Substance abuse evaluation completed	92%	88%	83%	60%	100%	63%	100%
Stage of change for s/a reflects assessment	30%	75%	50%	100%	88%	33%	50%

No	Requirement	Progress/Findings
		Psychiatric Update: Diagnosis  **Compliance: Partial**
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	**Findings:** The Hospital monitors this requirement through the CIPA and Psychiatric Update audits, and recently modified the Psychiatric Update audit to specifically monitor for the presence of a note by the attending physician where the assessment is completed by a trainee. The

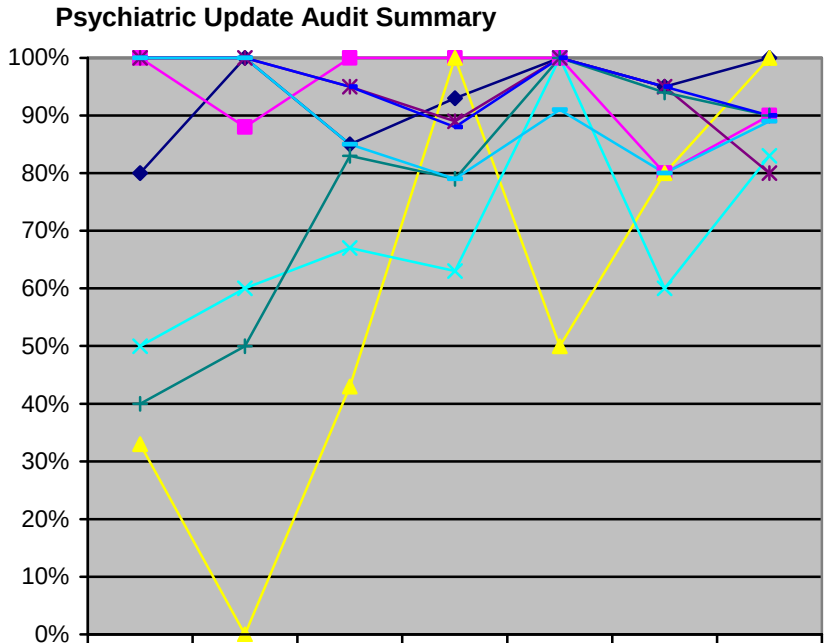
	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Diagnosis section completed	100%	100%	95%	96%	100%	100%	100%
Justification for deferred Axis II	33%	100%	100%	88%	50%	20%	0%
Justification for R/O or NOS	33%	83%	75%	88%	60%	57%	100%
Justification for continued hospitalization	100%	100%	100%	92%	100%	74%	100%

No	Requirement	Progress/Findings
	a note to accompany these assessments;	Avatar electronic medical record reports are now formatted so that each major document can be done in draft first, reviewed, and then put into final form. If a trainee initiates the form as a draft, the supervisor can review the trainee's submission, make any changes, add any comments, and then submit it as final. The report in Avatar will reflect the name of the person who initiated the document and the name of the person who finalized the document. Data from the audits, which include operational instructions that aligns with the Hospital policy requiring a note rather than just a countersignature show as follows: **Note by Attending After Review of Trainees' Assessment**  | | Aug | Sept | Oct | Nov | Dec | Jan | Feb | | CIPA | 73% | n/a | 100% | 100% | 67% | 75% | 71% | | Psy Update | 100% | 86% | 38% | 75% | 0% | 10% | 0% | *See Tab # 16 (CIPA Audit results) and Tab # 11(Psychiatric Update Audit results).* The audit reveals that in far too many cases, a countersignature is still being used in place of a specific note by the attending physician where the assessment is completed by a trainee. During this review period, SEH has maintained its facility-based residency training program in Psychiatry and continued to serve as a training site for forensic psychiatry fellows from Georgetown University and residents. In addition, SEH has continued to serve as a training site for psychiatry residents from Howard University and the Uniformed Services University Schools of Medicine as well as medical students from Georgetown University, George Washington University, Uniformed Services University, Ross University, Howard University and the American University of Antigua.

No	Requirement	Progress/Findings
		Compliance: Partial
VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and	**Findings:** See VI.A.1, VI.A.2, VI.A.3 and VI.A.4. **Findings:** Training was offered to clinical staff in the diagnosis and treatment of persons with drug induced movement disorders and in treatment of those with schizophrenia who are treatment resistive. *Tab # 84, Grand Rounds training and trainers.* **Compliance: Partial**
VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Findings:** See VI.A.1 through VI.A.6.a and VI.6.c
		Compliance: Partial
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:** Hospital policy requires the reassessment of an individual by a psychiatrist weekly for the first 60 days and monthly thereafter. Weekly updates are in the progress note section of the record, and the monthly updates are to be completed using the Psychiatric Update form. *Tab # 12, Assessment Policy,Tab # 13 Medical records policy.* The Hospital developed and implemented the psychiatric update form across all units of the Hospital, and it is completed at least monthly by physicians. It is not yet in Avatar, but is in the queue and should be completed within 4-6 months. The Update provides information on each of the following areas: 1. Legal status; 2. Subjective findings; 3. Objective findings and mental status examination; 4. Clinical history/course; 5. Current target symptoms; 6. Use of Stat medications, seclusion and/or restraints, including triggers for this use; 7. Use of involuntary medications;

No	Requirement	Progress/Findings
		8. Side effects of new generation antipsychotic medications (if applicable); 9. Rationale for polypharmacy (if applicable); 10. Risk assessment for violence/suicide; 11. Results of rating scales used; 12. Assessment of individual's progress; 13. Review of specific behavioral and/or psychodynamic issues affecting lack of progress (if applicable); 14. Diagnoses (five axes); 15. Justification for continued deferral of diagnosis and NOS diagnosis (if applicable); 16. Current medication regimen; 17. Abnormal laboratory results; 18. Plan of care (pharmacological and behavioral, with attention to high risk medication uses) and 19. Certification of necessity of inpatient level of care. Instructions are also completed and are available on the intranet. *See Tab # 17, Psychiatric Update form and instructions.* DOJ consultants recommended that a field to address "use of PRN medications" be added to the Psychiatric update. However, per Hospital policy, PRN orders may not be issued for oral or injectable psychotropic medication. Instead, if the individual's psychiatric condition is such that additional psychotropic medication is needed, then a STAT order may be appropriate. Therefore, the Hospital elected only to include a prompt for STAT medications in the Update to avoid confusion for the doctors. Data from the psychiatric update audit shows improvement is needed around rationale for various medication regimens and addressing the issue of abnormal laboratory levels. The Audit also finds that most of the psychiatric updates are timely and that documentation of rationale for use of STAT medications or more than 2 anti-psychotic medications is progressing. *Tab # 11 Psychiatric update audit results.*

No	Requirement	Progress/Findings



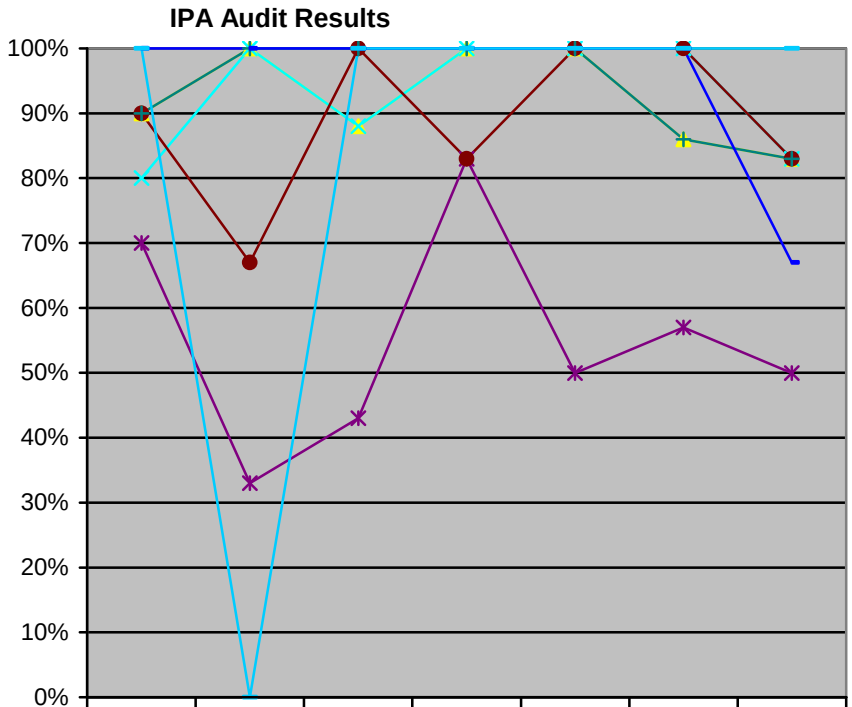
	Aug	Sept	Oct	Nov	Dec	Jan	Feb
MSE completed	80%	100%	85%	93%	100%	95%	100%
Timely	100%	88%	100%	100%	100%	80%	90%
Use of STAT medications	33%	0%	43%	100%	50%	80%	100%
Rationale for > 2 anti-psych	50%	60%	67%	63%	100%	60%	83%
Response to tx	100%	100%	95%	89%	100%	95%	80%
Lab levels	40%	50%	83%	79%	100%	94%	90%
Pharmacological plan appropriate	100%	100%	95%	88%	100%	95%	90%
Integrate behav/psych interventions	100%	100%	85%	79%	91%	80%	89%

See Psychiatric Update audit results, Tab # 11.

With respect to the integration of behavioral and psychiatric interventions, the PBS team leader began training staff in the PBS model. As of mid-March, all nurse managers and nursing leadership have received PBS overview training, as have all clinical administrators and psychologists. Sixty three night shift nursing staff have completed the overview as well, and a plan is in place to complete the overview training with all nursing staff and psychiatry

No	Requirement	Progress/Findings
		staff by May 31, 2010. **Compliance: Partial**
	B. Psychological Assessments	
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:** Psychology continues to complete an initial psychological assessment on all individuals admitted, *Tab # 19,* and also provided a broad range of other types of assessments, including risk assessments, psychological evaluations, neuropsychological assessments and behavioral assessments. *See Tab # 20 for templates and guidelines for psychological evaluations and risk assessments.* Auditing has only begun for Initial Psychological Assessment (IPA), *Tab # 21,* but audit tools for all other assessments have been completed and audits will begin in April, 2010. *Tab # 20, Psychology audit tools.* Results from the IPA audits show some areas of strength and others in need of improvement. Timeliness of completion of Part A of the IPA for the period of August 2009 through January, 2010, ranged from a low of 25% in December 2009 to a high of 75% in January, 2010; timeliness of Part B during this same period ranged from a low of 57% in November 2009 to a high of &5% in January, 2010. *Tab # 21 IPA audit results.* Psychology generally completed violence and suicide risk assessments in the majority of cases. Areas on need of improvement included addressing head trauma history and timeliness. However, performance was consistently high in completing the violence and suicide risk screening checklists and assessment findings and in completing recommendations for treatment or follow-up.

No	Requirement	Progress/Findings



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Previous hx assessed	90%	100%	88%	100%	100%	86%	83%
Substance hx assessed	80%	100%	88%	100%	100%	100%	83%
Head trauma	70%	33%	43%	83%	50%	57%	50%
Dx	90%	67%	100%	83%	100%	100%	83%
Violence risk checklist	90%	100%	100%	100%	100%	86%	83%
Suicide risk s checklist	100%	100%	100%	100%	100%	100%	67%
Recommendations included	100%	0%	100%	100%	100%	100%	100%

Psychology has assigned one additional psychologist ½ time to complete neuropsychological examinations and three additional psychologists were hired and are expected to start on March 28, 2010. This additional staff are expected also to result in improvement in the timely completion of the IPA. Upon relocation to the new hospital, the admission ward serving individuals admitted civilly have two psychologists which is expected also to improve the timely completion of the IPAs.

Compliance: Partial

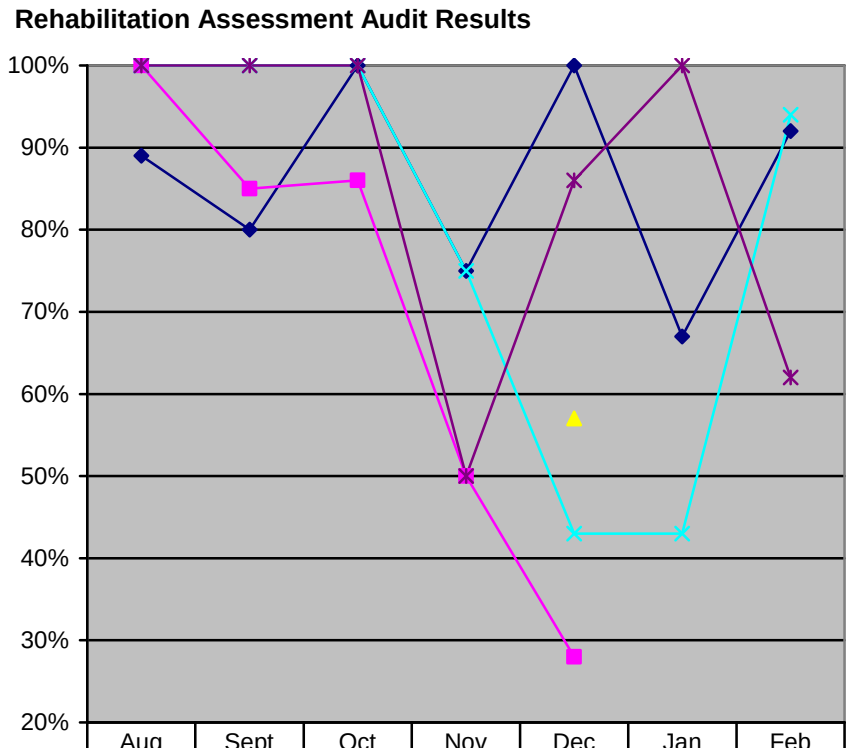
No	Requirement	Progress/Findings
VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments shall:	Please see sub-cells for findings and compliance.
VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Findings:** Current practice is to continue to include the purpose for the assessment in all reports. **Compliance: Substantial**
VI.B.2.b	be based on current and accurate data;	**Findings:** Current practice is to continue to be based on current and accurate data. **Compliance: Substantial**
VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Findings:** Risk Assessments are available and completed. **Compliance: Substantial**
VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Findings:** The assessments completed by psychology address the purpose of the assessment in the written reports. This will be audited beginning in April, 2010. In addition, the Psychology Department and the TLC staff are continuing to meet to determine how psychology can best assist in making specific recommendations about appropriate groups for the individual being assessed. **Compliance: Substantial**
VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Findings:** Completed assessments include a summary of the empirical basis for their conclusions. **Compliance: Substantial**

No	Requirement	Progress/Findings
VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	**Findings:** Psychology hired three additional psychologists, who began work on March 28, 2010. With the addition of these new staff, once the individuals and staff move to the new hospital, all units will have an assigned psychologist and the admission unit serving civil individuals will have two psychologists. This will facilitate implementation of the Hospital's process of using the ward based psychologists to assess whether individuals need additional psychological assessments. *See List of Psychologists, Tab # 38* **Compliance: Partial**
VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Findings:** Treatment teams are referring individuals to psychology for evaluations, which are being completed appropriately. **Compliance: Substantial**
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:** The Psychology Department developed and is using a form to track the presentation of the results and recommendations of a psychological or neuropsychological evaluation. The form tracks when it was discussed with the treatment team as well as the team's response to the recommendations. *Tab # 48, Acknowledgement of receipt of recommendations.* **Compliance: Partial**
	C. Rehabilitation Assessments	
VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.	**Findings:** Rehabilitation Services has been reorganized in anticipation of the move to the new hospital building, and there is no longer a division between civil or forensic rehabilitation services staff. Rehabilitation Services is now part of the Division of Treatment Programs, which consolidates all unit-based and TLC programming. Rehabilitation Services currently has 21 staff including the director, and 5 vacancies, four of which are in recruitment and one which is pending a table of organization change. *See Boggio Advanced Document request, Tab # 38.* In addition, all current individuals in care now have a completed rehabilitation assessment.

No	Requirement	Progress/Findings

This was a huge accomplishment for rehabilitation services staff.

Audit data from the rehabilitation assessments on admission show:



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Timeliness	89%	80%	100%	75%	100%	67%	92%
Past rehab therapies reflected	100%	85%	86%	50%	28%	n/a	n/a
Life skills	n/a	n/a	n/as	n/a	57%	n/a	n/a
Self reported interests	100%	100%	100%	75%	43%	43%	94%
Rehab strategies appropriate	100%	100%	100%	50%	86%	100%	62%

Tab # 25, Rehabilitation Services Audit results. Please note that the n/a for January and February was due to a technical glitch in Avatar which prevented auditors from accessing these sections.

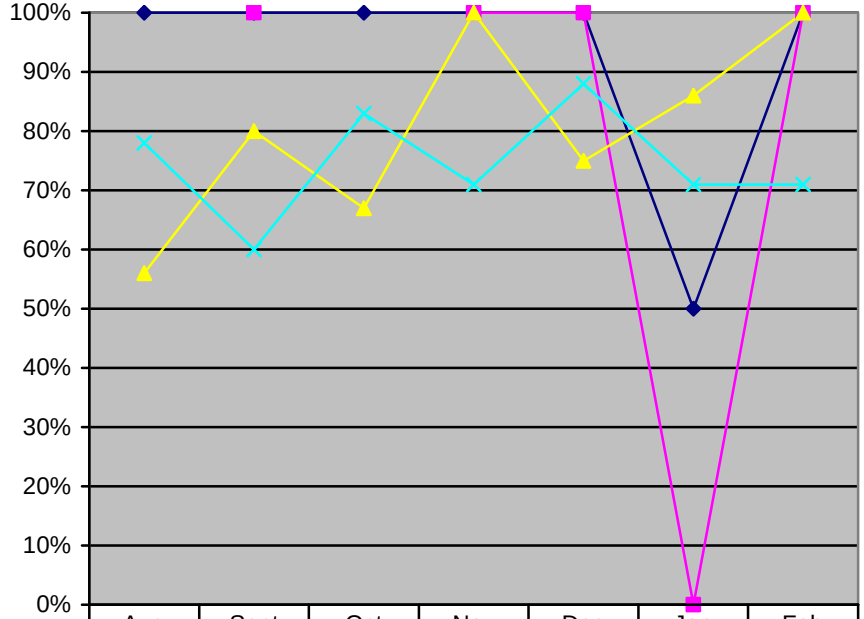
As noted earlier in the report, the treatment programming is undergoing a major realignment

No	Requirement	Progress/Findings
		as a result of the move to the new Hospital. All treatment programming, including TLC and ward based treatment, is now under the direction of a Director of Treatment Programs. There will be two therapeutic learning centers, one serving individuals in care that reside in the Intensive Treatment program and one serving individuals in care that reside in the Transitional Services program; individuals will be assigned to the program that best meets their needs. Each program has the capacity to provide treatment, skill-building and enrichment activities, and has services for those with substance abuse or cognitive impairments. *See Tab # 69 for Summary description of Treatment Programming.* Each discipline is expected to provide a specific number of group therapies per week and are now working with the Director of Treatment Programming to establish group therapies. *See Tab # 69 for Summary description of Treatment Programming.* The SAMHSA and Boston University curricula will continue to be used. **Compliance: Partial**
VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	
VI.C.2.a	be accurate as to the individual's functional abilities;	**Findings:** See VI.C.1 Audit data shows high performance in assessing functional levels, which is largely at 100%. *Tab # 25 Rehabilitation Services Audit results.* **Compliance: Substantial**
VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Findings:** See VI.C.1. Audit data relating to this requirement is only available beginning December, 2010 but the data from December through February on this indicator is not valid; auditors were precluded from accessing the necessary screens in Avatar. That issue has been resolved so data will be available beginning in March, 2010. **Compliance: Partial**
VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and	**Findings:** See VI.C.1. Audit data shows varying results as to compliance ranging from a low of 43%

No	Requirement	Progress/Findings
	weaknesses; and	in December, 2009 to a high of 100% in August, 2009. Data from February shows performance at the 77% mark. **Compliance: Partial**
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:** See VI.C.1. Audit data shows high compliance, though some inconsistency from month to month recently. The range of performance on this indicator in the audit is from a low of 50% in November, 2009 to a high of 100% in August through September, 2009. Performance was at 62% in February, 2010. **Compliance: Partial**
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:** See VI.C.1. Assessments on all previously admitted individuals have been completed. *See Boggio Advanced Documents, tab # 38 for list of completed assessments.* **Compliance: Substantial**
	D. Social History Assessments	
VI.D	By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.	**Findings:** The Hospital is generally completing a social work initial assessment (SWIA) within five days of admission and a social work update each month, and is auditing both assessments. Both assessments are now completed in Avatar. Audit results of the initial assessment show excellent performance across many indicators, with the exception of the discussion of the individual's goals and whether they are realistic or achievable. *Tab # 33, SWIA audit results.* In two indicators around identification of and resolution of discrepancies, data show higher performance in timeliness and the identification of factual discrepancies in history, but very uneven performance in the explanations of conclusions drawn about those discrepancies.

No	Requirement	Progress/Findings

SWIA Audit Results: Discrepencies

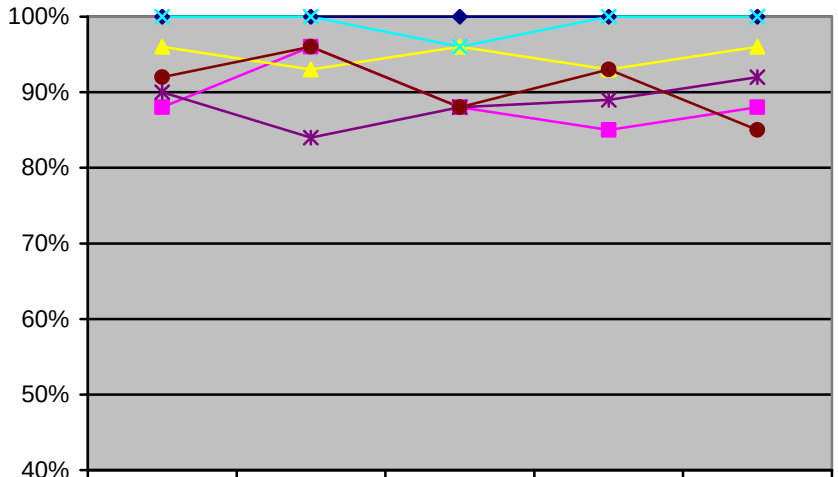


	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Discrepancies identified and efforts to resolve	100%	100%	100%	100%	100%	50%	100%
Rationale for conclusions relating to discrepancies	n/a	100%	n/a	100%	100%	0%	100%
Timely	56%	80%	67%	100%	75%	86%	100%
Includes discussion of individual's goals and if they are realistic	78%	60%	83%	71%	88%	71%	71%

Audit results from the social work update show consistently good quality. The lowest rated indicator concerns whether the documentation of intervention is appropriately descriptive. *Tab # 33, SW Assessment Update audit results.*

No	Requirement	Progress/Findings

Social Work Update: Factors



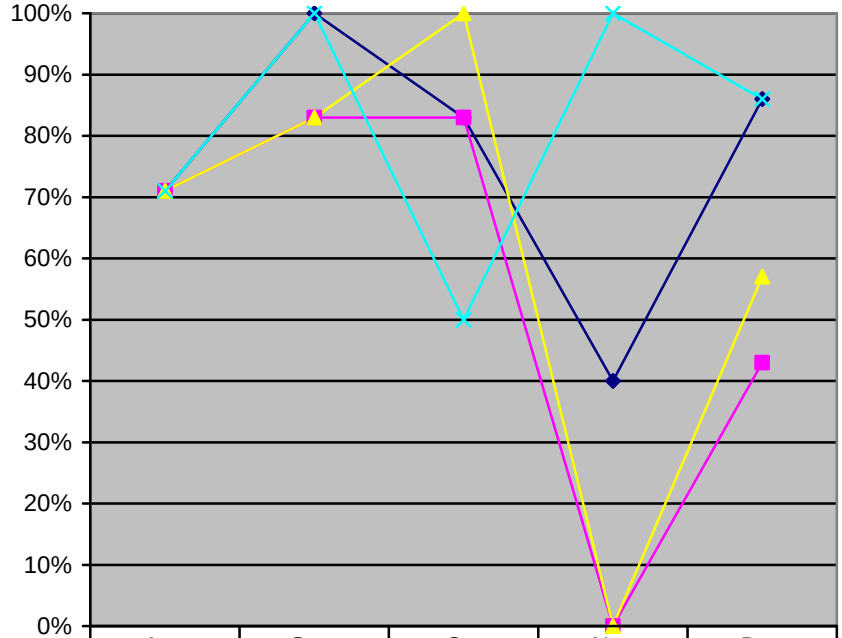
	Aug	Sept	Nov	Dec	Feb
Timely	100%	100%	100%	100%	100%
Documentation of intervention is descriptive	88%	96%	88%	85%	88%
Describes progress toward discharge	96%	93%	96%	93%	96%
Describes case manager's involvement	100%	100%	96%	100%	100%
Status of d/c barriers	90%	84%	88%	89%	92%
Assessment of services needed ford/c	92%	96%	88%	93%	85%

VII. Discharge Planning and Community Integration

No	Requirement	Progress/Findings
	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.	**Summary of Progress:** 1. The Hospital continues to monitor barriers to discharge and is using weekly meetings with key DMH administrators and representatives from community providers to address barriers. The Director, DMH monitors the barriers to discharge list each week. A log of the weekly meeting is maintained and information from the meetings is sent each week to the Clinical administrators for the specific individuals. 2. As of March, 2010, the Hospital census is generally between 311 and 325. Upon move to the new hospital building, the Hospital will have 13 units, 11 in the new hospital and 2 in the Annex (formerly RMB). 3. DMH hired an individual who will be monitoring the implementation of the discharge plans of care for those persons who were discharged from Saint Elizabeths. Beginning in January, 2010, data is available around the services provided for individuals discharged from SEH and whether discharge plans of care were implemented. DMH is monitoring if the individual is receiving housing and aftercare services consistent with the discharge plan of care. 4. The Hospital implemented the discharge plan of care instructions which is provided to individual in care upon discharge and to the Authority for post-discharge follow up. 5. The Hospital continues to monitor discharge planning through the conduct of discharge audits, and also through several indicators relating to discharge in the IRP Monitoring Observation audits. 6. The Hospital continues to use the integrated care contract to support discharge of the discharge resistive individuals. In addition, transition peer specialists began working in February 2010 and meet with individuals in care in the TLCs and provide support and assistance related to discharge issues. 7. Treatment programming will be modified in the new building, and will be tailored toward the individual's expected length of stay.
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:** The Hospital continues to monitor discharge planning through two main audits, the discharge audit (20% sample completed monthly) and the IRP Monitoring Observation audits, also completed monthly. *Tab # 67* (*Discharge audit tool), Tab # 68, Discharge audit results.* In reviewing the data, please note that the current discharge audit uses a met, partially met or not met standard, and the data below reflects met and partially met combined. This is being changed beginning with a new tool beginning this week which will only use a met/unmet standard. Discharge audits were completed monthly on a 20% sample of discharges. Data show generally good performance in providing the individual

No	Requirement	Progress/Findings
		with instructions upon discharge, and a focus on discharge upon admission. However, data around the provision of transitioning services and psychosocial rehabilitation services suggest that IRPs are not yet clearly reflecting a focus on interventions that will support discharge.

Discharge Audits



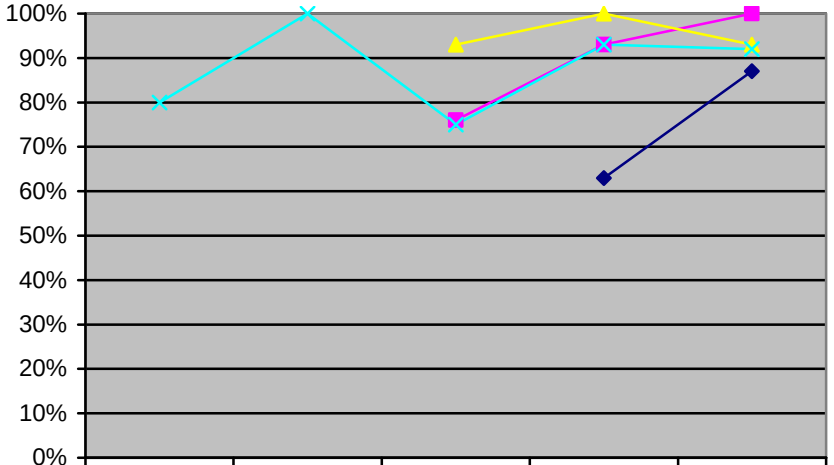
	Aug	Sept	Oct	Nov	Dec
D/C planning at admission	71%	100%	83%	40%	86%
Transitioning assistance	71%	83%	83%	0%	43%
Psychosocial rehab	71%	83%	100%	0%	57%
D/c instruction sheet given to individual	71%	100%	50%	100%	86%

See Tab # 67 (Discharge audit tools and instructions) and tab # 68, Discharge audit results.

PID and the Office of the Chief of Staff have significantly modified the discharge audit tool. *See Tab # 67 (Discharge audit tools and instructions).* The new tool includes new indicators that focus on rehabilitation and treatment occurring provided during the hospitalization, transition to outpatient services and the content of the IRP related to discharge.

No	Requirement	Progress/Findings
		The Hospital also monitors the individual's participation in IRP planning around discharge through the IRP Monitoring observations. The discharge-related indicators include whether the presentation of the present status during the clinical formulation update includes a description of discharge criteria (monitored beginning December, 2009); whether the team, if clinically appropriate, identified or discussed plans for discharge or movement to a less restrictive environment during Phase I (monitored since October, 2009); whether during Phase II the team reviewed with the individual discharge criteria, if clinically appropriate (monitored since October, 2009); and whether the team gave the individual an opportunity to be an active participant in discharge planning. *See Tab # 8, IRP Monitoring observation tools.*

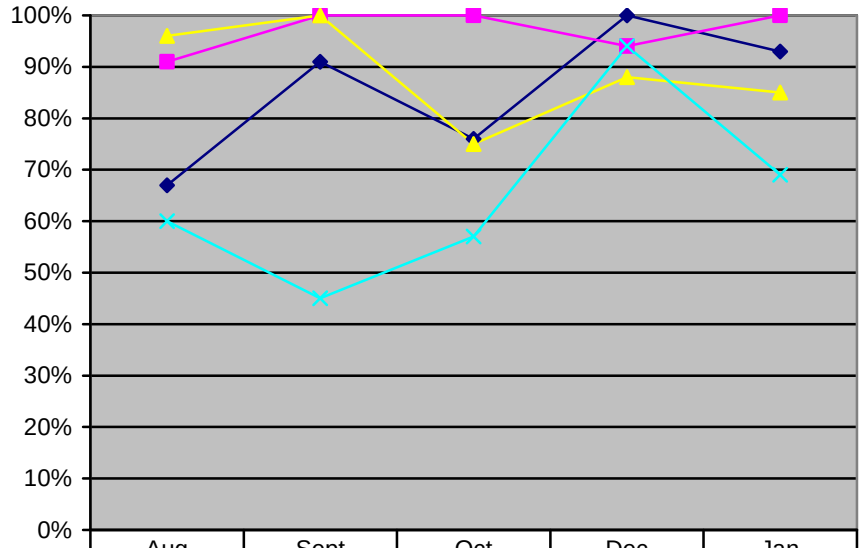
IRP Observations: Discharge Planning



	Aug	Sept	Oct	Dec	Jan
D/c criteria presented during clinical formulation	n/a	n/a	n/a	63%	87%
D/C during phase I	n/a	n/a	76%	93%	100%
Review with individual criteria for d/c	n/a	n/a	93%	100%	93%
Gave individual opportunity to participate actively in d/c planning	80%	100%	75%	93%	92%

See Tab # 8 (IRP Observation audit tools) and Tab # 9 (IRP audit results). Data shows improving performance in addressing discharge issues in IRP planning. Because the clinical chart audit has not been implemented yet, the Hospital is unable to determine if

No	Requirement	Progress/Findings
		there written IRPs consistently include more specific and individualized written discharge criteria. The Hospital recently awarded a contract with a consultant to provide IRP training around developing the IRP with a focus on discharge planning. *See Tab # 2, IRP consultant contract.* Services under that contract are expected to begin in April or early May, 2010. Services also include assistance with development of the clinical chart audit. In addition, coaches working with five units are also addressing the role of discharge planning in IRP development. *See coaching guidelines, Tab # 1* **Compliance: Partial**
VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Findings:** See VII.A. Based upon IRP observation data, IRP teams are improving in focusing on individual strengths, preferences and personal goals including those related to discharge.

No	Requirement	Progress/Findings
		IRP: Individual Involvement  Further, in IRP conferences observed by the Compliance Office staff, there is more consideration of the preferences of the individual and we are beginning to see more flexibility and creative thinking around respecting the individual's preferences. However, this will also be addressed in the IRP training under the new contract. **Compliance: Partial**
VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Findings:** See VII.A. and VII.A.1

	Aug	Sept	Oct	Dec	Jan
Strengths Reviewed with individual	67%	91%	76%	100%	93%
Life goal Reviewed with individual	91%	100%	100%	94%	100%
Individual's input into objectives	96%	100%	75%	88%	85%
Individual's input into interventions	60%	45%	57%	94%	69%

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>Compliance: Partial</td></tr>
<tr><td>VII.A.3</td><td>barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and</td><td>Findings:

See VII.A. and VII.A.1.

The Hospital continues to monitor and provide reports to the Director, DMH around systemic barriers to discharge. Tab # 62, Barriers to Discharge. As of March 23, 2010, there were 33 individuals on the list waiting discharge due to one or more barriers. Specifically, the breakdown of issues is as follows:

<table>
<tr><th>ISSUE</th><th>NUMBER</th></tr>
<tr><td>Housing placement</td><td>15</td></tr>
<tr><td>DDS related issues</td><td>3</td></tr>
<tr><td>Nursing home barriers</td><td>5</td></tr>
<tr><td>Rejected from placement options</td><td>0</td></tr>
<tr><td>Undocumented/language issues</td><td>0</td></tr>
<tr><td>Awaiting inspection/licensing of home</td><td>2</td></tr>
<tr><td>Resistive to discharge</td><td>8</td></tr>
</table>

Progress was made in addressing discharge barriers especially with individuals with a diagnosis of mental retardation. Last year, 8 individuals with MR diagnoses were discharged through work with Department of Disability Services, and this year, 9 others are targeted. Nursing home placements continue to be in short supply; United Medical is considering opening nursing home beds, but it is unclear if and when that might occur so other options are being considered.

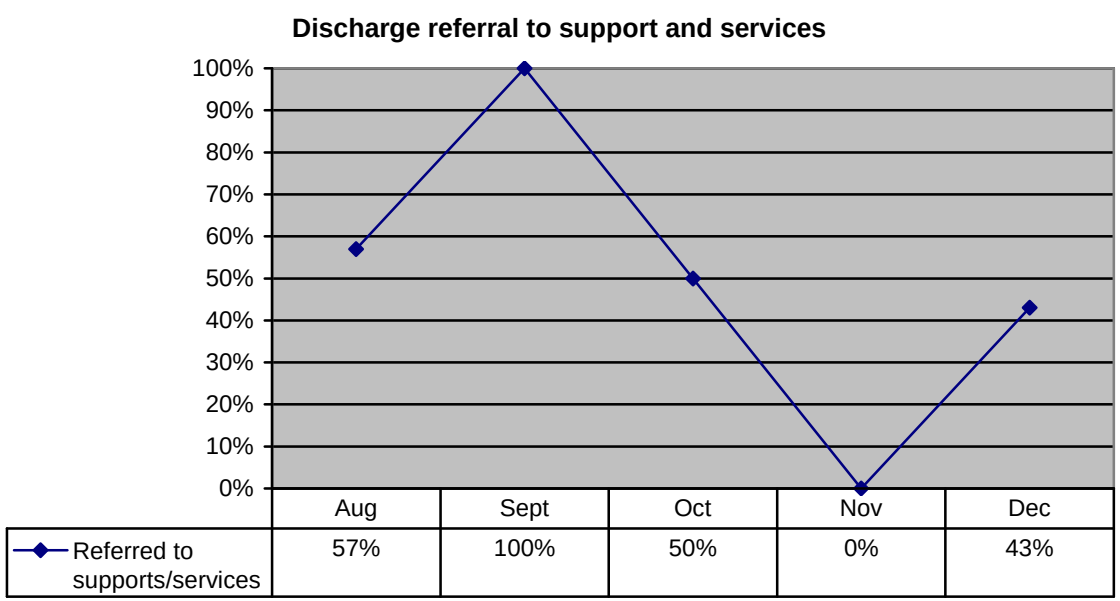
The Hospital continues its weekly meetings with community services providers to address issues that are preventing discharge of specific individuals. During these meetings, individuals are discussed with their Core Service Agencies (“CSAs”) to plan for discharge and address issues related to the individual’s hospitalization that may be unresolved. A log is kept reflecting the issues and action steps to occur. While in the past that information was shared with the treatment team by the supervisory social workers who attend the meeting, beginning April 1, 2010, the log itself will be shared with the clinical administrator for the individuals. See Tab # 72 Discharge Weekly Meeting activity log

Compliance: Partial</td></tr>
<tr><td>VII.A.4</td><td>the skills necessary to live in a setting in</td><td>Findings:</td></tr>
</table>

No	Requirement	Progress/Findings
	which the individual may be placed.	See VII.A. and VII.A.1 As discussed in more detail elsewhere in the report, the treatment programming at the Hospital is undergoing a restructuring to be implemented at the time of the move to the new Hospital. The programming will include additional skill-based interventions that reflect the individual's cognitive levels and functioning. *See Tab # 69, Treatment Programming Summary.* The programs will be curricula-based and still utilize the Illness Management and Recovery Model from SAMHSA and the Psychiatric Rehabilitation Model from Boston University. All disciplines will be providing groups to aid individuals in developing skills needed for successful discharge. **Compliance: Partial**
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:** See VII.A. and VII.A.1. **Compliance: Partial**
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:** See VII.A. and VII.A.1 **Compliance: Partial**
VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Findings:** The Hospital updated the clinical formulation and clinical formulation update instructions to provide additional guidance on discharge criteria development and related IRP interventions. *See Tab # 6 and 7.* Additional examples are provided in completing the discharge criteria. In addition, the IRP consultation contract includes training in developing the interventions that support progress toward discharge, as well as assistance in further improving the IRP manual. *See Tab # 2, IRP consultation contract.* **Compliance: Partial**

No	Requirement	Progress/Findings
VII.C.2	the persons responsible for accomplishing the interventions; and	**Findings:** The Hospital has not yet begun to complete the clinical chart audits but will conduct the audits in two phases. The first phase will focus on the completion and quality of the clinical formulation/update. The audit tool is completed for this phase and audits by designated clinical managers will begin in May, 2010. This will give an opportunity for the IRP consultant to provide comments on the tool. At this time, the Hospital does not have any data reflecting the written content of the IRP. In the meantime, the Hospital made some modification to the IRP form (*See Tab # 5)* to address some recommendations made during the last review, and now IRPs are completed in Avatar. The system requires a specific name for each intervention as well as frequency in order to finalize the IRP. **Compliance: Partial**
VII.C.3	the time frames for completion of the interventions.	**Findings:** See VII.C.2 **Compliance: Partial**
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 receive adequate assistance in transitioning prior to discharge.	**Findings:** The Hospital offers a number of transitioning activities for individuals transitioning to the community. Currently, 23 individuals attend community day treatment programs. *Tab # 79, List of individuals attending day treatment program.* In addition, a number of treatment mall groups provide skill building for transition to the community which will also be enhanced upon move to the new hospital. *See Tab # 69, Treatment programming information.* Because of the changes to the mall programming and of the time spent on new programming planning, the mall monitoring audit tool was not finalized or implemented. It is expected that a tool will be developed to address the new programming over the summer, 2010. Rehabilitation Services also sponsors other social activities in the community. These include the 7 – 9 club, which is held weekly in the evenings at a local church; Tacoma Park Social Club, held weekly during the daytime; Downtown social club, held weekly during the day; Community Awareness and Community Reentry groups make weekly trips to the city for leisure activities; and once monthly, an outing to the Ida Mae Campbell Center for

No	Requirement	Progress/Findings
		activity night (this will increase to twice monthly in the summer). Volunteer Services also sponsors activities that support individual transitioning to the community. These include daily computer classes taught by community volunteers, art workshops with local artists, twice monthly sing along with a local entertainer, volunteer "visitors" who visit individuals who have requested one, and volunteer poets and photographers who work with individuals in the Lens and Pens program. In addition, the MH Authority recently initiated an initiative in which peer specialists will work with individuals around transition to discharge. **Compliance: Partial**
VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Findings:** The Hospital implemented the discharge instruction sheet which is given to the individual upon discharge. See VII.A for data. It also continues with weekly meetings with community services providers to address issues that are preventing discharge of specific individuals. During these meetings, individuals are discussed with their Core Service Agencies ("CSAs") to plan for discharge and address issues related to the individual's hospitalization that may be unresolved. A log is kept reflecting the issues and action steps to occur. While in the past that information was shared with the treatment team by the supervisory social workers who attend the meeting, beginning April 1, 2010, the log itself will be shared with the clinical administrator for the individuals. *SeeTab # 72 Discharge: Weekly Meeting activity log* The audits of the records of those ready for but resistive to discharge were suspended but restarted in March, 2010. Data from a review of four records show that in general, there is no documentation that reflects the results of the weekly meetings, that there are often not specific strategies identified to address the resistance and that in no cases did the community case manager work with the Hospital to effect discharge. None of the four individuals were discharged. *Tab # 78, Resistive Patients tracking audit.* It is expected that the new protocol where the log is shared with each clinical administrator will improve documentation and outcomes for these individuals. Finally the discharge record audits include an indicator as to whether the individual was referred to supports and services at the time of discharge. Data shows low compliance with this, but it is believed that this is in part due to poor documentation and not lack of referrals.

No	Requirement	Progress/Findings
		 Data is now available that tracks individuals post discharge and determines which of the prescribed support services were provided upon discharge. See Section F. below. **Compliance: Partial**
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 Division of Integrated Care at the DMH Authority is now conducting detailed follow up audits of supports and services provided to individuals discharged from SEH. Its staff position was filled in late December 2009 and monitoring began in January, 2010. The reviews look at individuals 30, 60 and 90 days post discharge, and address the following factors: • Are the individuals in housing? • Are they in the type of housing recommended at discharge? • If applicable, are they attending a day treatment program or other day activity (i.e. work)? • Are they receiving support services if recommended? • Are they receiving medication management if recommended? • Are the receiving assertive community treatment if recommended?

No	Requirement	Progress/Findings
		• Are they receiving counseling if recommended? • Are they receiving medical follow up if recommended? *See Tab # 73 DMH, Hospital Discharge Support audit results.* Audits have been completed for both January, 2010 and February, 2010, reviewing individuals discharged from Saint Elizabeths within 30 and 60 days of discharge. (Next month, data will be available 30, 60 and 90 days post discharge.) Data around housing shows that of 19 cases of those who reached the 30 day mark were reviewed, 15 (79%) were still living in the housing to which they were discharged 30 days. Three cases of those discharged sixty days prior were reviewed, of those two remained in housing. There continues to be a high rate of drop out from the day programming – 33% in both January and February 2010. However, both individuals discharged to an ACT program and out 60 days continue in their ACT program. *See Tab # 73 DMH, Hospital Discharge Support audit results.* **Compliance: Substantial**
VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Findings:** See VII.F. **Compliance: Substantial**
VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Findings:** See VII.F. **Compliance: Substantial**

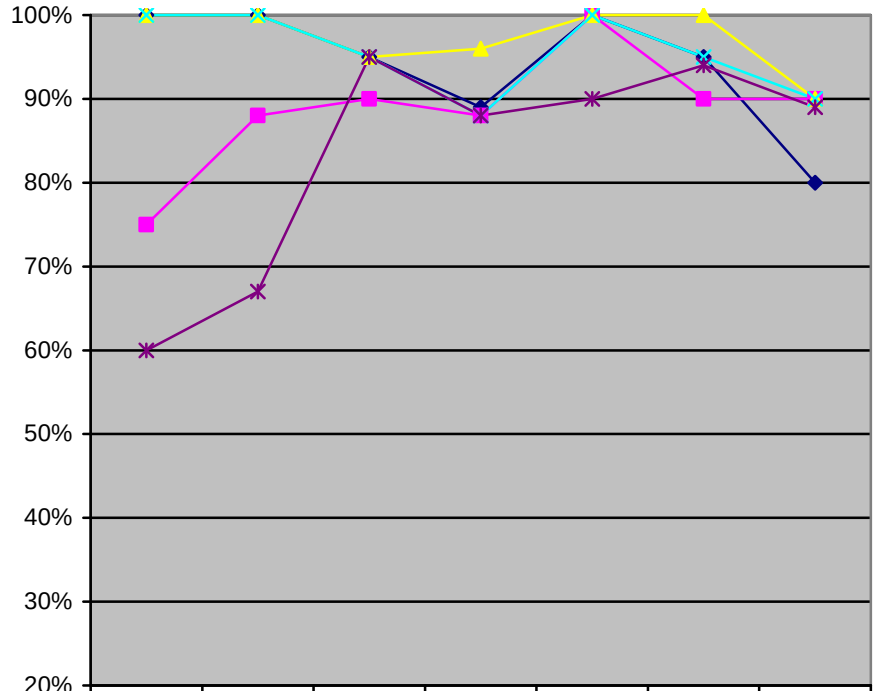
VIII. Specific Treatment Services

No	Requirement	Progress/Findings
		Summary of Progress: 1. The Hospital remains in substantial compliance with the requirement regarding psychiatric staffing levels. This is expected to continue upon relocation to the new building, at which time the Hospital will reduce the number of units from 15 to13. 2. The Hospital continues to utilize its individualized medication guidelines. The guidelines for clozaril were updated. 3. SEH is conducting two Drug Evaluation Utilization reviews during the review period. The first DUE concerns use of polypharmacy; reviews of the cases as of the writing of this report are almost complete and the analysis will begin immediately thereafter. The second DUE concerns the long term regular use of benzodiazepines in high risk populations including the elderly and those with diagnoses of substance abuse or cognitive disorders. It is in progress. 4. The Hospital implemented the new reporting structures for both medication variances and adverse reporting. Nursing has conducted training on reporting medication variances, and there is recent improvement in reporting by Nursing. Pharmacy conducted training with medical staff on reporting adverse reactions and while reporting somewhat improved, it still is lower than expected. One intensive case analysis was conducted relating to adverse medication instances. A Six Sigma team conducted an in-depth study of medication variances that involved lack of documentation around medication administration. 5. The Hospital continues to conduct monthly medication audits, and results are shared with Pharmacy and Therapeutics Committee. It should be noted that because reviews are conducted ward by ward and not a random sample, the results are trended only in six months intervals. The Hospital also conducted audits of individuals in care with a diagnosis of tardive dyskinesia. 6. The Hospital hired a leader for its Positive Behavioral support team who began training staff. As of mid March, over 100 staff among nursing, psychology and clinical administrators received PBS overview training. Two behavioral support technicians were also hired, and recruiting continues for a data analyst; recruitment for a nurse member of the team will begin once the table of organization is revised. 7. A contract for PBS training and support was finalized in late March, 2010, with services to begin in late April or early May, 2010. 8. Nursing continues to focus on staffing and skill building for nurses. Since January 1, 2010, all shifts on all units have had an assigned RN. In addition, nursing care hours per patient day have increased from an average of 4 in September to 5.37 for the period of October, 2009 through February 2010. Hiring is proceeding. Nurse Managers were made to compete for their jobs when they were upgraded. Eight were retained, three

No	Requirement	Progress/Findings
		were not. New structured interview questions were developed to better assess competencies prior to hiring. Recruitment is also underway for additional nurse educators. 9. All units have now been trained in the EARN program and implementation is underway; it will be implemented hospital-wide by early May 2010. Intensive training has been held relating to Medication Administration and seclusion and restraint, among other areas. 10. The Infection Control Program continues to operate within generally accepted standards. Data is collected and presented to the infection control committee.
	A. Psychiatric Care	
VIII.A.1	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	
VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Findings:** See Sections VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c. And VI.A.7 for specific information and data. The Hospital has updated its Assessment and Medical Records policies to ensure consistency. Full psychiatric assessments are due within 24 hours and psychiatric updates (reassessments) are due at least monthly or more often if the individual's condition warrants. In addition, weekly progress notes by the psychiatrist are required for the first sixty days of admission. *See Tab # 12 (Assessment policy) and Tab # 13 (Medical records policy).* The quality of the CIPA and Psychiatric Update is generally improving, but is not yet consistently at expected levels. *See Tab # 16 (CIPA audit results), Tab # 11, (Psychiatric Update audit results).* In the next six months medical staff will be addressing documentation issues that reflect the thinking of the physician around treatment and medication regimens. **Compliance: Partial**
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.

No	Requirement	Progress/Findings
		The psychiatric update audits began in August, 2009. Data show generally good performance on most indicators that address progress or change in condition. Performance is consistently high in completing the diagnosis and updating the pharmacological plan of care. There has been some progress over time in updating the risk assessment and current discharge barriers and in ensuring all aspects of the update reflect current progress.

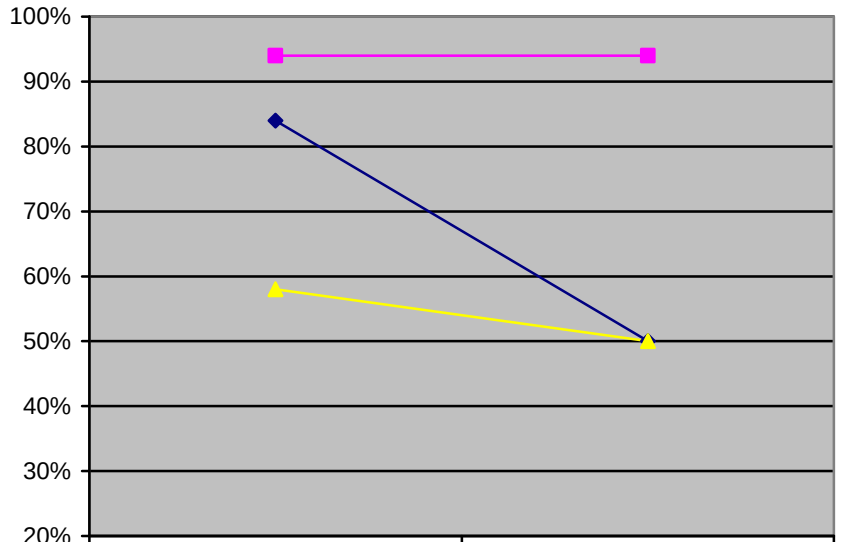
Psychiatrist's Clinical Updates: Psychiatric Update



	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Psych Update reflect progress/ treatment	100%	100%	95%	89%	100%	95%	80%
Risk Assessment Update	75%	88%	90%	88%	100%	90%	90%
Diagnosis Complete	100%	100%	95%	96%	100%	100%	90%
Pharmacological plan update care reflects progress	100%	100%	95%	88%	100%	95%	90%
Update reflect current barriers to d/c	60%	67%	95%	88%	90%	94%	89%

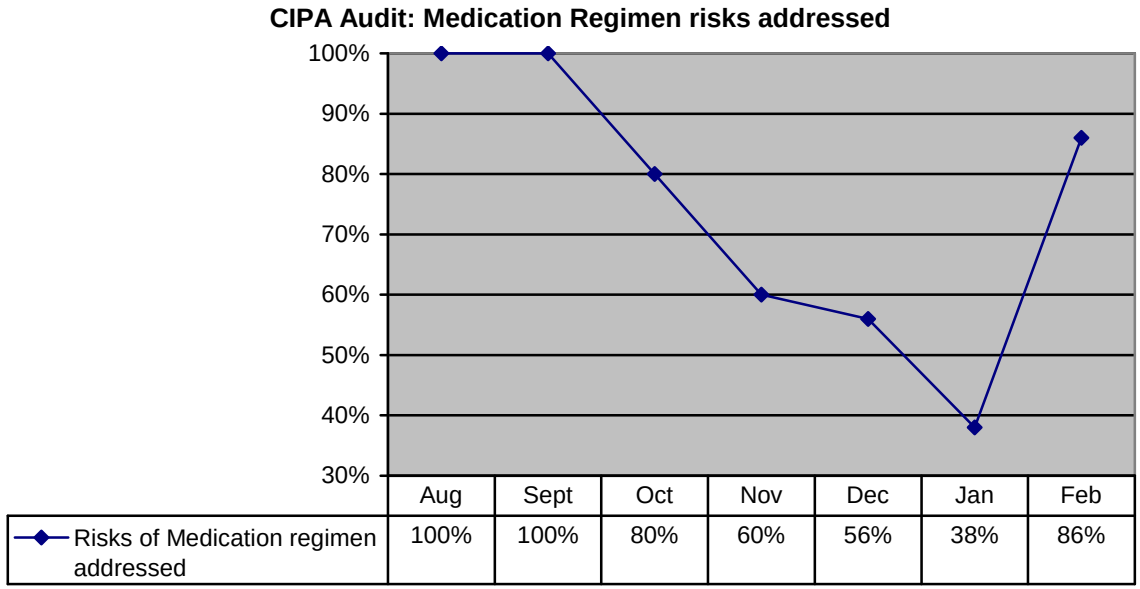
See Tab #11, Psychiatric Update Audit results.

No	Requirement	Progress/Findings
		In an effort to get even better data around the quality of the assessment updates and whether they accurately reflect progress, the psychiatric audit tool was revised effective April 1, 2010 to include several additional indicators that measure whether the updates address changes in clinical status and whether follow up issues were addressed. *See Psychiatric Update audit tools, Tab # 18.* Beginning December 2009, the IRP observers began assessing whether the psychiatrist is completing the psychiatric update prior to the IRP conference. Observers are also now reporting on the quality of the psychiatrist's participation in the IRP conference, including a specific indicator as to whether the psychiatrist addressed whether the individual has progressed due to the psychiatrist's interventions; an additional indicator assesses whether the psychiatrist recommended changes to the interventions if progress is not evident. Data show that psychiatrists are not consistently recommending changes to interventions when the individual is not making progress. Further, psychiatrists need to improve in completing the update within the 2 to 10 day window.

No	Requirement	Progress/Findings
		Psychiatrist's Clinical Updates: IRP  *Tab # 9, IRP Monitoring Observation results.*
VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Findings:** See VI.A.7 and VIII.A.1.b. **Compliance: Partial**
VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Findings:** See also VI.A.7. Some data are available from the CIPA and Psychiatric Update audits reflecting whether doctors are documenting the risks versus benefits of a particular medication regimen. The CIPA audit includes an indicator as to whether the initial

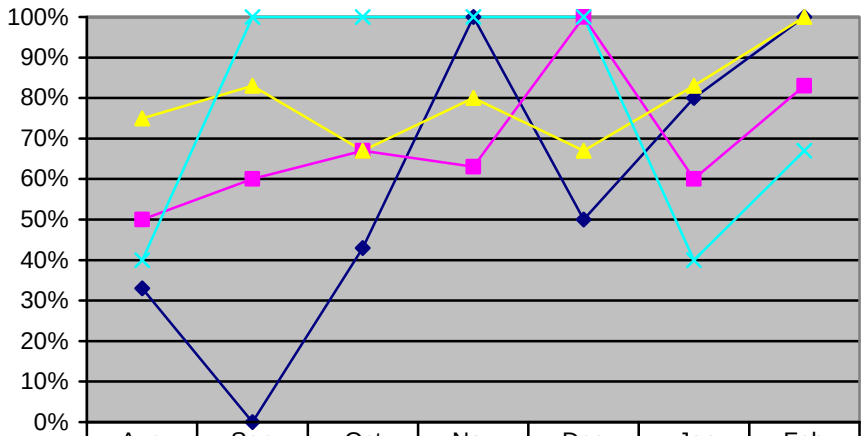
	Dec	Jan
Psych Update completed 2 > 10 days prior to IRP	84%	50%
Psychiatrist Reports on Progress during IRP	94%	94%
Psych Recommends Changes to Interventions	58%	50%

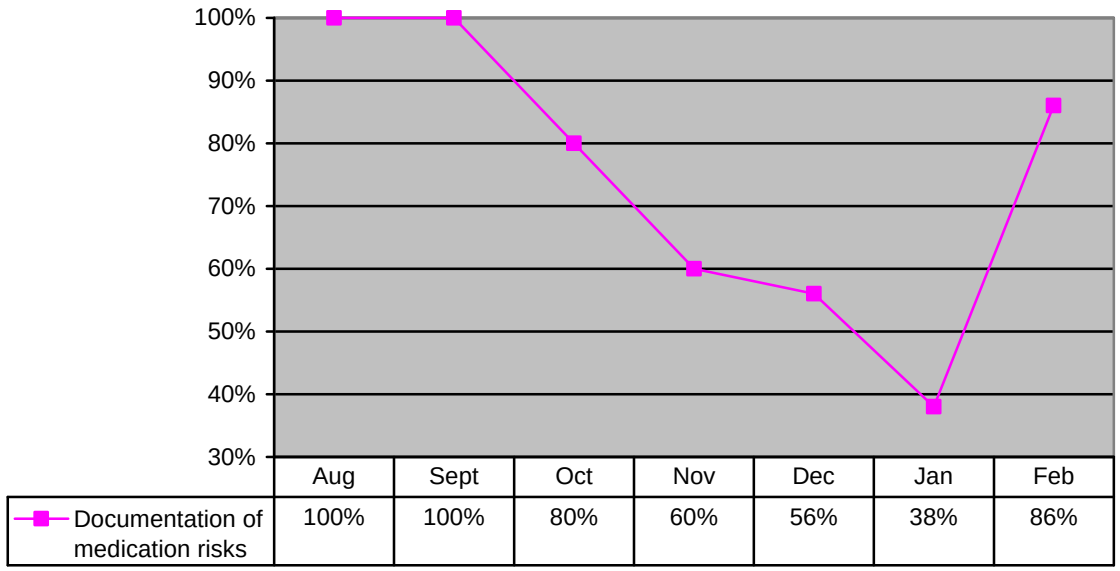
No	Requirement	Progress/Findings
		assessment addresses the risks associated with a particular medication regimen. *See Tab # 14.* The data set out below show that performance is erratic and thus that improvement is needed.



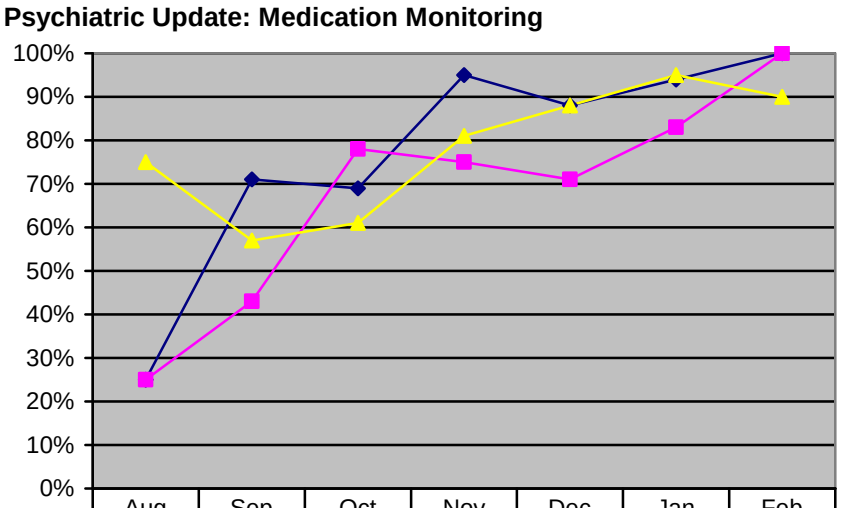
See Tab # 16, CIPA audit results.

The psychiatric update audits also assess if the updates include written documentation of the benefits of chosen treatment interventions, including use of benzodiazepines and anti-cholinergics in high risk groups and use of seclusion, restraint or STAT medications. *See Tab # 18, Psychiatric audit tool.* Data show:

No	Requirement	Progress/Findings
		Psychiatrist's Clinical Updates: Benefits of Treatment  Aug Sep Oct Nov Dec Jan Feb Adequate explanation: use of Stat meds or s/r: 33% 0% 43% 100% 50% 80% 100% Benefit of > 2 antipsychotics explained: 50% 60% 67% 63% 100% 60% 83% Adequate justiication: anti-cholinergics in high risk group: 75% 83% 67% 80% 67% 83% 100% Adequate justification: benzos in high risk group: 40% 100% 100% 100% 100% 40% 67% *Tab # 11, Psychiatric Update audit results.* This is being reviewed in more detail through the Drug utilization evaluation reviews concerning the use of polypharmacy and benzodiazepines in high risk groups. **Compliance: Partial**
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 VI.A.2. The Hospital recently revised its process around high risk triggers. *See Tab # 56, High Risk Trigger Process and information.* Under the new process, the Medical Director, and Assistant Medical Directors will be notified each week of individuals who have three or more unusual incidents of any type. He or his designee will then review the record and make

No	Requirement	Progress/Findings
		recommendations to the treatment team and document the recommendations in the progress notes in the record. The team is then expected to follow up and either accept, modify or reject the recommendations with documentation of the same. PID is monitoring the implementation of recommendations. This revised protocol was effective in early March, so its effectiveness has not yet been assessed. However, this protocol captures any type of UI, so it is broader than the prior protocol that focused on restraint or seclusion episodes. **Compliance: Partial**
VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Findings:** See VI.A.7. The CIPA audit includes an assessment of whether the CIPA includes documentation of the risks associated with the medication regimen and again show inconsistent performance. Data show: **CIPA: Risks of Medication Documentation**  *Tab # 16, CIPA audit results.* The Psychiatric Update audits also evaluate documentation around whether the psychiatrist is monitoring the individual for side effects from the medication, abnormal lab levels, and adverse reactions to the medication. Data show performance is generally improving on all

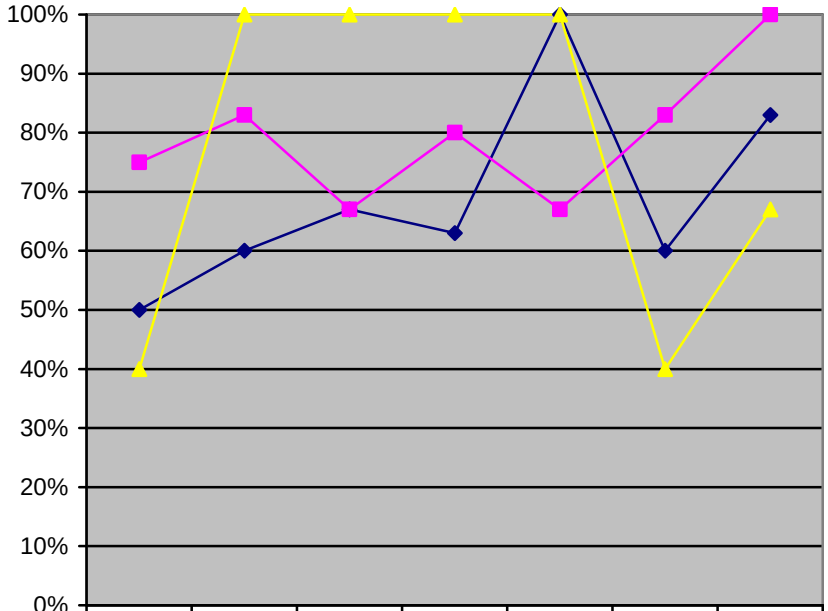
	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Documentation of medication risks	100%	100%	80%	60%	56%	38%	86%

No	Requirement	Progress/Findings
		three indicators:  *Tab # 11, Psychiatric Update Audit results* **Compliance: Partial**
VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Findings:** See VI.A.7 and VIII.A.1.f. The Hospital is making significant strides in reducing the use of polypharmacy. As of February 28, 2010 there were 11 individuals prescribed three or more anti-psychotic medications, down from 22 in July, 2009. The Hospital also is monitoring this requirement through the Psychiatric Update audits which began in August, 2009. Data from the psychiatric update audit show:

	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Adverse reactions noted	25%	71%	69%	95%	88%	94%	100%
Abnormal lab levels monitored	25%	43%	78%	75%	71%	83%	100%
Ongoing monitoring for side effects	75%	57%	61%	81%	88%	95%	90%

No	Requirement	Progress/Findings

Psychiatric Update:
Documentation for Use of Complex Medication Regimen



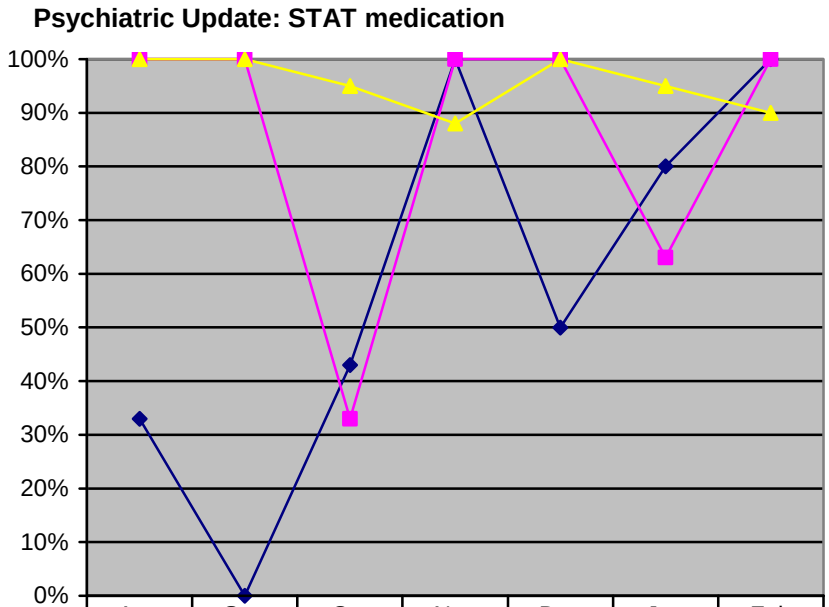
	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Rationale for use of > 2 antipschotics	50%	60%	67%	63%	100%	60%	83%
Use of anticholinergics with dx of cognitive d/o	75%	83%	67%	80%	67%	83%	100%
Use of benzos with substance abuse dx	40%	100%	100%	100%	100%	40%	67%

See Tab # 11, Psychiatric Update audit results.

The Hospital audits each month the medication regimens of individuals by ward. *Tab # 66, Medication Audit results.* Among other indicators, the audits review the use of polypharmacy. It should be noted that because the audits are completed monthly by ward (so that all individual's regimens are reviewed at least once per year) and not as a random sample across all units, monthly trend data would not yield valid conclusions. Therefore, rather than trend the data by month, it is trended in six month intervals. The trend of the data from these audits are consistent with that of the Psychiatric Update audits, as both shows improvement in documentation around high risk medication practices.

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Indicator</th><th>Jan-July 09</th><th>Aug- Feb 10</th></tr>
<tr><td>Documented rationale for use of 3 or more psychotropic meds in same class</td><td>73%</td><td>80%</td></tr>
<tr><td>Documented rationale for use of 4 or more psychotropic meds from different class</td><td>14%</td><td>67%</td></tr>
</table>
See Tab a# 65 (Medication audit tool and instructions) and # 66 (Medication audit results)
Finally, the Hospital is completing a DUE of polypharmacy and a second DUE of benzodiazepines that evaluates whether the use is consistent with the Hospital’s medication guidelines. Tab # 86 DUE tools. The results of the DUEs may be available during DOJ’s visit.
Compliance: Partial
</td></tr>
<tr><td>VIII.A.1.h</td><td>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.</td><td>
Findings:
See VI.A.7
The Hospital policy specifies that PRN may not be used for ordering psychotropic medications; instead, doctors must use a Now (non-emergency) or a STAT (emergency) order for use of psychotropic medication that is outside the regular medication regimen. This is monitored through a management report available on line daily.
The medication audits also monitor implementation of this policy, and show only one case in the six month period beginning August 2009 to February 2010 where PRN was used for psychotropic medication. Tab # 66 Medication Audit results; Tab # 65 Medication Monitoring Tool and instructions.
The Hospital is also monitoring this requirement through the Psychiatric Update audits. Tab # 18, Psychiatric Update tools and instructions. Specifically, the Psychiatric Update audit assesses if there is a written explanation for use of STAT medication, if there is an explanation for use of emergency psychotropic medications and if the pharmacological plan of care section of the Update addresses the use of STAT medication as part of the individual’s response to treatment. Data show improving performance on these indicators:
</td></tr>
</table>

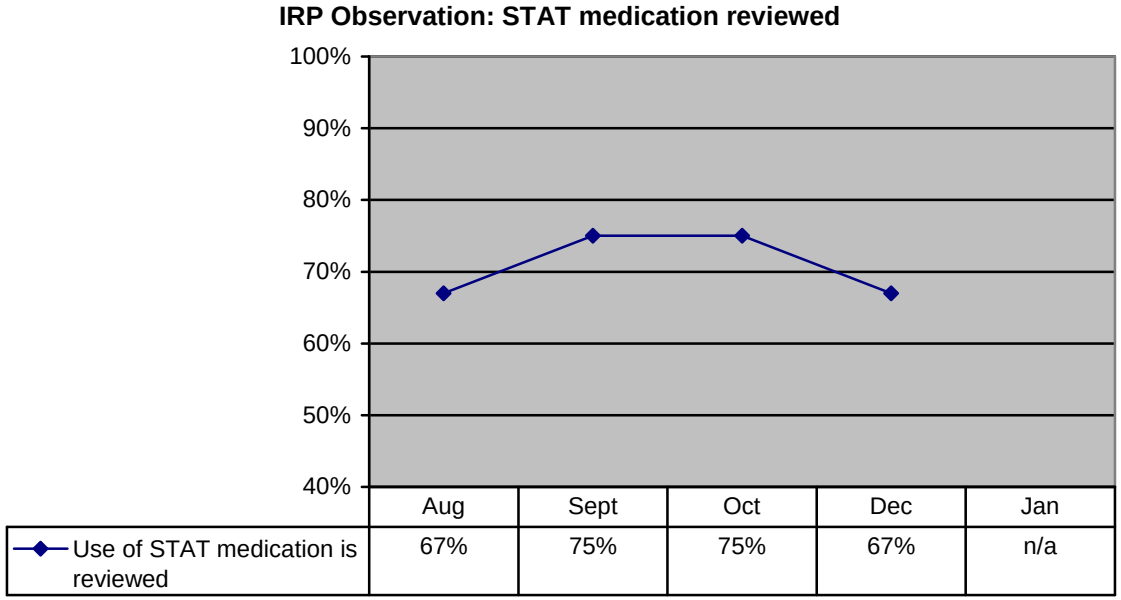
No	Requirement	Progress/Findings



	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Explanation for use of STAT meds	33%	0%	43%	100%	50%	80%	100%
Use of emergency psychotropic meds described	100%	100%	33%	100%	100%	63%	100%
Pharmacological plan reflect tx response, incl use of STAT meds	100%	100%	95%	88%	100%	95%	90%

Tab # 11 Psychiatric Update Audit results.

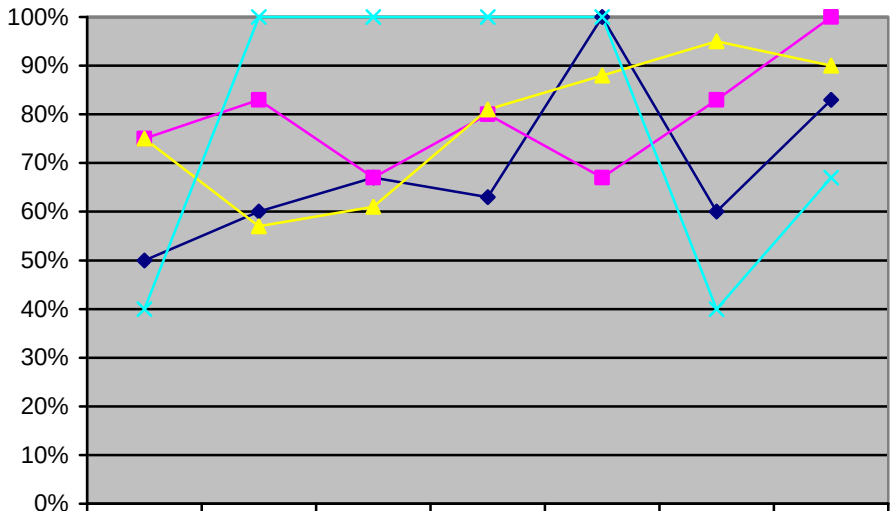
As noted, the Medication Monitoring audit also reviews use of PRN and STAT medications. The audits show that the majority of individuals who require STAT medications require more than one administration (67%) that the majority are administered medication by injection (80%) and that only in 27% of cases is there a documented face-to-face assessment within an hour of the administration. Finally, in only half (50%) of the cases in which there were 4 or more STAT administrations in a 30 day period was there a documented review of the medication regimen. This data suggests physicians are not reviewing or weighing the use of STAT medication during their monthly updates to the extent appropriate. *See Tab # 66, Medication audits results.*

No	Requirement	Progress/Findings
		Finally, the IRP observation tool has observers check prior to the IRP conference and then assess whether, if STAT medications had been administered, the team reviews the orders as part of the presentation of clinical status and uses it as part of IRP planning. Data shows that teams are weighing use of STAT medication in only about two thirds of cases in which STAT medications were used.  *See tab # 9 IRP Monitoring Observation audit results.* **Compliance: Partial**
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:	See below
VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	See below
VIII.A.2.a.i	clinically justified;	**Findings:**

No	Requirement	Progress/Findings
		See VI.A.2.b.i and VI.A.2.b.iv and VIII.A.1 The Hospital made significant improvement in the use of high risk medications during this review period. Data shows that as of the date of this report, there were 14 persons with medication regimens that fit the definition of polypharmacy, and 19 individuals prescribed benzodiazepines longer than ninety days who fit one or more of the following categories – substance use diagnoses (9), cognitive disorder diagnoses (8) or elderly (11) (Nb –some individuals fit more than one category). As of the end of February, 2010, the Hospital is prescribing new generation anti-psychotic medications to 240 individuals in care and anti-cholinergic medications to 23 individuals in care with a diagnosis of a cognitive disorder. These categories are also monitored through two audits, the medication monitoring audits, *Tab # 65 and 66,* and the Psychiatric Update audits, *Tab # 18 and 11.* Data from the Psychiatric Update audits show a wide range of practice around documenting the rationale for certain medication practices:

No	Requirement	Progress/Findings

Psychiatric Update: Medication practices



	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Rationale for >2 antipsychotics	50%	60%	67%	63%	100%	60%	83%
Rationale: anti-cholinergics with cogn d/o dx	75%	83%	67%	80%	67%	83%	100%
Monitoring FGA or SGA for side effects	75%	57%	61%	81%	88%	95%	90%
Rationale: benzos with susbtance use dx	40%	100%	100%	100%	100%	40%	67%

The medication monitoring audits showed similar results:

1. In the period August 2009 through February 2010, fewer individuals are being prescribed polypharmacy, and documentation of rationale improved compared with the period of January through July, 2009. The percentage of persons prescribed three or more intra class medications dropped from 6% to 2% while documentation improved from 73% to 80%. The percentage of 4 or more interclass fell from 3% to 1% and documentation of rationale improved from 14% to 67%. This is being further evaluated as part of a DUE that is ongoing.
2. The percentage of geriatric patients prescribed medications that can cause delirium fell from 58% to 26%, monitoring of creatinine clearance improved from 37% to 93%, the percentage with compromised creatinine levels fell from 20% to 5%.

No	Requirement	Progress/Findings
		Changes around the risk of falls due to medications remained at similar levels but there was an increase in prescribing of medications on the BEERS list. 3. Practice around the use of anti-cholinergic medications improved in some aspects. The percentage of individuals prescribed them with a diagnosis of cognitive disorder fell from 19% to 6% and the documentation of use of the medications with cognitive disorders improved from 0% to 40%. Eight percent of those with a TD diagnosis are prescribed anti-cholinergic medications, up from 5% for the prior period. Finally, in 27% of cases where anti-cholinergic medications are prescribed there is documentation of side effects in the record. It is an increase of 22% from 5% for the prior six months. 4. Practice around use of benzodiazepines is also improved in some aspects. Prescription of benzodiazepines as part of the regular medication regimen fell for those with a cognitive disorder from 36% to 11% and documentation of the risks of the regimen improved from 8% to 24%, although further improvement is needed. Use of benzodiazepines in those with a history of substance use however increased in the sample. This is being reviewed as part of a DUE underway. 5. Practice with the new generation anti-psychotics is also improving as well. Treatment teams are doing a better job of monitoring BMIs, and the percentage of those prescribed NGAs with a diagnosis of diabetes decreased from 19% to 17%. In addition, the evaluation of the risk of diabetes for those using NGAs occurred in 25% of cases, up from 8% during the prior audit period. Finally, labs are being ordered and reviewed per the medication guidelines in 98% of cases and in those that were not, the pharmacists followed up in 3 out of 4 cases. *See tab # 66 Medication audit results.* **Compliance: Partial**
VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	See VIII.A.2.a.i
VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	See VIII.A.2.a.i
VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	See VIII.A.2.a.i
VIII.A.2.a.v	evaluated for side effects; and	See VIII.A.2.a.i
VIII.A.2.a.vi	documented.	See VIII.A.2.a.i

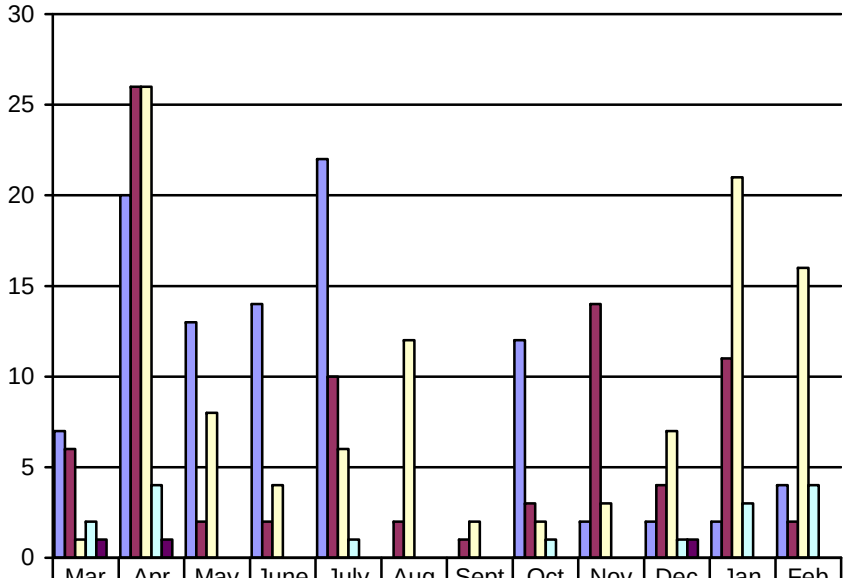
No	Requirement	Progress/Findings
VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	
VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Findings:** The Hospital recently updated its guideline for Clozapine and regularly reviews the guidelines for needed updates. *See Tab # 87 Medication Guidelines, updated.* The clozapine guidelines incorporated recommendations from the most recent DOJ report. The Hospital is also using the medication guidelines in evaluating the medication practices that are part of the various DUEs it is currently conducting. **Compliance: Partial**
VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;	**Findings:** See VIII.A.1.h. **Compliance: Partial**
VIII.A.2.b.iii	establish a system for the pharmacist to communicate to the medical staff; and	**Findings:** The Hospital established and is using a system for pharmacists to communicate with physicians. In addition to an email notice of a drug alert by pharmacy, all drug alerts are posted on the intranet and reviewed by Pharmacy and Therapeutics Committee. There were 8 drug alerts issued between August 1, 2009 and February 28, 2010. *Tab # 88 Drug alert summary.* In addition, the Hospital also has a system by which the pharmacist can notify the physician of drug interactions or other issues associated with a prescription. *Tab # 103, Pharmacist to*

No	Requirement	Progress/Findings
		Physician Communications. From August 2009 to March 2010, there were 153 communications between pharmacists and physicians, of which 18% were considered major and 33% were moderate. The largest category of intervention related to order entry (33%) followed by provider clinical consultation (20%) and dosage issues (12%). In 11% of the cases, the order was renewed, in 5% the medication was discontinued, in 10% the medication was changed. In 9% of cases, the issue is unresolved. **Compliance: Substantial**
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:** <u>Adverse Drug Reactions</u>: The Hospital implemented its revised ADR reporting form in September, 2009. *Tab # 94 ADR reporting form/instructions.* Medical staff were trained on the new form at a medical staff meeting, and refresher training was completed in March, 2010. The Hospital currently tracks ADR through a monthly report that is provided to and reviewed by the Pharmacy and Therapeutics Committee. *Tab # 93 Pharmacy and Medication Monthly report and ADR data report.* In addition to the monthly report, the specific incidents are summarized for and reviewed by the committee. *Tab # 90, Pharmacy and Therapeutics Committee Minutes.* There were 30 ADRs reported from August 2009 through February, 2010. For the prior reporting period, 44 ADRs were reported. Of the ADRs reported, 76% did not harm the individual but required a significant reduction in dosage or discontinuation of the medication, 5% resulted in temporary harm and required some type of hospitalization, and 1% required intervention necessary to sustain life. The Hospital continues to struggle with physician reporting of ADRs. From August 2009 through February 2010, there were 20 ADRS reported by Physicians but it appears likely that the number of possible ADRs exceeds 20. Specifically, the Medication Audits include a review in some categories to determine if a possible ADR occurred and if it was reported. The audits found 14 cases during this review period (compared with 15 during last review period) in which auditors concluded an ADR should have been reported, but in not a single case was a report received. *See Tab # 66 Medication audit results.* Additional training on the ADR form was conducted at a recent medical staff meeting, and the Medical Director continues to work with staff on the importance of reporting. One intensive case analysis of an ADR was completed. *Tab # 100, Intensive case analysis.* The review was completed in February, 2010, and involved the likely development of Stevens-Johnson syndrome from the administration of carbamazepine. The

No	Requirement	Progress/Findings
		individual involved was admitted on Dec 22, 2009. On December 28, 2009, carbamazepine was added to his medication regimen. He became feverish on January 2, 2010. Carbamazepine was stopped on January 4, 2010. Because it was viewed as an unpreventable ADR, the recommendation was to educate staff concerning the medications that can cause SJ syndrome as well symptoms. Drug Utilization Evaluation: The Hospital is conducting two DUEs during this period focusing on high risk medication practices. *Tab # 86 Drug utilization use review tools and instructions*. The first DUE focuses on polypharmacy. Approximately 12 cases (those for whom polypharmacy orders were in place as of January, 2010) were reviewed. The Hospital is finalizing the review as of the writing of this report. The second DUE focuses on the long term use of benzodiazepines on three categories of individuals, those with substance use diagnoses, those with cognitive disorder diagnoses, and those sixty or older. Nineteen cases are being reviewed across the three categories (some individuals fall within more than one category). This is underway and results and analysis from both may be available by the May site visit. The audit tools and instructions incorporate relevant provisions from the guidelines. Medication Variances: The Hospital implemented the new reporting form for Medication Variance. *Tab # 92 MVR form and instructions.* It continues to collect data about medication variances and report it to the Pharmacy and Therapeutics Committee. *Tab # 93.* Of the medication variances reported over the last twelve months, almost 36% were in the most critical categories, and this trend is higher for the August 2009 to February 2010 period than for the prior six months (February 2009 through July, 2009). Thirteen percent (13%) of errors occurred in administering, five percent (5%) in dispensing, one percent (1%) in monitoring, thirty three percent (33%) in prescribing, and 10.5 % in transcribing/documenting. There was a significant increase in reporting by nursing although pharmacy still reports most of the variances. While nursing reported only 8 variances in the period of March through August, it reported 29 during the period of September through February. Reports by nursing is expected to continue to improve since all nurses recently completed training on medication administration which included a component around medication variances and reporting. *Tab # 93.*

No	Requirement	Progress/Findings

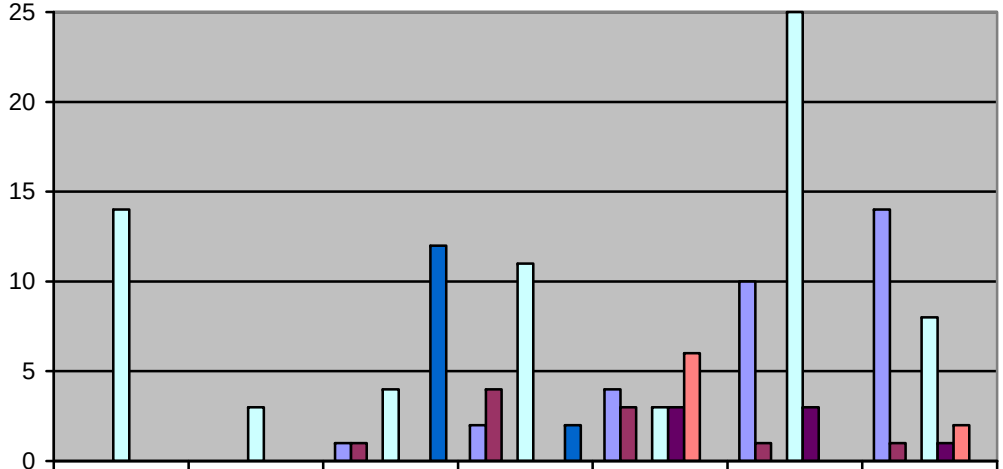
Med Variances by Category



	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Capacity to cause error	7	20	13	14	22	0	0	12	2	2	2	4
Error occurred, didn't reach pt	6	26	2	2	10	2	1	3	14	4	11	2
Reached pt, no harm	1	26	8	4	6	12	2	2	3	7	21	16
Reached pt, req't monitoring/intervention to prevent harm	2	4	0	0	1	0	0	1	0	1	3	4
Temp Harm	1	1	0	0	0	0	0	0	0	1	0	0
Harm and hospitalization	0	0	0	0	0	0	0	0	0	0	0	0

No	Requirement	Progress/Findings

Med Variances by Critical Breakdown

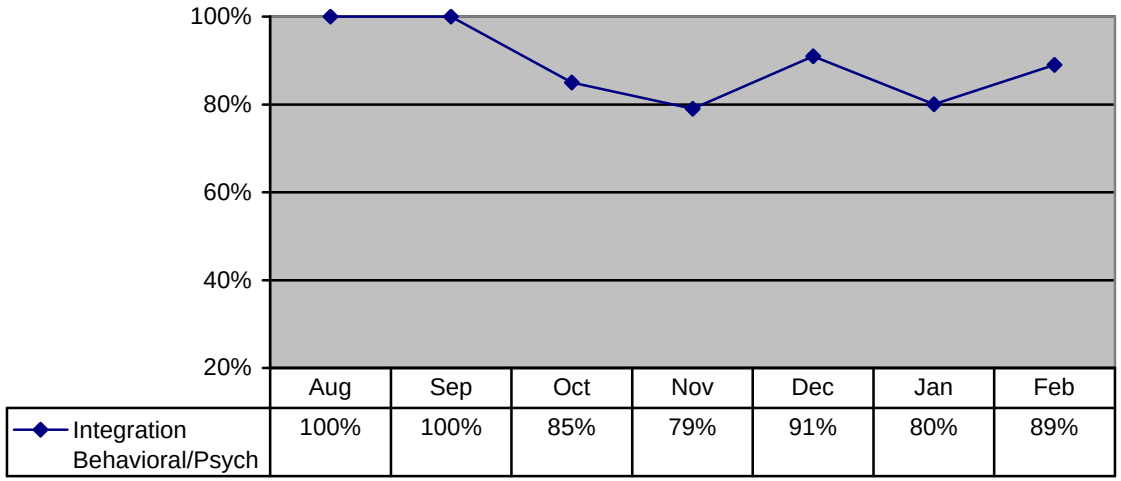


	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Administering	0	0	1	2	4	10	14
Dispensing	0	0	1	4	3	1	1
Monitoring	0	0	0	0	-	0	0
Prescribing	14	3	4	11	3	25	8
Transcrb/Doc	0	0	0	0	3	3	1
Other	0	0	0	0	6	0	2
Cat A	0	0	12	2	0	n/a	n/a

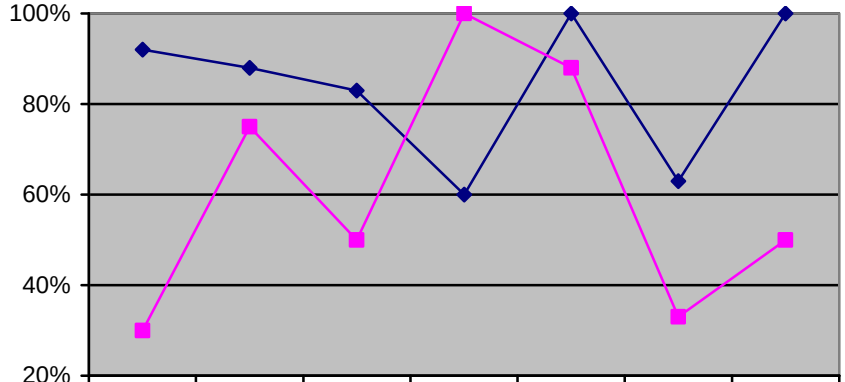
The Pharmacy and Therapeutics Committee reviews medication variance reports regularly. The variances are aggregated and analyzed by the Pharmacy Department and presented to the Committee for its review on a quarterly basis. *Tab # 90, Pharmacy and Therapeutics Committee Minutes.*

In January, 2010, an individual in care died, and while we do not yet have the results from the autopsy, it is possible that the death was related to a medication variance caused when the individual in care periodically refused medication related to a thyroid condition in the days preceding her death and staff did not appropriately address the refusals. As a result, the Medical Director and Chief Nurse Executive issued a protocol that requires nursing staff, among other things, to notify the physician (or physician on call) if an individual in care refuses vital signs, and notify the physician (or physician on call) and pharmacist if the individual refuses a high alert medication. *See Tab # 157.* Nursing staff and medical staff were trained in the protocol, and it was also placed in the intranet.

No	Requirement	Progress/Findings
		On March 12, 2010, the Hospital announced a request for proposals for an automated dispensing system for medication. *See Tab # 158, RFP for Automated Dispensing System for medication.* It is anticipated that this system may reduce medication variances of certain types. A team of staff at the Hospital also looked at medication variances as part of a study for a Six Sigma course. While initially analyzing data about medication variances in general, the project turned its focus on medication variances in documenting administration (or failure to administer) medication. *See Tab # 102 Six Sigma reports.* Information from the analysis is being used by nursing as it sets up the medication room procedures in the new hospital building. Mortality Reviews: The Hospital has Patient Death and Sentinel Event Review policies in place and are implementing them. The Patient Death Review policy requires a review of all patient deaths (anticipated or unanticipated) by the Hospital's Mortality and Morbidity Review Committee, which is charged with an interdisciplinary review and development of a report. If the death is unanticipated, then a Sentinel Event Review Committee (SERC) is appointed and must meet and also review the death. DMH policy requires the reports of the Mortality and Morbidity Review Committee and the SERC (If applicable) are sent to the DMH, Office of Accountability, for external review. There, the reports are reviewed by a medical doctor, who then can refer the review to the Department's full Mortality Review Committee for review and action. *See Tab # 95, Patient Death Review policy.* Since August 2009, the Hospital's Mortality and Morbidity Review Committee reviewed deaths of the four inpatients who died between August, 2009 and March 2010. Of the four deaths, three were anticipated due to medical conditions, and one was unanticipated. A Sentinel Event Review was held for that unanticipated death in accordance with the policy. **Compliance: Partial for ADR and Medication Variances. Substantial for Mortality reviews**
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 meets caseload ratios on all units. Currently, each admission units has two psychiatrists, and the long term units have one psychiatrist for every 24 individuals. *See Tab # 37.* This will be maintained upon the move to the new hospital building. **Compliance: Substantial**

No	Requirement	Progress/Findings
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 V.A.2.e and VI.A.7. The Hospital hired a team leader for the Positive Behavioral support team in December, 2009. Additionally, two PBS support technicians were recently hired and recruitment is underway for a data analyst; recruitment for a nurse member for the team will begin upon completion of a table of organization change. The team leader trained the clinical administrators in PBS principles and is working with nursing to train its staff. By mid March 2010, 17 nurse educators and nurse managers have been trained in basic PBS principles, as have 63 night staff. Training with other nursing staff is underway. In addition, a contract with a consultant to assist in training was recently finalized. *See tab # PBS consultation contract.* In addition, the PBS procedure was updated. *See PBS policy and procedure.* One plan and two guidelines are currently being implemented. The Psychiatric Update audit includes one indicator that assesses whether the update includes an appropriate plan that integrates behavioral and psychiatric interventions. Instructions direct the auditor to determine if there was a referral for behavioral intervention if indicated, and, upon receipt of the results of the referral, whether the recommendations were implemented or if not, why implementation is not appropriate. *See Tab # 18, Psychiatric Update Audit Tool/Instructions.* Audits results for the period of August through February, *See Tab # 11*, show: **Psychiatric Update: Integration Behavioral and Psychiatric Interventions**  Aug | Sep | Oct | Nov | Dec | Jan | Feb Integration Behavioral/Psych: 100% | 100% | 85% | 79% | 91% | 80% | 89%

No	Requirement	Progress/Findings
		Compliance: Partial
VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	Same as above.
VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	Same as above.
VIII.A.4.c	integrate psychiatric and behavioral treatments.	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:** See VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Compliance: Partial**
VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Findings:** The Hospital completes a substance abuse screening on each individual upon admission. Audits of the CIPA show excellent performance in completing the substance abuse assessment sections of the CIPA, but only marginal performance in designating the appropriate stage of change:

No	Requirement	Progress/Findings
		CIPA audits: Substance Abuse  Aug Sep Oct Nov Dec Jan Feb Substance Abuse screening completed: 92% 88% 83% 60% 100% 63% 100% Stage of change reflects assessment result: 30% 75% 50% 100% 88% 33% 50% *See Tab # 16, CIPA audit results.* In addition, if, in the course of hospitalization a substance abuse assessment is needed, a referral to the Co-occurring disorders program can be made and an assessment completed. The IRP includes a dedicated focus area to address substance use issues and the IRP manual contains instructions and examples regarding the development of focus statements, objectives and interventions related to substance use. Treatment teams are required to identify the stage of change relevant to objectives and develop appropriate interventions that address substance use disorders. The co-occurring disorders program recently completed an audit tool to address if the IRP objectives and interventions align with the individual's substance abuse needs and stage of change. *See Tab # 56 Co-Occurring Disorder audit tool.* Audits are expected to begin in April, 2010. **Compliance: Partial**
VIII.A.7	By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at	**Findings:** The Hospital is able to track individuals with a diagnosis of tardive dyskinesia (TD) and is

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td>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.</td><td>conducting audits of the records of those with a diagnosis of TD. There are currently 39 persons with a diagnosis of TD. As evidenced from the data, practice is improving around treatment and management of TD. Data show:

<table>
<tr><th>Indicator</th><th>% Compliant
March, 2010 (Aug 2009)</th></tr>
<tr><td>AIMS conducted w/ 6 mo.</td><td>92% (36%)</td></tr>
<tr><td>Neurology consult</td><td>72% (57%)</td></tr>
<tr><td>Medication choices considered</td><td>87% (50%)</td></tr>
<tr><td>IRP interventions address TD</td><td>69% (43%)</td></tr>
<tr><td>FGA prescribed</td><td>41% (n/a)</td></tr>
<tr><td>Adequate documented rationale for use of FGA?</td><td>75% (57%)</td></tr>
<tr><td>Anti-cholinergics prescribed</td><td>21% (n/a)</td></tr>
<tr><td>Justification for anti-cholinergics in the record</td><td>63% (n/a)</td></tr>
<tr><td>Discuss audit with doctor</td><td>74% (n/a)</td></tr>
</table>

See Tab # 63 TD audit tool and Tab # 64 TD audit results.

Data also show that AIMS tests are completed upon admission in a range of 100% (October) to a low of 25% (Nov). of admissions. In the past three months, AIMS tests were completed in 67% of admissions reviewed (Dec), 75% of admissions reviewed (Jan) and 71% of admissions reviewed (Feb) See Tab # 16 (CIPA audit results)

Compliance: Partial</td></tr>
<tr><td></td><td>B. Psychological Care</td><td></td></tr>
<tr><td>VIII.B.1</td><td>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:</td><td>See below</td></tr>
<tr><td>VIII.B.1.a</td><td>ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans,</td><td>Findings:
The Hospital hired three additional psychologists who began work at the end of March, 2010 and who have been assigned to provide unit support. All units have coverage by a</td></tr>
</table>

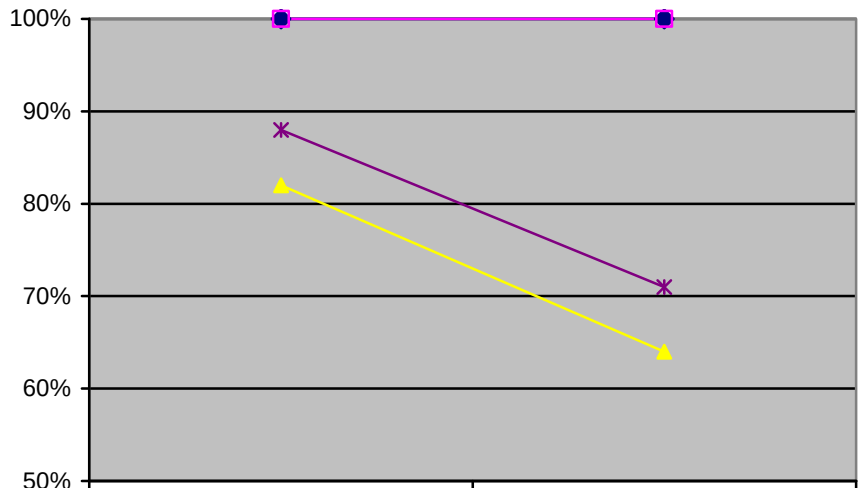
No	Requirement	Progress/Findings
	particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	dedicated psychologist. Individuals are screened at admission for risk of violence and suicide. Psychology staff have reviewed individuals on their units and identified those in need an assessment. *See Boggio Advanced Document request, Tab # 4.* A PBS team leader was hired and began work in December 2009. In addition, two behavioral support technicians were hired and began work in March, 2010. Recruitment continues for a data analyst; recruitment for a nurse is expected this Spring. One PBS plan and two guidelines have been completed and implemented to date. The new PBS leader began training staff, including nursing leadership and educators and the clinical administrators. A training plan for nursing staff is being implemented, starting with night staff. By mid March, 17 nurse educators and nurse managers were trained in basic PBS principles, as have 63 night nursing staff. In addition, the team leader is working with TLC leadership to ensure PBS plans will be implemented in TLC programs and not just on the ward. A contract with a consultant for PBS training and other support was recently finalized. Services are expected to begin in April or early May. *See Tab # 89, PBS Contract.* **Compliance: Partial**
VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement;	**Findings:** See VIII.B.1.a Two new behavioral guidelines were implemented this review period, and one additional PBS plan. A new PBS plan/guideline monitoring form was developed and implemented the middle of March, 2010. Data should be available during the May visit. **Compliance: Partial**
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.a and VIII.B.1.b None of the three plans/guidelines includes aversive contingencies. **Compliance: Substantial**

No	Requirement	Progress/Findings
VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	**Findings:** See VIII.B.1.a **Compliance: Partial**
VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Findings:** The PBS plans and guidelines include expected documentation by nursing staff at the end of each shift. A new monitoring tool was developed, and auditing began in mid March, 2010. Data may be available by the May visit. The new PBS leader has begun training staff, including nursing leadership and educators and the clinical administrators. A training plan for nursing staff is being implemented, starting with night staff. In addition, the team leader is working with TLC leadership to ensure PBS plans will be implemented in TLC programs and not just on the ward. A contract with a consultant for PBS training and other support was recently finalized. Services are expected to begin in April or early May. *See Tab # 89, PBS Contract* **Compliance: Partial**
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:** Three new psychologists were hired to provide support for units and now all units have an assigned psychologist. A PBS team leader was hired and began work in December 2009. In addition, two behavioral support technicians were hired. Recruitment is expected to begin for a nurse dedicated to the PBS team and is already underway for a PBS data analyst. **Compliance: Partial**
VIII.B.2	By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that	**Findings:** As noted previously in the report, the treatment programming is undergoing a

No	Requirement	Progress/Findings
	individuals are assigned to groups that are appropriate to their individual needs.	reorganization to better match the new hospital structure. Like the current structure, most individuals will attend one of two treatment TLCs depending on their acuity and level of security. (Each TLC is expected to serve from 120-140 individuals and will include pre-trial individuals). The programming will continue to be recovery focused, will use the same models (either the SAMHSA Illness Management and Recovery Model or the Boston University Psychiatric Rehabilitation Model) and will be curriculum based. Staff will represent the full spectrum of disciplines, and include psychiatry, nursing, social workers, psychologists, creative arts therapists, recreational therapists, occupational therapists, co-occurring disorder therapists, dieticians, and other clinical staff. Each department will be expected to provide a minimum number of groups and/or hours of treatment as set out in the Treatment Programming overview found at *Tab # 69*. Groups will be tailored to cognitive functioning as well as stage of change for substance abuse groups. Individuals in care will in general attend fewer types of groups per week, but will attend a particular group more than once a week. Most individual will have 5 groups per day, 5 days per week. Individuals will complete a one week orientation during which he or she is oriented to the TLC and clinical staff can evaluate him or her for the most appropriate group placement. At the completion of the orientation program, the individual will work with the TLC administrator and treatment team to establish the schedule. For those individuals for whom the TLC is not appropriate, ward based programming will be implemented. *See generally, Tab # 69, Treatment Programming overview.* One hundred and sixty seven people currently attend the TLCs. *Tab # 80.* The TLCs in the new building are expected to serve approximately 240 individuals for some part or all of the day. **Compliance: Partial**
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 VIII.B.3. **Compliance: Partial**
VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	
VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the	**Findings:** See VIII.B.1.c.

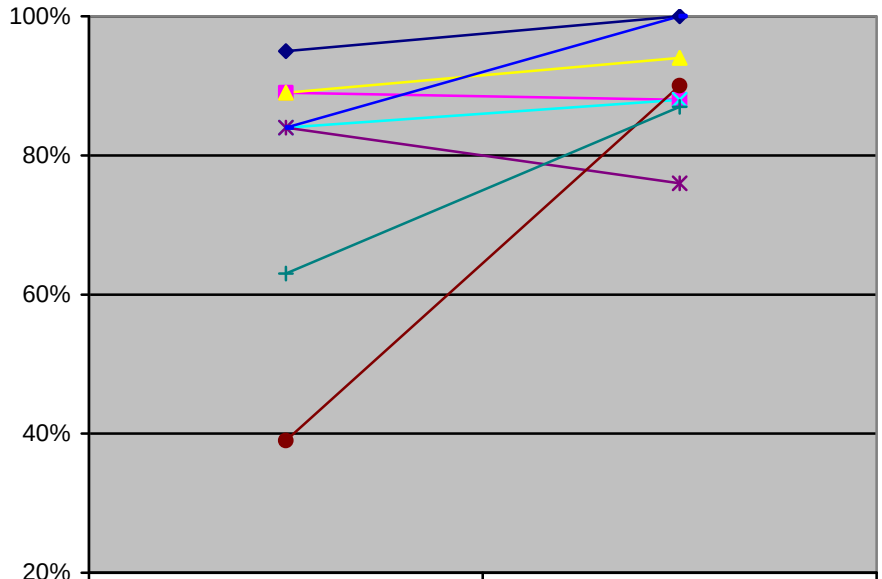
No	Requirement	Progress/Findings
	extent possible;	**Compliance: Partial**
VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Findings:** See VIII.B.2. *See generally, Tab # 69, Treatment Programming overview* Currently, 167 individuals are attending the TLCs; upon relocation to the new building, approximately 240 will attend TLC programming for all or part of the day. There are currently 12 staff trained in co-occurring disorder treatment that lead 48 group sessions per week. Substance abuse groups are available on all pretrial units for pretrial individuals. Substance abuse groups include Living Sober, SMART recovery, conflict resolution, relapse prevention, stages of change, seeking safety, double trouble in recovery, anger management, stress reduction and relaxation, AA meetings, Healthy choices, and NA groups. An expanded focus on relapse prevention is planned for the hospital programs. **Compliance: Partial**
VIII.B.4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Findings:** The Hospital is working closely with the Department of Disability Services to develop community living plans for individuals with diagnoses of mental retardation. In the last six months, 8 individuals with MR diagnoses were placed with the assistance of DDS, which developed community plans for them. Currently, there are 5 individuals with whom the Hospital is working with DDS and it expected up to 4 additional individuals will be added to the initiative. The Hospital also expanded its capacity around the completion of neuropsychological evaluations by assigning a qualified psychologist half time in addition to the neuropsychologist and trainees. In addition, neuropsychology also uses the Acknowledgement of Receipt of Recommendations. *See Tab # 48.* **Compliance: Partial**
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:** The current level of practice is maintained. **Compliance: Substantial**

No	Requirement	Progress/Findings
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:** A new contract for IRP training was recently finalized and services expected to begin in April, 2010. Further the Hospital is monitoring this requirement through the IRP Monitoring Observation tool, *Tab # 9.* While the specific indicator was modified effective with the December 2009 reviews, the Hospital is now monitoring this through a specific indicator; specifically if the team doesn't believe the individual is benefitting from a specific intervention, did it revise the pertinent intervention. Data on this specific indicator shows that in both December, 2009 and January, 2010, 100% of the teams modified interventions based upon the individual's lack of progress. *See Tab # 9, IRP Audit Results* Other indicators that assess changes to interventions include:

No	Requirement	Progress/Findings
		IRP Planning: Response to Progress  **Compliance: Partial**
VIII.B.4.f	clinically relevant information remains readily accessible; and	**Findings:** Prior practice continues, except clinical chart audits were not completed during this review period. Effective December, 2009, the IRP observation tool was modified to provide additional focus on whether the relevant information is presented at the IRP conferences. *See Tab # 8, IRP Monitoring Observation Tool and instructions.* Under the new tool, observers assess the presentation of the clinical formulation or clinical formulation update to determine if all

	Dec	Jan
Discussion: benefiting from therapies?	100%	100%
If not benefiting, revise related intervention?	100%	100%
Team review progress in meeting objectives	82%	64%
Objectives and interventions reflect functioning, needs, goals?	88%	71%

No	Requirement	Progress/Findings
		aspects of the present status are presented and if each member of the team presented information about the interventions they provided and their effectiveness. *See Tab # 9, IRP monitoring results.* Data show:



	Dec	Jan
Current symptoms	95%	100%
Functional status	89%	88%
Current risk factors	89%	94%
Current interventions	84%	88%
Response to interventions	84%	76%
Testing results	39%	90%
D/c criteria	63%	87%
input from team	84%	100%

See Tab # 9, IRP audit results. The audits also assess if each discipline proposes alternative interventions in the event that progress is not being made. The data suggest, and observations confirm, that the treatment teams are better focusing on the individual's current condition and what are effective interventions.

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>Compliance: Partial</td></tr>
<tr><td>VIII.B.4.g</td><td>staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.</td><td>Findings:

See B.1.a

Compliance: Partial</td></tr>
<tr><td></td><td>C. Pharmacy Services</td><td></td></tr>
<tr><td>VIII.C.1</td><td>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</td><td>Findings:

During the period of August 10, 2009 to March 30, 2010, the Pharmacy Department at SEH provided 153 recommendations to the medical staff based on reviews of medication regimens. The breakdown is as follows:
<table>
<tr><th>Category</th><th>Percentage</th></tr>
<tr><td>Allergy</td><td>5%</td></tr>
<tr><td>Dosage Issues</td><td>12%</td></tr>
<tr><td>Dosage/frequency</td><td>1%</td></tr>
<tr><td>Drug information</td><td>6%</td></tr>
<tr><td>Formulary</td><td>1%</td></tr>
<tr><td>Interaction</td><td>2%</td></tr>
<tr><td>Order clarification</td><td>5%</td></tr>
<tr><td>Order Entry</td><td>33%</td></tr>
<tr><td>Patient Monitoring</td><td>8%</td></tr>
<tr><td>Polypharmacy</td><td>1%</td></tr>
<tr><td>Provider clinical consult</td><td>20%</td></tr>
<tr><td>Side effects</td><td>1%</td></tr>
<tr><td>Other</td><td>5%</td></tr>
</table>

See Tab # 103. Pharmacy continues to verify orders as they are entered and is also reviewing records (each individual’s record will be reviewed once per year) as part of the monthly audits.

Compliance: Partial</td></tr>
</table>

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td>VIII.C.2</td><td>physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.</td><td>Findings:

Same as above.

The Hospital’s pharmacy system is able to track if the physician accepts the recommendation, declines or fails to respond. Data show that 9% of recommendations/communications are unresolved as of March, 2010. Tab # 103. There is not yet a system in place of tracking subsequent actions by the pharmacist if the issue is not appropriately resolved.

Compliance: Partial</td></tr>
<tr><td></td><td>D. Nursing and Unit-Based Services</td><td></td></tr>
<tr><td>VIII. D</td><td>SEH shall within 24 months provide nursing services that shall result in SEH residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:</td><td>Nursing leadership at the Hospital focused during this period on raising the level of nursing practice, competency and accountability. Two strategies were employed, one relating to recruitment and discipline and the second related to training and skill building.

First, six RNs were hired during the review period and 23 nursing staff of all types left employment. The breakdown is as follows:

<table>
<tr><th>Position</th><th>Hiring</th><th>Terminations</th><th>Resignations</th><th>Death</th></tr>
<tr><td>Nurse Manager</td><td>10 (includes 8 rehired)</td><td>3</td><td>2</td><td></td></tr>
<tr><td>RN</td><td>6</td><td>1</td><td>3</td><td></td></tr>
<tr><td>LPN</td><td>0</td><td></td><td>2</td><td></td></tr>
<tr><td>PNA</td><td>0</td><td>3</td><td></td><td></td></tr>
<tr><td>FPT</td><td>0</td><td>4</td><td>4</td><td>1</td></tr>
<tr><td>Total</td><td>16</td><td>11</td><td>11</td><td>1</td></tr>
</table>

Decisions were made to not renew appointments or to terminate staff based upon performance issues. Twelve nursing staff were placed on administrative leave pending investigations. More specific information will be available during the site visit if needed.

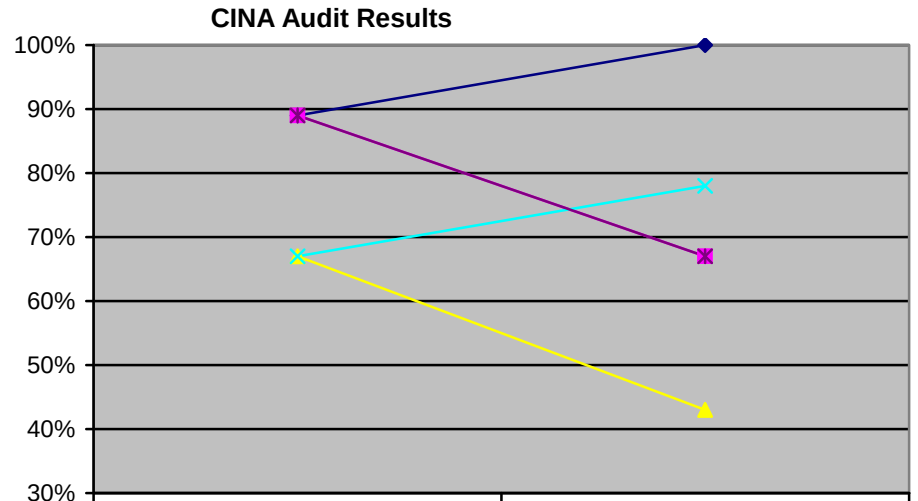
Nursing leadership sought and secured the ability to hire part-time staff. With the addition of these half time positions, nursing should be able to draw from a new pool of potential staff who for whatever reason may only being seeking part-time work. These positions offer new flexibility in scheduling to cover weekends without utilizing overtime and overtaxing staff.</td></tr>
</table>

No	Requirement	Progress/Findings
		In addition, Nursing was substantially more selective in the hiring of new staff. While over 90 candidates were interviewed (including current Nurse managers who were required to reapply for their positions), fewer than 35 were offered positions. Interviews are conducted by a panel using a structured set of interview questions that are behaviorally based and tied to seventeen competencies. *See Tab # 124, Nursing Behavioral- Based Interview questions.* Interviewers select questions from each competency category. Areas of competency selected for interviews include accountability, adaptability, analysis, communication, continuous learning, excellence, judgment, initiative, leadership, motivation, negotiation, patient services, planning, problem-solving, presentation, teamwork, professional proficiency and work standards. In most cases, candidates are interviewed twice. Based upon the new hiring process, the nursing leadership believes that they are hiring more qualified candidates who have an accurate set of expectations about the position and who are willing to commit to a high level of practice and accountability. Nursing leadership also redeployed staff based upon census and unit closings. As a result of these efforts, not only are staff working fewer overtime hours, but an RN has been assigned and on duty, since January 1, 2010, to every unit across the Hospital, on every shift. In addition, nursing care hours per patient day rose from 4 hours in September, 2009, to an average of 5.37 hours from October 2009 through February 2010. Nursing Services also refined and/or developed nursing competencies in targeted areas. *Tab # 116, Nursing Competency Standards.* Clear accountability is given to the nurse manager to assess competency of unit nursing personal, which shall be completed at least annually or more frequently as needed. Areas of competency include medical/clinical knowledge, technical/clinical skills, clinical judgment, critical thinking, interpersonal skills, communication skills and professionalism. Specific competencies are now in place for skills such as insulin administration, medication administration, choking assessments, shift charge nurse, seclusion and restraint, among others. To improve engagement of individuals, the EARN program is being implemented across the Hospital. Clinical leadership across disciplines were given an overview of EARN, eleven units have completed orientation in EARN principles and have completed or are in the midst of trauma informed care training, and nine units have implemented EARN. All units have implemented 30 minutes check with individuals in care, and the Hospital is expected to have completed training and fully implement EARN on all units and by early May, 2010. During this review period, nurse education also provided training to staff to build competencies in key areas. One hundred percent of nurses completed training and passed competencies around medication administration and nursing documentation. The number

No	Requirement	Progress/Findings
		of nursing staff that the new completed seclusion and restraint training rose from 32% in September to 81% at this time. Training in physical and mental health assessment is scheduled for late Spring. The nursing skill lab is also operational. Training stations include Code Blue, Medication Administration and Variances, Documentation, EARN, Restraint and seclusion, Physical Observation, Diabetes, Seizures, Choking/swallowing, Infection Control and Critical Thinking. Recruitment is underway for additional nurse trainers. Nursing has completed Phase II of Avatar training, and is now using Avatar to complete their initial assessments, progress notes and other forms. The Nursing Update is not yet in Avatar, but is in queue. The CINA audit tool was revised and tested; the Nursing Update audit tool was tested and further revisions are underway. These tools require some additional modification, but it is expected that the revisions will be completed in time for audits to be done in May. Nursing attendance at IRP conferences has improved significantly, and over 90% of IRP conferences now have the RN attending.
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:** The Hospital finalized and developed curricula to support the competency for topics such as mental diagnosis and symptoms, choking assessment, medication and side effects and documentation. They are also competencies for nurse managers, staff nurses, and paraprofessional staff. *See Tab # 116 Nursing competency standards. See also Delacy advanced document requests, Tab # 2.* It is also implementing an assessment of new employees at the time of employment to assess proficiency in a number of areas, and also at the conclusion of the first 45 days of employment. Also underway is a review of the new employee orientation, and revisions are being made. The nursing orientation will include self-assessments, treasure hunts of the units and preceptorship training for the senior nursing staff. The training will be focused on unit specific domains, as well as competencies specific to the units to which the orientee will be assigned. To date, the Nursing Department created and implemented a thorough Medication Administration Competency Checklist that addresses a prior recommendation. Similar competency checklists will be created as nurse education implements additional trainings. The content of new employee orientation training will be available during the site visit. In addition training in physical assessment is set to begin in late Spring, 2010, and will be scheduled so as not to be disrupted by the move to the new hospital building.

No	Requirement	Progress/Findings
		Nursing education focused on providing training to nursing staff during this review period on three key areas: Medication Administration (100% completed training); EARN training (all units completed the EARN orientation) and Seclusion and Restraint training (81% completed). The nursing education department has a list of annual trainings that the nursing staff are required to complete which includes both verbal and demonstration competency assessments. It is currently revising some of the programs due to the transition to the new building since there will be changes to unit and treatment TLC procedures; it is soliciting input from staff around changes to the content of some training modules. A process is developed to notify the staff and manager at least a month in advance of the expiration of various annual training modules. Only 11% of nursing staff are current in all modules of annual training. Other clinical trainings include 80% of nursing staff current in CPR, 59% current with non-violent crisis intervention training, and 81% current in restraint and seclusion training. *Tab # 120.* The Hospital also held one mock code red exercise in September, 2009, one mock code 13 exercise and two actual medical codes in December 2009 and January 2010. *Tab # 120.* The Hospital developed a formal nursing procedure, titled Guidelines for Nursing Basic Skills and Competency Assessment Process, which specifies what will occur when a competency has not been met. *See Tab # 121, Nursing Procedure for Guidelines for Nursing Basic Skills and Competency Assessment Process.* Under the policy, and unless formal discipline is imposed, employees who fail to achieve competency are placed on a performance improvement plan and are referred to nursing education. They are given three opportunities to prove they have achieved or maintained a competency. Upon the third failure, the employee will be prohibited from working in his or her normal position, and Hospital leadership will pursue appropriate disciplinary actions if it had not done so previously. Nursing has identified several barriers to nursing staff attendance at required trainings and proposed solutions. An electronic scheduling system that allows nursing leadership and frontline staff to schedule and view schedules for work and trainings is needed. The Hospital is exploring several software packages that may enhance its ability to resolve this issue. While this is pending, the ADONs, Nurse Managers, and Nurse Education department regularly consult each other to schedule required trainings and work schedules for individuals are better coordinated with the training schedules. On-line registration for training and flexible training schedules have also assisted nursing immediately address this issue.

No	Requirement	Progress/Findings
		While the big rollout of training around physical assessment is scheduled for later this Spring and the curriculum is still being updated, nursing staff are receiving training in the SAMPLEPQRST, to help them focus their history taking skills prior to calling the doctor. Communication with the physician is now expected to be done by use of the SBAR. Training is currently in process. **Compliance: Partial**
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:** The Hospital is now implementing the new initial nursing assessment in Avatar. *Tab # 26 CINA form.* It is also implementing the nursing update although that is not yet in Avatar. *Tab # 28, Nursing update form.* The Hospital completed two audits using the new CINA audit tool for the months of January and February, 2010, but has not completed an audit of the nursing update. T*ab# 27 CINA Audit tool and results.* The Nursing update audit tool is being revised, *Tab # 29, Nursing Update audit tool,* but monthly audits are expected to begin in April, 2010. At this time the documentation is internally inconsistent, at other times sections are not completed.

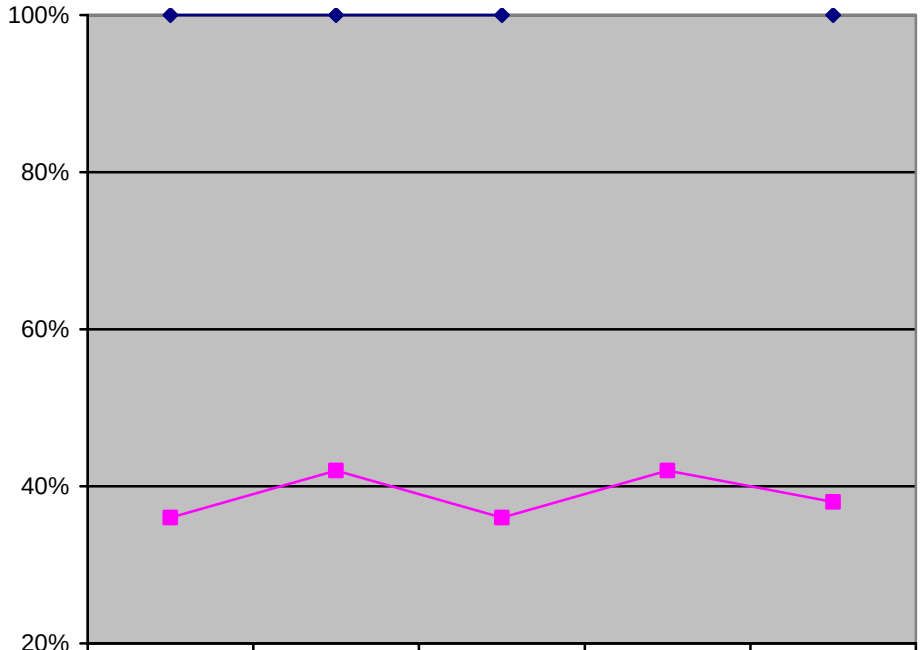
No	Requirement	Progress/Findings
		

	Jan	Feb
Timely completed	89%	100%
Physical assessment completed	89%	67%
Prior medical hx appropriately described	67%	43%
MSE findings supported	67%	78%
Recovery assessment completed	89%	67%

The Hospital also is collecting data about nursing documentation and participation in the IRP conferences. Data show:

No	Requirement	Progress/Findings

IRP Audits: Timeliness of Nursing Assessments by Type



	Aug	Sept	Oct	Dec	Jan
Initial assessments	100%	100%	100%	n/a	100%
Nursing Updates	36%	42%	36%	42%	38%

See Tab # 9, IRP Monitoring Observation Audit Results.

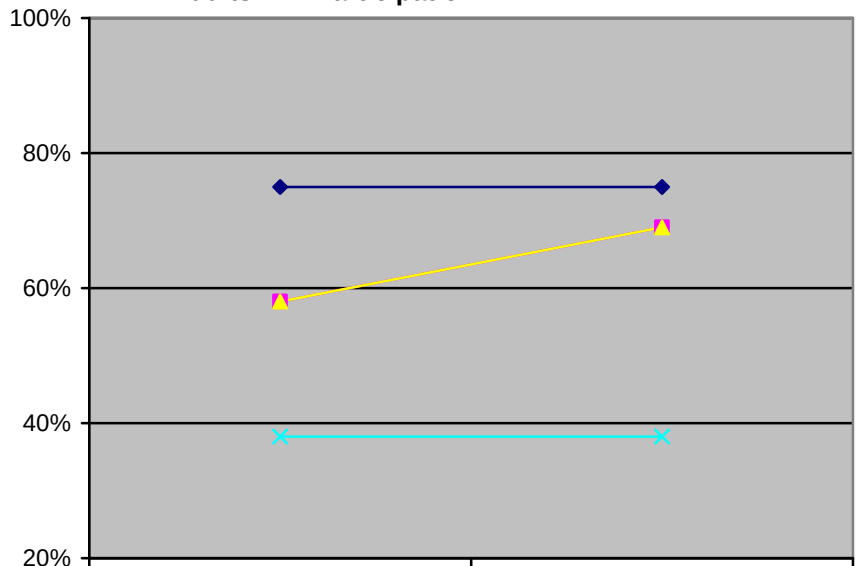
It should be noted that in a significant number of cases the Nursing update is completed, but not completed between 2 and 10 days as required by policy. The data also shows that attendance by an RN at the IRP conferences is improving. As the table below indicates:

Aug	Sep	Oct	Dec	Jan
83%	91%	100%	84%	94%

Attendance by paraprofessional staff remains low, averaging 32% from Aug to January 2010.

Finally, beginning with December, 2009, the Hospital has data concerning the quality of the participation of the registered nurse.

No	Requirement	Progress/Findings
		IRP Audits: RN Participation

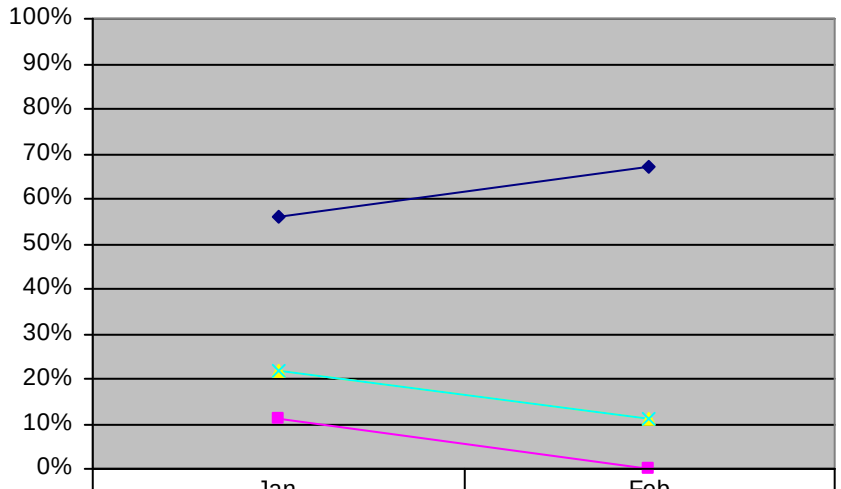


	Dec	Jan
General discussion of interventions	75%	75%
Specifics of interventions	58%	69%
Report progress or lack thereof	58%	69%
Recommend alternatives	38%	38%

See Tab # 9, IRP Monitoring Observation Audit results. Nursing interventions are still often not specific in the IRP, and at times nursing interventions that are regularly being provided were not included in the interventions or were very general. In fact, data from the CINA audits for January and February 2010 show:

No	Requirement	Progress/Findings

CINA Audit Results



	Jan	Feb
Nursing Interventions developed	56%	67%
Nursing intervention developed for each risk identified	11%	0%
Nursing interventions specific and individualized	22%	11%
Inerventions appropriate to functional level	22%	11%

The IRP consultation contract that recently was finalized includes training and consultation around the writing of interventions.

The nursing procedure around documentation requirements was revised, *Tab # 106,* and training is underway. There is also a station at the nursing skills lab to improve documentation skills. A policy was developed that establishes a format for nursing documentation; it requires nursing staff to document care in the format of SOAPIE notes for the RN and LPN and Narrative for the FPT, PNA and MHC. Training is currently in progress in the nursing skills lab. The notes are to be titled so the reader knows what the note is discussing in accordance to the IRP foci (i.e. RN progress note: Problem #2 Diabetes Management). Nursing is still working to strengthen the links between the CINA and the nursing interventions in the IIRP.

No	Requirement	Progress/Findings
		Compliance: Partial
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:** The Hospital modified its Nursing procedure around physical observation data collection effective March 2010. The policy requires minimum monthly measures for temperature, heart rate, blood pressure, respiratory rate, pain, pulses, neurological assessment, menses, bowel movement, and edema. Weight is measured on admission, transfer, monthly and when ordered. The procedure establishes Hospital wide standards around physical assessment and observation by nursing, and also it is clear that while nursing should focus on an individual's chief complaint, nursing must also review all systems. A section on pain assessment was also included. The change of condition form was modified, but an audit tool has not been developed, as nursing will review usage for one month, and develop audit tool in early May. A separate procedure was developed around oxygen monitoring. The Hospital modified its change of shift report and developed a new form. *Tab # 109 Change of Shift Report.* Nurse managers are currently monitoring the nursing shift reports and making recommendations for improvement as necessary. An audit tool has not been developed. The Medical Response policy was revised, incorporating those recommendations with which the Hospital agreed. The Hospital is creating three policies, Medical Response, Medical Services, and Seizure Management. *See Tab # 70.* **Compliance: Partial**
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Findings:** The Hospital implemented a competency based retraining of all licensed nurses around medication administration and made some modifications to the procedure. An outline of the curricula and competency checklist can be found at *Delacy Advances Document request Tab # 2.* One hundred percent of staff completed the training. Nursing also was trained on reporting medication variances. While still not at expected levels, the recent trend is an increase in medication variances reported by nursing. Nursing reported only 8 variances, which are 3% of the total of 164 variances reported in the period of March through August; it reported 29, which are 21% of the total of 141 variances reported during the period of September through February. In August, 2009, nursing

No	Requirement	Progress/Findings
		reported 0% of the medication variances, but in February, 2010, they reported 30%. *Tab # 93, Medication Variance Summary.* The Hospital included the monitoring of the individual's response to first dose of medication in its policy titled Medication Ordering and Administering Policy, *Tab # 125.* In addition, nursing is currently working with the physicians and the Avatar steering committee to ensure that the first dose is identified in the Avatar for the nurses to be able to recognize the medication as a first dose. Nurses are instructed to inquire about all medications that appear in the Avatar for the first time to alert the doctor about the change. At this point, the nurses treat this medication as a first time medication and monitor the patient for the first 15 minute, document response and follow-up every 30 minutes for the next 2 hours and again document response. This was a part of training in the medication administration class. An audit tool was recently developed to monitor first dose medication but audits have not yet started. The Six Sigma team conducted an analysis of data relating to medication variance, with a focus in nursing documentation around medication administration. *Tab # 102 Six Sigma reports.* Nursing leadership is using the information from the report in a number of ways, including the design of the medication rooms in the new hospital building. **Compliance: Partial**
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:** See VIII.D.4. The Medication administration training included an hour long session on medication variance reporting. Nurses were instructed on how to recognize a medication variance and the steps needed to ensure the variance(s) are reported to pharmacy. *See Tab # 114* The nursing procedure was also compared with the hospital policy around medication variances. *Tab # 114.* A new nursing procedure titled Controlled Substance Audit Policy effective October, 2009 was finalized. It provided clear directions for the storing, locking and auditing of controlled substances. *Tab # 105.* **Compliance: Partial**
VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that	**Findings:**

No	Requirement	Progress/Findings
	appropriate follow-up occurs to prevent recurrence of such errors;	See VIII.D.4 and 5. **Compliance: Partial**
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.5**.** As a part of the medication administration training, the nursing staff (RN/LPN) were trained in using the "6 Rights". This includes educating the individual about his/her medication prior to administering and to remind them to tell staff and for staff to observe for side-effects. The documentation of the response is to be recorded in the results section of the eMAR or the note section. **Compliance: Partial**
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 VIII.D.1. **Compliance: Partial**
VIII.D.9	Ensure that each individual's treatment plan identifies:	
VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Findings:** See VIII.D.1 and VIII.D.2. and VIII.D.10. Per DOJ recommendation, the nursing procedure around choking assessment was revised. *Tab # 111, Nursing Procedure around choking.* The Hospital considered renaming the procedure with use of dysphasia, but elected not to do so. The IIRP is now completed in Avatar. Now that it is Avatar, nursing, after discussion with the doctor as appropriate, will be identifying and entering nursing interventions into the IIRP. Training in Avatar to complete this is underway, and it is expected that nursing will assume this function fully by mid April 2010. **Compliance: Partial**

No	Requirement	Progress/Findings
VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Findings:** See VIII.D.1 and VIII.D.2. A new nursing documentation policy was developed. *See Tab # 106.* The policy details nursing responsibilities for documentation, and distinguishes the various types of progress notes. It also includes a one-page flow sheet to which nurses can refer regarding the frequency of nursing documentation. Beginning this Spring, progress notes are to be completed using the SOAPIE formula. Notes should include subjective data, objective data, assessment data, plan, intervention and evaluate. Training is also available through the skills lab and was also addressed during the Medication Administration training. The Nursing Update form contains prompts for nursing to provide some information relative to each IRP focus. *Tab # 28.* The nursing update form is not yet completed in Avatar. The Change of Shift report also included some information about the IRP. **Compliance: Partial**
VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Findings:** Revisions were made to the insulin administration procedure. *See Tab # 115.* The policy includes the signs of hypoglycemia and hyperglycemia. All nurses who administer medications are required to attend the medication administration training in the nursing skills lab which clarifies that during double checks of insulin, the second nurse must be present when the insulin is drawn up. This will ensure that it is the right medication when taken from its storage area, and that second nurse must observe that the indications for this patient to receive this medication are accurate. **Compliance: Partial**
VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	
VIII.D. 10.a	actively collect data with regard to infections and communicable diseases;	**Findings:** Continued progress is being made in the infection control program. The Infection Control Coordinator reports significant progress in the reporting and tracking of individuals placed in

No	Requirement	Progress/Findings
		isolation as well as in the implementation of precautions. Data on infections is collected monthly and reported quarterly. A copy of the Calendar year 2009 report is attached at *Tab # 131.* Data shows that health care acquired infections were at 1.1 per 1000 patient days at JHP and 1.2 at RMB, each of which is better than the 2009 goal of 2.0 per patient day. The Hospital also performed better than its goal with respect to MDROs. Other activities included standard precautions and transmission based precautions monitoring; staff education around rabies, H1N1 and seasonal flu as well as tuberculosis; environmental monitoring; and hand hygiene monitoring. Three investigations were conducted around rabies, recovery of a bat in the Hospital and an influenza-like illness cluster outbreak in March, 2010. The Infection Control Officer is also monitoring the monthly antibiotic report for trends and other relevant information. Hand hygiene compliance is generally improving although observations are somewhat limited due to resources. *Tab # 131.* Despite that, a new hand hygiene initiative was introduced in February, 2010 that should expand monitoring. The Infection Control Officer also created a form for tracking of employee infections. However, he is still working with employee health on its implementation. *Tab # 132.* The Infection Control Committee meets on a monthly basis. It continues to respond to priority IC issues, receives regular reports from the IC Coordinator, and reviews trends in data. Safety syringes have been ordered, and the Hospital is evaluating the appropriate respiratory mask to purchase. Currently it is evaluating purchase of a "PAPR" mask but is waiting for a demonstration from the company that makes the masks before making a decision. The IC Coordinator continues to develop and implement strategies that can be used to monitor implementation of the program at both the individual patient and hospital wide levels. **Compliance: Substantial**
VIII.D. 10.b	assess these data for trends;	**Findings:** See VIII.D.10.a. Collection of data around employee infections is lagging behind patient related collections.

No	Requirement	Progress/Findings
		Compliance: Substantial
VIII.D. 10.c	initiate inquiries regarding problematic trends;	**Findings:** The Infection Control Committee is reviewing data and as appropriate identifies trends or issues. *Tab # 130 Infection Control Committee.* **Compliance: Partial**
VIII.D. 10.d	identify necessary corrective action;	**Findings:** The Infection Control Officer and Committee have identified issues and proposed corrective actions in a number of areas. For example, the Committee is addressing an issue of an employee needle stick when the employee GMO was not called. Corrective actions included a review of the needle stick policies as well as a proposal to gather additional information upon admission. The Infection Control Officer also has worked out a structure with the Safety Officer so that infection control aspects of the monthly safety surveys and quarterly environmental reports are presented to the Infection Control Committee. The Committee reviewed the survey items and identified those that are relevant to its mission. Issues that are revealed as a result of the survey are assigned to committee members for follow up. **Compliance: Partial**
VIII.D. 10.e	monitor to ensure that appropriate remedies are achieved;	**Findings:** See VIII.10.d. The Infection Control program continues to strengthen. The Performance Improvement policy within the Infection Control Manual was modified to clarify how infection control will relate to PID as well as how the environmental surveys will be used for infection control purposes. **Compliance: Partial**
VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Findings:**

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>See VIII.D.10.e

Compliance: Partial</td></tr>
<tr><td>VIII.D.
10.g</td><td>ensure that nursing staff implement the infection control program.</td><td>Findings:

The Infection Control Officer reports some progress with nursing staff around infection control. Implementation of isolation precautions has improved, and the hand hygiene observations show some improvement in implementing standard precautions, although performance is not yet at expected levels.

Compliance: Partial</td></tr>
<tr><td>VIII.D.11</td><td>Ensure sufficient nursing staff to provide nursing care and services.</td><td>Findings:

First, 6 RNs and 3 nursing supervisors (including assistant chief nurse) were hired during the review period and 23 left employment. The breakdown is as follows:

<table>
<tr><th>Position</th><th>Hiring</th><th>Terminations</th><th>Resignations</th><th>Death</th></tr>
<tr><td>Nurse Manager</td><td>10 (includes 8 rehired)</td><td>3</td><td>2</td><td></td></tr>
<tr><td>RN</td><td>6</td><td>1</td><td>3</td><td></td></tr>
<tr><td>LPN</td><td>0</td><td></td><td>2</td><td></td></tr>
<tr><td>PNA</td><td>0</td><td>3</td><td></td><td></td></tr>
<tr><td>FPT</td><td>0</td><td>4</td><td>4</td><td>1</td></tr>
<tr><td>Total</td><td>16</td><td>11</td><td>11</td><td>1</td></tr>
</table>

Decisions were made to not renew appointments or to terminate staff based upon performance issues. Hiring has substantially slowed since the last review probably due to new hiring procedures in place, but there are currently 3 nurse manager positions in recruitment, 15 nurse positions in recruitment and 6 paraprofessional staff positions awaiting announcement. Both the Risk Manager and PID Director positions were filled in December, 2009. More specific information will be available during the site visit if needed.

Nursing leadership sought and secured the ability to hire part-time staff. With the addition of these half time positions, nursing should be able to draw from a new pool of potential staff who for whatever reason may only being seeking part-time work. These positions offer new flexibility in scheduling to cover weekends without utilizing overtime and overtaxing staff.</td></tr>
</table>

No	Requirement	Progress/Findings
		In addition, Nursing was substantially more selective in the hiring of new staff. While over 90 candidates were interviewed (including current Nurse managers who were required to reapply for their positions), fewer than 35 were offered positions. Interviews were conducted by a panel using a structured set of interview questions that are behaviorally based and tied to seventeen competencies. *See Tab # 124, Nursing Behavioral- Based Interview questions.* Interviewers select questions from each competency category. Areas of competency selected for interviews include accountability, adaptability, analysis, communication, continuous learning, excellence, judgment, initiative, leadership, motivation, negotiation, patient services, planning, problem-solving, presentation, teamwork, professional proficiency and work standards. In most cases, candidates are interviewed twice. Based upon the new hiring process, the nursing leadership believes that they are hiring more qualified candidates who have an accurate set of expectations about the position and who are willing to commit to a high level of practice and accountability. Nursing leadership also redeployed staff based upon census and unit closings. **As a result of these efforts, not only are staff working fewer overtime hours, but an RN has been assigned and on duty, since January 1, 2010, to every unit across the Hospital, on every shift.** In addition, **nursing care hours per patient day rose from 4 hours in September, 2009, to an average of 5.37 hours hospital wide from October 2009 through February 2010** moving the Hospital closer to the planned 6 hours of nursing care hours per patient day**.** *See Tab # 108, Nursing care hours per patient day summary.* The average NCHPPD for Forensic from October 2009 through February, 2010 is 5.08 hours, and for civil is 5.64, both significantly hire than at the time of the last review. The Hospital continues to work toward a mix of nursing staff to achieve a 30% of RNs on duty, but is not yet reaching the target. Hiring continues. *List of positions in recruitment, Tab # 42.* Nursing also has filled several of the off hour supervisor positions. The evening shift during the week is now filled, a candidate for nights during the week was selected but must be approved by the Director, DMH for reasons related to the District's residency preference, the candidate for weekend nights is identified, but is related to the residency preference issue, and recruitment continues for the weekend day supervisor. The Hospital elected to hold off developing unit nursing plans for provision of care because unit staffing and missions are changing as part of the move to a new hospital. The procedure for Nursing provision of care was modified. *Tab # 107* The Risk Manager position was filled December 14, 2009, and the PID Director position

No	Requirement	Progress/Findings
		was filled on December 21, 2009. **Compliance: Partial**

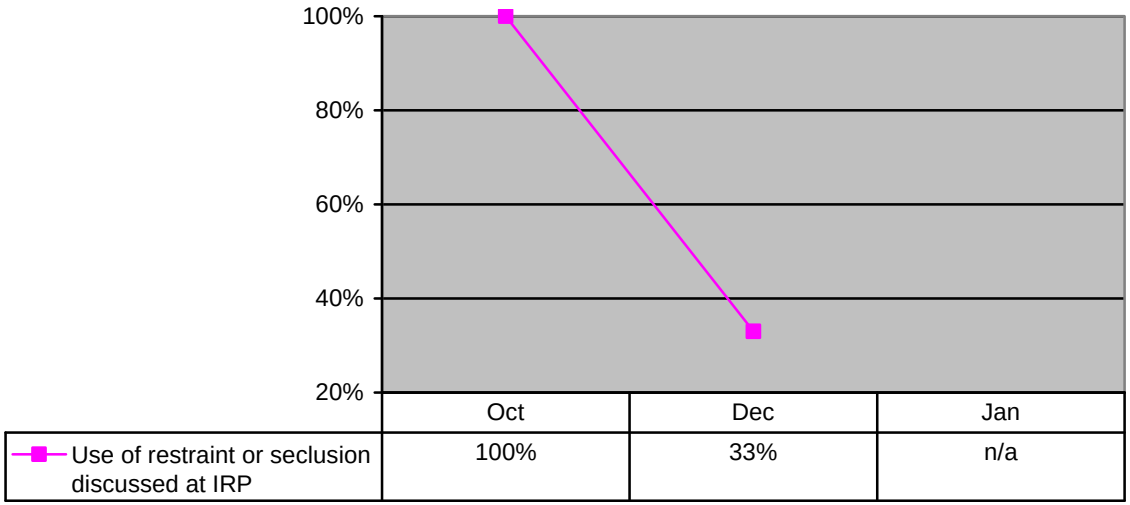
IX. Documentation

No	Requirement	Progress/Findings
	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.	**Summary of Progress:** See Sections V, VI, VII, VIII and X.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications

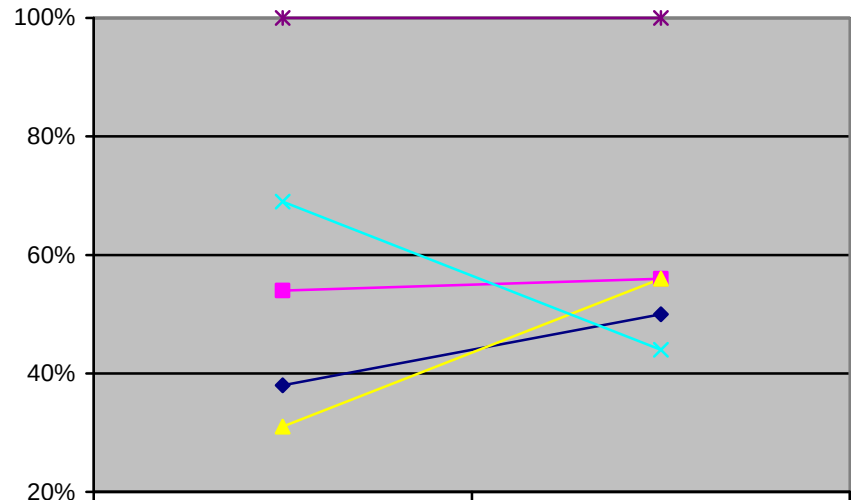
No	Requirement	Progress/Findings
	By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	**Summary of Progress:** 1. The Hospital completed a reconciliation of the Restraint and Seclusion for Behavioral Reasons, the Use of Protective Devices and the Involuntary Administration of Medication policies. Changes were made, including clarification of the definition of "drug used as a restraint." 2. Use of restraint and seclusion continues to be well below the national average in both the percent of patients secluded or restrained, as well as in the total hours. Data continues to be reported monthly. 3. As of the writing of this report, no individuals are using side rails. 4. The Hospital continues to audit 100% of the incidents of restraint and seclusion. Data shows improving performance across some indicators, but in some indicators (post event treatment team meetings) performance is still lagging. Eighty one percent (81%) of nursing staff have completed the new seclusion and restraint training. 5. Treatment teams are now assessed as to whether, in IRP conferences, they consider use of restraint or seclusion during the prior two months and modify IRP plans accordingly. Data is available on this performance indicator and is reported below. 6. Nursing continues to train its staff on use of the quiet room. As many individuals in the new building have their own rooms and there is a specific designated comfort room on each unit, it is expected that this may also ensure that the quiet room is not used in a manner that suggests seclusion. 7. The Hospital's Pharmacy and Therapeutics Committee recently forwarded to the Medical Staff Executive Committee a recommendation to clarify that under Hospital protocols, the use of the word "STAT" in a medication order means emergency, and if needed, administer the medication involuntarily. The selection "NOW" would be used if it is an emergency but the medication should not be given involuntarily. Nursing will then record if the medication was given involuntarily by selecting the same on the medication administration screen in eMar. If accepted by the Medical Staff Executive Committee, a report should be able to be generated in Avatar to track emergency involuntary medication use.
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:** The Hospital modified its Restraint and Seclusion for Behavioral Reasons policy to address issues from the most recent DOJ report and to ensure consistency with other related policies. The revised policy makes clear that use of restraint or seclusion is an emergency intervention to protect the individual or others, and is not a treatment intervention. The Hospital also amended its restraint and seclusion and involuntary medication policies to

No	Requirement	Progress/Findings
		clarify what constitutes a "drug used as a restraint" and to reaffirm that drugs may not be used as a restraint. *Tab # 51, Restraint and Seclusion for Behavioral Reasons policy.* The Doctor's Order and Levels of Observation forms for seclusion and restraint are currently in Avatar and revisions are planned but have not yet been made; it is in the queue for Avatar modifications. Therefore, while the Hospital expects to remove all references to target symptoms and "drugs used as a restraint" in the Order, that has not yet been completed. Other changes to the policies include clarifying the type of restraints permitted (four-point), clarification around advanced directives versus advanced instructions, comfort plans, physical versus therapeutic holds and examples of low level of interventions. The training curriculum for seclusion and restraint was updated in June, 2009 and all Nurse Managers participated in a train-the-trainer session on the topic. Training began in mid July. Training is continuing and, as of the writing of this report, 81% of nursing staff have completed training. Training is ongoing. *Tab # 120, Nursing training data.* In addition, the Risk Manager recently completed a "primer" for treatment team members (RN, MD, social workers, psychologists and clinical administrators) around seclusion and restraint, with a specific focus around appropriate use of the "quiet room." *See Tab # 85, Rights of Individuals Receiving Care: Restraint and Seclusion.* It is also expected that the move to the new building should also result in improvements. Specifically, unlike current units, on each unit and at the TLCs there is designation of a particular room as the comfort room, and most individuals in care will also have their own room in which to go if they become upset or need some quiet space. Data reporting use of restraint and seclusion data is included in the monthly PRISM reports and unit data is also provided. Unit data from PRISM is now sent to the clinical administrators and nurse managers for each unit each month. The rate of seclusion or restraint continues to be well below the national rate, as does the percent of individuals restrained or secluded (except for the month of November which is explained in more detail below) During the month of February 2010, there were no incidents of seclusion in RMB, and one episode involving one individual on an admissions unit in JHP, and there were no incidents of restraint in the hospital at all. *See Tab # 53, PRISM reports.* Effective with the October 2009 IRP observations, the Hospital also modified its IRP observation tool in an effort to assess whether treatment teams are weighing changes in interventions for those individuals for whom restraint or seclusion were used. Specifically, observers are checking the UI data base and the records to see if restraints or seclusion were used, and then monitoring to ensure that the treatment teams discuss the event[s] and what changes may be needed in the IRP. Data show:

No	Requirement	Progress/Findings
		IRP: Seclusion and Restraint Discussion  Oct / Dec / Jan Use of restraint or seclusion discussed at IRP: 100% / 33% / n/a *See Tab # 9, IRP Monitoring Observation Audit results.* No cases in which restraint or seclusion were used were observed in January, 2010. The Hospital continues monthly audits of 100% of the incidents of restraint and seclusion. However, because usage is so low, data is presented in three month blocks. A completed comfort plan was found in all charts of individuals for who restraint or seclusion was utilized. Data from the most recent reviews show that low to moderate levels of interventions are used only in about half of the cases, but staff are using these interventions with more frequency:

No	Requirement	Progress/Findings

Seclusion and Restraint: Interventions Used



	Aug to Oct	Nov to Jan
Low level interventions used-nursing	38%	50%
Low level interventions used-physician	54%	56%
Moderate level interventions used- nursing	31%	56%
Moderate level interventions used-physicians	69%	44%
Comfort Plan in Chart	100%	100%

Because this audit only reviews cases where restraint or seclusion was used, it does not capture the cases in which low or moderate level interventions were used and were effective in preventing the use of restraint/seclusion. The indicator in which performance continues to falter most is related to whether the treatment team is meeting within 24 hours of a restraint or seclusion event.

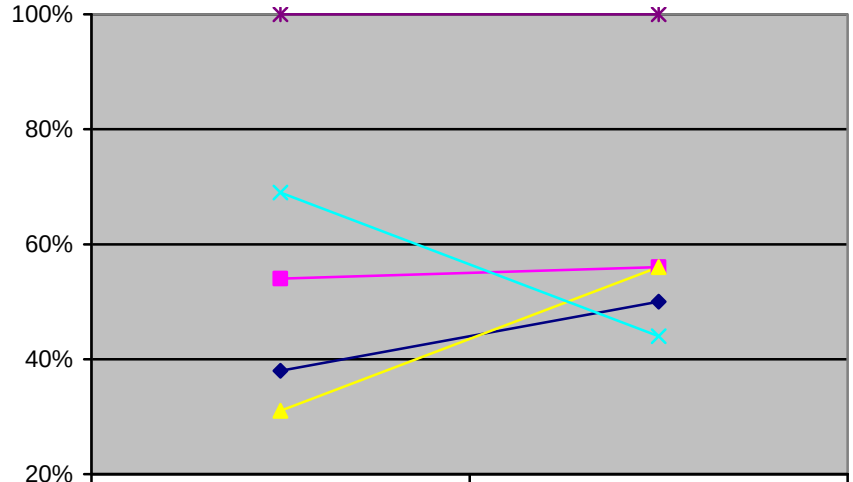
It should be noted that there was an incident in one unit at JHP involving inappropriate use of “quiet rooms”. In November 2009, the Director of Consumer Affairs received a complaint from two individuals in care that all individuals on the unit were told they had to stay in their rooms during shift report from day to evening shift. Both Consumer Affairs and the Risk Manager reviewed the matter. While no other individuals in care objected to the restrictions and no individual was locked in his room, it was immediately stopped that day

No	Requirement	Progress/Findings
		and recorded as seclusion, which accounts for the spike in November in Forensic Services. In a second case, the psychiatrist and an administrator from Forensic Services discovered an individual locked in his bedroom without an order. That was reported, the staff member involved was placed on administrative leave and he was required to re-establish his restraint and seclusion competencies.
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:** The use of prone restraints, prone containment, and/or prone transportation continues to be prohibited in the SEH Restraint and Seclusion for Behavioral Reasons policy. *Tab # 51, Restraint and Seclusion for Behavioral Reasons policy.* It is also prohibited by the Nursing Restraint and Seclusion procedure, There is no evidence of prone restraint use in the records reviewed. **Compliance: Partial**
X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Findings:** The Hospital is continuing training around use of restraint and seclusion, using the curriculum for *Restraint and Seclusion for Behavioral Reasons* developed in August, 2009. To date, 81% of nursing staff have completed restraint and seclusion training and 69% of psychiatrists are current in their training. Fifty eight percent (58%) of nursing staff and 55% of psychiatry are current in the Non-violent Crisis Intervention training. **Compliance: Partial**
X.A.3	the use of side rails on beds, including a plan:	**Findings:** Prior to the last review, the Hospital created and provided a stand alone policy that governs the use of Protective Measures. *Tab # 154, Use of Protective Devices Policy.* Currently, no individuals use side rails. New side rails were purchased to coordinate with the furniture being used in the new building. **Compliance: Substantial**
X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual	**Findings:**

No	Requirement	Progress/Findings
	way to ensure safety; and	See X.A.3. **Compliance: Substantial**
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:** See X.A.3. **Compliance: Substantial**
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:** Data continues to show use of restraint or seclusion is far below the national average in both episodes and hours. See X.A. for discussion of November data. The percentage of individuals restrained ranged from a high of 1.1% to a low of 0.0%; the percentage of individual secluded ranged from a high of 7% (November) to a low of 0.2% for the period of August to January, 2010. The number of restraint episodes ranged from a high of 4 (August 2009 and January 2010) to a low of 0 (February, 2010) and the number of seclusion episodes ranged from a high of 50 (November) to a low of 1 (August 2009, February 2010). *See Tab # 53, PRISM Report and 2009 Trend Analysis.*
X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Findings:** See X.A.1. and X.A.2. The Hospital continues monthly audits of 100% of the incidents of restraint and seclusion. However, because usage is so low, data is presented in three month intervals as opposed to monthly. Data from the most recent reviews show that low to moderate levels of interventions are used in about half of the cases, but usage by nursing of these interventions is improving:

No	Requirement	Progress/Findings

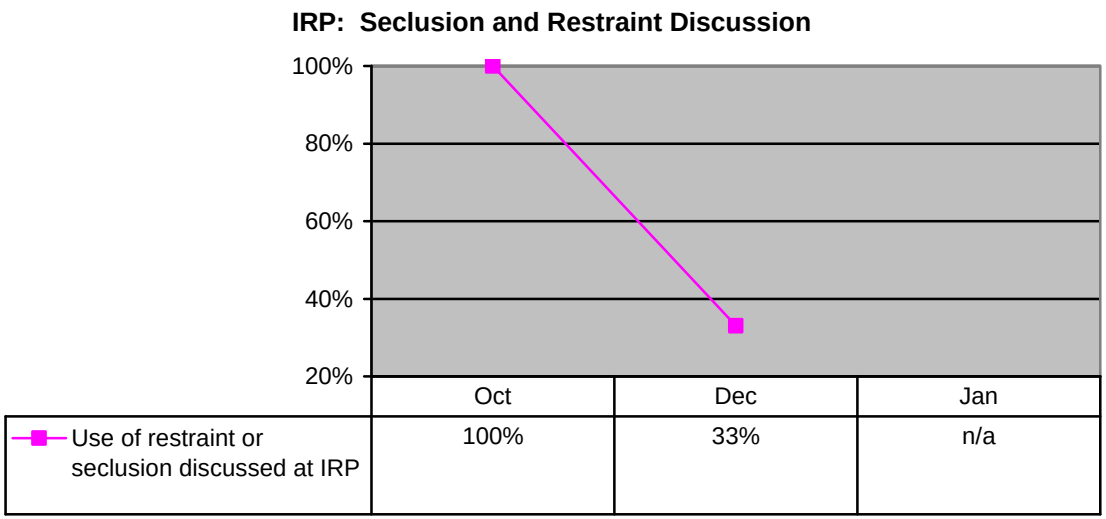
Seclusion and Restraint: Interventions Used

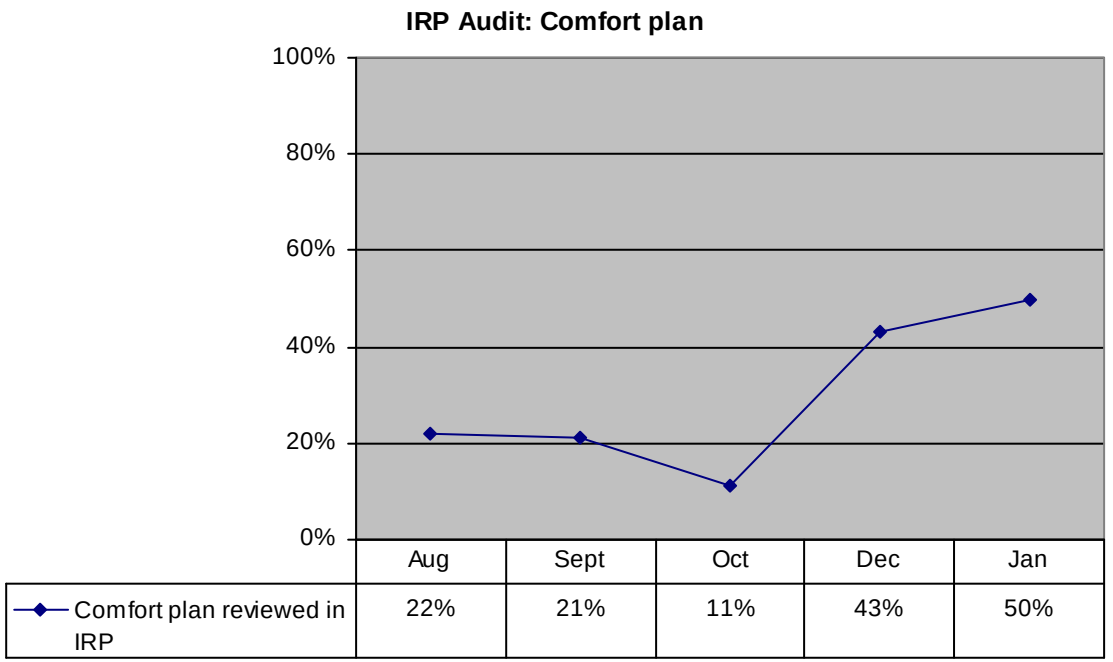


	Aug to Oct	Nov to Jan
Low level interventions used-nursing	38%	50%
Low level interventions used-physician	54%	56%
Moderate level interventions used- nursing	31%	56%
Moderate level interventions used-physicians	69%	44%
Comfort Plan in Chart	100%	100%

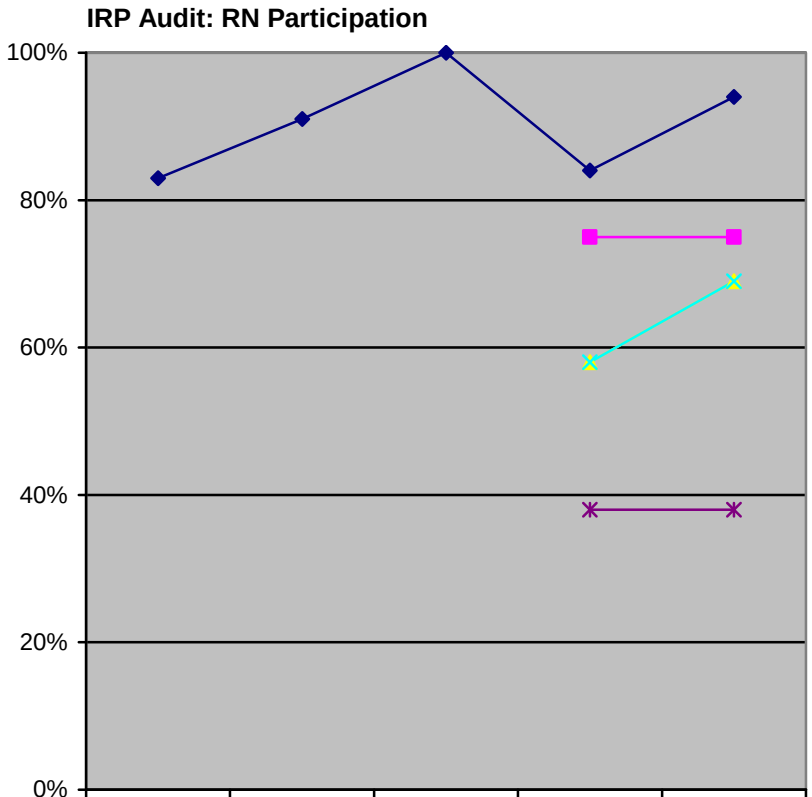
See Tab # 54 Seclusion audit tool and Tab # 55 Seclusion Audit results. However, because this audit only looks to those cases in which restraint or seclusion were used, this data does not capture all the incidents in which low to moderate interventions were effective in avoiding the use of restraint or seclusion.

In an effort to improve the identification of more effective interventions in addressing challenging behaviors, the Hospital is monitoring whether the IRP conferences are addressing use of restraint or seclusion, whether there are discussions concerning need to update the comfort plan, and finally, the attendance of and participation by nursing in the IRP conference. Data suggest there is some improvement in the modification of IRP interventions following restraint or seclusion use, but modifications are still not consistently occurring or even discussed at the IRP conference.

No	Requirement	Progress/Findings
		 *See Tab # 9, IRP Monitoring Observation Audit Results.* The Restraint and Seclusion audit results are consistent with the IRP observation audits. The seclusion and restraint audits found that during the August to October 2009 audit period, in only 29% of cases did the team address the episode in the following IRP meeting; that fell to 18% in the November 2009 to January 2010 audit period. The Hospital modified the IRP conference protocol and asked teams to determine at each IRP conference if comfort plans needed updating and update them with the individual if necessary. Data show improvement in addressing the need for revisions to the comfort plans:

No	Requirement	Progress/Findings
		 The Hospital continues to monitor RN participation in the IRP conference, and in December 2009 began assessing the quality of nursing's participation in discussing interventions and progress. In an effort to improve quality of participation, nurse managers are now reviewing with staff nurses each week the nursing update and discussing preparation for the IRPs scheduled for the upcoming week. These efforts are designed to increase the attention to interventions that may address challenging behaviors. The data show these efforts may be beginning to be effective:

No	Requirement	Progress/Findings



	Aug	Sept	Oct	Dec	Jan
RN Attendance	83%	91%	100%	84%	94%
RN discuss interventions in general	n/a	n/a	n/a	75%	75%
RN discuss specific interventions	n/a	n/a	n/a	58%	69%
RN report on progress	n/a	n/a	n/a	58%	69%
RN recommend revised interventions	n/a	n/a	n/a	38%	38%

See Tab # 9, IRP Monitoring Observation audits.

The Hospital is also continuing with its Violence in the Workplace Initiative. *See Tab # 155.* The subcommittee of the Risk Management and Safety Committee presented an overview of the initiative at the March 2010 all staff meeting, and is developing a work plan.

No	Requirement	Progress/Findings
		Among the steps included are a hospital-wide assessment of environmental and personal risks for violence, development of hospital policies and protocols around violence, staff education, among other things. Further, staff injury data began being included in PRISM and will be trended after several months of data are available. **Compliance: Partial**
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 Hospital continues to audit whether restraint or seclusion was used as an alternative to treatment or as a convenience to staff. *See Tab # 54, Restraint/Seclusion audit tool and instructions.* Audit results show that staff generally do not use restraint or seclusion to punish the individual or for staff convenience. In the period of August through October, 2009, in none of the incidents of restraint or seclusion was there evidence it was used for punishment or convenience; for the period of November, 2009 through January, 2010 the auditor found it was used for convenience in 11% of cases. See X.A.1 for circumstances of use for convenience in November, 2009. *See Tab # 55, Restraint/seclusion audit results.* Staff training in EARN is continuing and the program is expected to be completed and implemented on all units by the time of the move to the new hospital building. Implementation of EARN will also include the use of the Comfort Plan as a first response guide at comforting the patient before a crisis occurs. Individuals in care have responded well to the new engagement and needs assessment initiative. Interventions that were used are included in the nursing update to be shared in the IRP meetings and included as a problem to be regularly addressed. To date, approximately 60% of staff have been trained in EARN with the expectation that 100% will be trained by April 30, 2010. **Compliance: Partial**
X.B.3	are not used as part of a behavioral intervention; and	**Findings:** The Hospital prohibits the use of restraint/seclusion as part of a behavioral intervention, and there are no plans that include these measures. **Compliance: Substantial**
X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Findings:** *See Tab # 55 Restraint/seclusion audit results.* According to the seclusion and restraint

<table>
<tr><th>No</th><th>Requirement</th><th>Progress/Findings</th></tr>
<tr><td></td><td></td><td>audits:

<table>
<tr><th>Indicator</th><th>Aug ’09– Oct ’09</th><th>Nov ’09– Jan ’10</th></tr>
<tr><td>Episode terminated as soon as no longer imminent danger</td><td>100%</td><td>89%</td></tr>
<tr><td>Assessed readiness for release every 15 minutes</td><td>100%</td><td>100%</td></tr>
<tr><td>Documentation individual informed of criteria for release</td><td>67%</td><td>100%</td></tr>
</table>

The Hospital is aware that the Levels of Observation Sheet in Avatar requires modification to improve tracking of this requirement. Plans are to modify it, and it is in the queue for modification. Tab # 156, Avatar Issues List.

Compliance: Partial</td></tr>
<tr><td>X.C</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that a physician’s order for seclusion or restraint include:</td><td></td></tr>
<tr><td>X.C.1</td><td>the specific behaviors requiring the procedure;</td><td>Findings:

The Hospital is using the Doctor’s order form for seclusion and restraint that is in Avatar, which includes a prompt to document the specific behaviors requiring restraint/seclusion. SEH reported that in 100% of the episodes for the period of August 2009 through January, 2010, the specific behaviors were documented in the order. See Tab # 55 Restraint/seclusion audit results. It will modify the order to remove the reference to target symptoms, but this will not occur immediately due to other priorities around Avatar implementation.

Compliance: Substantial</td></tr>
<tr><td>X.C.2</td><td>the maximum duration of the order;</td><td>Findings:

The “Doctor’s Order…” form contains a prompt to record the maximum duration of the order and it was present in the records reviewed. At this point there is no data available, but the audit form is being revised, and this will be included in the revised audit tool.

Compliance: Partial</td></tr>
<tr><td>X.C.3</td><td>behavioral criteria for release which, if</td><td>Findings:</td></tr>
</table>

No	Requirement	Progress/Findings
	met, require the individual's release even if the maximum duration of the initiating order has not expired;	SEH reported that in 100% of the all episodes, there were individualized criteria for release. *See Tab # 55, Restraint/seclusion audit results.* However, based upon the review of a small subset of cases, it appears that in a number of cases, the criteria for release are not behavioral in nature. The Hospital is expecting to modify the Doctor's Order for Restraint/seclusion form in Avatar to remove the phrase targeted symptoms, but that is not expected until Spring due to other priorities. **Compliance: Partial**
X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Findings:** According to audit data, it appears 100% of cases where the treating psychiatrist was not the ordering physician the treating psychiatrist was notified of the use of restraint or seclusion during the August to October period but that number fell to 44% for the period of November 2009 to January, 2010. However, the indicators in the audit tool on this requirement are awkwardly phrased, so there is some doubt about the accuracy of the data. This is expected to be clarified in the revisions to the audit tool. *See Tab # 55 Restraint/seclusion audit results.* **Compliance: Partial**
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:** See X.B.4 **Compliance: Partial**
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:** The Hospital includes this requirement in the restraint and seclusion audit and performance is still below expected levels. According to audit data, for the period of August to October, in only 15% of cases was a team debriefing within 24 hours, and in only 29% did the team address the incident in the next IRP conference. For the period of November 2009 to January 2010, the incidence of debriefing was 6%; in18% of cases was there evidence that it was considered in the next IRP. **Compliance: Noncompliance**

No	Requirement	Progress/Findings
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 two incidents in which individuals were secluded without a doctor's order. The first occurred in November, 2009 at JHP and is explained above. A second occurred when an individual was locked in his own room, which also occurred at JHP. One staff in that incident was placed on administrative leave and was required to show competency in restraint and seclusion through retraining. Audit results reveal that in 50% of the episodes from November to January, there was documented evidence of a face-to-face assessment within one hour of the episode; it was at 82% in the period of August through October, 2009. **Compliance: Partial**
X.C.8	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.	**Findings:** See VIII.D.1. **Compliance: Partial**
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:** The Hospital is improving its data collection around use of restraint and seclusion, and is probably over reporting slightly the emergency involuntary administration of medication. The Risk Manager is tracking restraint and seclusion reporting by comparing nursing's 24 hour shift report with the unusual incident database and the evidence is showing improvement. From August through October, 2009, 100% of incidents were reported by the timely completion of a UI report. That number at 83% in November 2009 through January, 2010. *See Tab # 55, Restraint/seclusion audit results.* With respect to use of emergency involuntary medication the Hospital is reporting to Pharmacy and Therapeutics Committee data that reflects use of certain parenteral tranquilizers on a STAT basis and by unit. *Tab # 93, Pharmacy and Medication Monthly report.* After several months of data, the Committee concluded that the data presented in that format probably overstated the incidence of emergency involuntary medication. Therefore, the Committee is presenting a recommendation to Medical staff executive

No	Requirement	Progress/Findings
		committee that the NOW choice in eMar = non-emergent and STAT = emergent. It would be understood that STAT would mean that, if necessary, the medication is to be given involuntarily. When the nurse goes to administer the medication it will be determined if it was done so voluntarily or involuntarily and that will be indicated in the administration event in eMAR. If it was administered involuntarily then the physician would be notified to fill out a UI. Once implemented, a report could be run from eMar that identifies emergency involuntary medication. **Compliance: Partial**
X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Findings:** The Hospital implemented its high risk indicator tracking that tracks individuals with 3 or more unusual incidents (any type) in a 30 day period. This would capture the use of restraint or seclusion in a 30 day period. Under the process: ▪ Risk Management sends notification to the respective Medical Director. ▪ The Medical Director/designees will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification. ▪ The Medical Director/designee will enter any recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations into the next IRP. PID will track the recommendations. *See Tab # 56.* The Medical Directors, clinical faculty for the residency program and other psychiatrists are available and do consult as needed. See Also X.C.6 **Compliance: Partial**
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,	

No	Requirement	Progress/Findings
	requiring that:	
X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Findings:** The Hospital continues its policy of prohibiting the use of psychotropic mediations on a PRN basis and a report is available on line in Avatar concerning use of STAT medications. Data is presented monthly to Pharmacy and Therapeutics Committee as to possible emergency involuntary medication use. *Tab # 93.* In addition, the Hospital is presenting a recommendation to Medical Staff Executive Committee that the NOW choice in eMar = non-emergent and STAT = emergent. It would be understood that STAT would mean that, if necessary the medication is to be given involuntarily. When the nurse goes to administer the medication it will be determined if it was done so voluntarily or involuntarily and that will be indicated in the administration event in eMAR. If it was administered involuntarily then the physician would be notified to fill out a UI. Once implemented, a report could be run from eMar that identifies emergency involuntary medication. The IRP Monitoring Observations is monitoring whether teams address use of stat or prn medication in the IRPs. Data shows: **IRP Audit: Review of STAT/PRN Use**  This suggests improvement in consideration by the treatment teams of the effectiveness on interventions during IRP and the usefulness of review of emergency medication during the

	Aug	Sept	Oct	Dec	Jan
STAT/PRN meds use reviewed at IRP	67%	75%	75%	67%	n/a

No	Requirement	Progress/Findings
		prior IRP period. *See Tab # 9.* **Compliance: Partial**
X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Findings:** The Medication Ordering and Administration and the Involuntary Medication Administration policies require that the physician assess the individual within one hour of the administration of emergency involuntary psychotropic medication. *Tab # 125, # 140*. The Hospital still does not have an audit tool or data to assess progress on this requirement other than in those circumstances in which both emergency involuntary medication is given and restraint or seclusion is used. In those cases, face-to-face assessment within one hour occurred in a range of 50% to 82% of cases. However, if the Medical Staff Executive Committee approves the recommendation of the Pharmacy and Therapeutics Committee, some data may be available. **Compliance: Partial**
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:** See X.F.1. and X.E. The Hospital is tracking this requirement through the high risk trigger process. **Compliance: Partial**
X.G	By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Findings:** See VIII.D.1 and X.C.8 **Compliance: Partial**

XI. Protection from Harm

No	Requirement	Progress/Findings
	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.	**Summary of Progress:** 1. The Hospital is moving into its new facility in May, 2010. There will be 11 units there, and 2 remaining in the RMB annex. The Hospital is a state of the art facility with more individuals having their own rooms, recreational facilities, access to outside areas off all first floor units and separate space for the treatment programs. 2. The annual retraining of staff on reporting abuse and neglect is ongoing as of the writing of this report. Data will be available at the time of the visit. 3. The Risk Manager, who presently investigates the vast majority A/N/E incidents (sometimes with the assistance of the Safety Officer), is equipped by training, talent, and temperament for this work. All investigations are reviewed by the Director of the Performance Improvement Department. The Risk Manager is assisted by an investigator and an additional position is in recruitment. 4. The Risk Manager is implementing the use of a face sheet for investigations as recommended by DOJ. 5. The hospital's review of the criminal history and abuse registry check of all employees comports with the requirements of the District of Columbia. 6. Staff continue to provide for the physical needs of an individual who was hurt. It remains the practice to remove staff from clinical duties during the investigations of allegations of A/N/E, except where the allegations are assessed as incredible.

XII. Incident Management

No	Requirement	Progress/Findings
	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.	**Summary of Progress:** 1. The Hospital revised its *Reporting Unusual Incident*, *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* and *Unusual Incident Investigations* policies to ensure consistency and to incorporate recommendations by DOJ. 2. The Hospital has now fully implemented the new UI form and the data base was revised so that data is collected by patient and by staff, by type of incident etc. 3. The Hospital hired a new PID Director and Risk Manager in December 2009. The new Risk Manager was promoted from his prior position as Director of Consumer Affairs for the Hospital. An investigator continues to assist the Risk Manager in conducting interviews. The new PID director has experience in psychiatric facilities. 4. The Hospital continues to conduct investigations into all reported suspected allegations of abuse or neglect, suicide or suicide attempts, and elopements of dangerous patients. Investigations incorporate the preponderance of the evidence standard and written reports include a face sheet that summarizes the findings. 5. The Hospital developed and implemented an on-going training program for staff that governs reporting suspected abuse and neglect of individuals in care. To date, 45% of staff have received the annual review of the Reporting Suspected Abuse or Neglect training and 95% of new employees received the initial training. 6. The UI data is reported monthly. Unit specific data is made available to treatment teams. Specific data around elopements and patient injury is also highlighted in the monthly PRISM reports. Staff injury data is also now included in PRISM reports. 7. The review process was followed in all deaths.
	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Findings**: The Hospital revised its Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care policy based upon DOJ recommendations. The definition of sexual assault was removed from this policy but is in the Unusual Incident policy. Sexual behavior perpetrated by another individual is referenced in this policy as a failure to supervise under the Neglect definition. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care*

No	Requirement	Progress/Findings
		Policy Tab # 133. Further, the definition of Unprofessional Relationship was defined more narrowly to reflect a breach of fiduciary relationship as opposed to activity that would constitute sexual abuse. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care, Tab # 133*. The Hospital also revised its *Unusual Incident Investigation Policy, Tab # 136* and *Unusual Incident Reporting policy, Tab # 134* to ensure consistency between policies and PID procedures. **Compliance: Substantial**
XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Findings**: The Hospital is tracking the accuracy of seclusion and restraint reporting in part through the seclusion and restraint audits; audits indicated that only 10% of incidents of seclusion and restraint were documented with a UI report. *Seclusion and Restraint Audit Results, Tab # 55.* The Risk Manager and other members of the PID staff continue to conduct daily and weekly reviews of all data entered into UI database for accuracy and timeliness. There continues to be one dedicated clerk who inputs UI data. Further, the UI database was also enhanced with a data verification tool which generates error messages that alert the Risk Manager of certain data errors. The Risk Manager utilizes additional checks and balances as a means to immediately identify that a UI has not been reported according to the UI policy. Daily, he conducts a review of the 24 Hour Nursing Report to identify incidents in which a UI should be completed, and also follows up on whether a UI is received for each verbal UI notification that he has received. The Risk Manager utilizes the information obtained from data verification and other checks and balances to inform additional UI training to staff by way of presenting additional UI trainings at Senior Staff Meetings, Hospital intranet postings, emails and one-on-one trainings. The Nursing Education and Training department provided a revised comprehensive Restraints and Seclusion training to Nursing staff. To date 81% of nursing staff have received the revised training. In addition, the Risk Manager presented on *Reporting Unusual Incidents* at the clinical leadership meeting and at nurse manager meetings. The elopement rate, patient injury rate and medication variance rates are included in the

No	Requirement	Progress/Findings
		monthly *PRISM Report*. *PRISM Report*, *Tab # 53* **Compliance: Partial**
XII.A.2	immediate reporting by staff to supervisory personnel and S.E.H.'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:** UI data shows an increase in the number of UIs reported over the period of August 2009 through February 2010, which may reflect improved reporting due to the ongoing training efforts. The number of reports of abuse, neglect or exploitation allegations has slightly decreased during the six months of September, 2009 though February, 2010, and the percentage of UIs involving A/N/E allegations also decreased, from 6.7% for the period of March 2009 through August 2009, to 4.7% for the period of September, 2009 to February, 2010. *Unusual Incident Monthly Report, Tab # 142.* Unusual Incidents that report allegations of abuse and neglect account on average for 5.7% of Unusual Incidents reported during the past 12 months. *Unusual Incident Monthly Report, Tab #142.* The timeliness in reporting of UIs declined from November 2009 to January 2010. On average, there was a 3.5 day delay in November, 4.5 day delay in December and a 6.1 day delay in January 2009. February data shows improvement in that there is now generally a 3.1 day delay in timeliness. *Unusual Incident Monthly Report, Tab # 142.* Additional data provided during the site visit will show whether this positive trend will continue. The Risk Manager continues to address the timeliness issue with Hospital staff by providing feedback through additional training presentations, intranet postings and email alerts. On average, it is taking three days from the time of the incident to report UIs. The data also shows that only 45% of reports of abuse, neglect or exploitation were reported timely. *UI Monthly Report , Tab # 142.* Some of the delay may be a result of delay between the time of the alleged A/N/E and the time it was reported to staff. A review of abuse, neglect or exploitation allegations showed one instance where the summary of incident in a UI Report revealed that there was a failure of staff to report an incident upon initial notification of an allegation of abuse toward an individual in care. Although the Risk Manager's investigation report concluded that the allegations of abuse were unsubstantiated, the failure to report was not identified nor addressed in the Risk Manager's investigation report of the underlying allegation. Reporting abuse and neglect continues to be mandatory training that is provided in the new employee orientation and the annual training for experienced staff. The Hospital is in the process of providing the annual training of this curriculum and it is scheduled to be completed in April. The final training data will be provided during the Site Survey.

No	Requirement	Progress/Findings
		Compliance: Partial
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 has revised its existing *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* policy to permit specified limited exceptions to the current requirement that an employee against whom an allegation of abuse and neglect is made must be reassigned to non-patient areas or to be placed on administrative leave pending the outcome of an investigation. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care Policy, Tab # 133*. The current practice is that the Risk Manager conducts an initial review immediately upon receiving a UI with an allegation of abuse, neglect or exploitation to determine if there is any potential that the allegations are supported. From this preliminary review, if the Risk Manager finds that there is a reasonable probability the allegations are true, the Risk Manager will then recommend that the alleged staff aggressor be placed on administrative leave or reassigned to a non-patient care area. Between August 2009 and February 2010 there were 44 UIs received which reported allegations of Abuse, Neglect or Exploitation of an individual in care. Of these reports, the Risk Manager deemed that there was some likelihood of abuse, neglect or exploitation based upon his initial investigation and 15 employees were reassigned or placed on administrative leave. Disciplinary action was taken against five employees in separate incidents. **Compliance: Partial**
XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Findings:** The Hospital continues to provide mandatory competency based training on reporting suspected abuse and neglect. There are now two distinct training modules, one which is a two hour module that is incorporated into the new employee orientation and an annual refresher module for all employees. The annual refresher training reiterates key points of the *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* policy as well as addresses those reporting issues which are identified by the Risk Manager‘s review of A/N/E UIs. *Training Materials and Data. Tab # 119*. The training curricula and training data are included in the Advanced Document request for Ms. Chura.

No	Requirement	Progress/Findings
		To date, 20 of 21 hospital new hires have completed training on reporting suspected abuse and neglect. The annual refresher training for experienced staff is underway. On March 8, 2010, the refresher training began roll out to hospital staff by work cohort groupings. By the end of March, approximately 20% of hospital staff have received the refresher training. The annual refresher training is slated for completion by end of April, 2010. Updated training data will be provided to Ms. Chura during the next site visit. The Risk Manager utilizes the information obtained from data verification and other checks and balances of the UI database to inform additional UI training to staff by way of presenting additional UI trainings at Senior Staff Meetings, Hospital intranet postings, emails and one-on-one trainings. **Compliance: Substantial**
XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents SEH and District officials;	**Findings:** See XII.A.4 , XII.A.5 The Hospital continues to provide mandatory competency based training on reporting suspected abuse and neglect. There are now two distinct training modules, one which is a two hour comprehensive module that is incorporated into the new employee orientation and the second is an annual refresher module for remaining staff. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care Training Materials and Data, Tab #119.* The annual refresher training covers key points of the *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* policy as well as addresses those reporting issues which are identified by the Risk Manager's review of A/N/E UIs. The training curricula and training data are included in the Advanced Document request for Ms. Chura. To date, of the 21 hospital new hires, 20 completed training on reporting suspected abuse and neglect. **Compliance: Substantial**
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.

No	Requirement	Progress/Findings
		Compliance: Substantial
XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Findings:** The UI policy was revised to include a specific requirement that all cases involving potential criminal action shall be reported to MPD, regardless of the wishes of the individuals involved. It also includes a provision that makes a security official subject to discipline for failure to report to MPD. *Unusual Incident Reporting Policy Tab # 134*. The reporting of incidents to the Police is also covered in the *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* training. *Tab #119* Although these policies set forth the requirements on when to notify MPD, there is no systemic way to track this process. Security continues to use a written log system as opposed to a more formal database. Consequently, there is no data that is available that tracks the reporting to MPD. **Compliance: Partial**
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 acts 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 Suspected Abuse, Neglect and Exploitation of Individuals in Care* includes a specific statement that a reporter shall be free from retaliation. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care Policy*, *Tab # 133.* Language in DC regulations governing consumer rights similarly protects patients who may seek to file a grievance. The issue of the right to be free from retaliation for reporting an incident continues to be covered in both the new employee and refresher modules of the reporting abuse and neglect training. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* training, *Tab # 119.* **Compliance: Substantial**
XII.B	By 24 months from the Effective Date thereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Findings:** The Hospital revised its existing Reporting Suspected Patient Abuse, Neglect, and Exploitation of Individuals in Care, Reporting Unusual Incidents, and Unusual Incident Investigations policies to permit specified limited exceptions to the current requirement that an employee suspected of abuse and neglect is to be reassigned to non-patient areas or to be placed on administrative leave pending the outcome of an investigation. The policies now comport with the current practice of the Risk Manager in conducting an initial review

No	Requirement	Progress/Findings
		immediately upon receiving a UI with an allegation of abuse, neglect or exploitation to determine if there is any reasonable likelihood that the allegations are true. From this preliminary review, if the Risk Manager finds that there is a likelihood that the allegations are true, the Risk Manager will then make recommendation that the alleged staff aggressor be placed on administrative leave or reassigned to a non-patient care area, and staff are thereafter reassigned. The Risk Manager has updated the *Investigation Report Facesheet* and the *Investigation Report Template, Tab # 159,* to incorporate preponderance of the evidence as the standard of proof for all investigations conducted by the Risk Manager. The Risk Manager investigation reports reviewed met the standards set forth by the *Unusual Incident Investigations, Tab # 136* policy governing content of the written report. The Hospital also revised its *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* policy based upon DOJ recommendations. The definition of sexual assault was removed. Sexual behavior perpetrated by another individual is referenced in this policy as a failure to supervise under the Neglect definition. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care*, *Tab # 133*. Further, the definition of Unprofessional Relationship was narrowed to reflect a breach of fiduciary relationship as opposed to activity that would constitute sexual abuse. *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care, Tab # 133*. The Hospital also revised its *Unusual Incident Investigation Policy, Tab # 136* and *Unusual Incident Reporting Policy, Tab # 134* to ensure consistency between policies and PID procedures. The Hospital hired a new Risk Manager in December 2009. The new Risk Manager served previously the Director of Consumer Affairs for the Hospital. An investigator continues to assist the Risk Manager in conducting interviews. The Risk Manager continues to use protocols for the review of UI forms to ensure all information is reported and is accurate. Data entry is now done by only one individual and each month the data is reviewed for accuracy. Further, the UI database was enhanced with a data verification tool which alerts the Risk Manager of certain data errors. The Risk Manager devised a tracking mechanism to ensure that recommendations are considered by Executive staff, approved and implemented. **Compliance: Substantial**
XII.B.1	require that such investigations be comprehensive, include consideration of	**Findings:**

No	Requirement	Progress/Findings
	staff's adherence to programmatic requirements, and be performed by independent investigators;	The Hospital continues to utilize a standard face sheet for A/N/E investigations, *Tab # 159,* as well as a standard template for the Risk Manager Investigation Report, *Tab # 159,* that capture the key elements of standard investigation procedures as previously recommended. The Risk Manager updated the Investigation Facesheet and the Investigation Template form to incorporate preponderance of the evidence as the standard of proof for all investigations conducted by the Risk Manager. The Risk Manager investigation reports reviewed met the standards set forth by the *UI Investigations* policy for the written report. In the Risk Manager Investigation reports reviewed, preponderance of the evidence was the standard of proof for all investigations conducted by the Risk Manager. While the timeliness of reporting of UIs had declined with unusual incidents being reported on average within 3 – 6 days in November, 2009 to January, 2010; February data shows an improvement in timeliness by three days. *Unusual Incident Monthly Report, Tab # 142*. Additional data provided during the site visit will show whether this positive trend will continue. The Risk Manager continues to address the timeliness issue with Hospital staff by providing feedback through additional training presentations, Hospital-wide intranet postings and email alerts. See XII.B.3 **Compliance: Substantial**
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:** In December 2009, the Hospital hired a new Risk Manager who was the former Director of Consumer Affairs for the Hospital. The Risk Manager is expected to complete investigations training in April 2010. An additional staff member continues to assist the Risk Manager in conducting investigations. The Investigation training certification for that individual was provided during the previous site survey. **Compliance: Substantial**
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	**Findings:** The Risk Manager Investigation Report Template includes a "Findings" section that guides the Risk Manager/Investigator to make both positive and problematic findings identified from an investigation. This section also provides operational instructions on specific questions that should be answered in making findings, such as whether staff comply with

No	Requirement	Progress/Findings
	completion of investigations of serious incidents; and	reporting and notification requirements; whether there was any stated fear of retaliation; and whether there was consistent medical documentation and statements from patient(s) and staff. The "Recommendations" section of this template instructs the Risk Manager/Investigator to make corrective action recommendations based upon the investigative findings by listing each problematic finding and linking each problematic finding to a specific corrective action recommendation. Review of the Investigation Reports show that findings were made consistent with investigatory procedures and that all parties who may have had direct knowledge of an incident were questioned. See XII.B. The Risk Manager's reports continue to be 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. *Patient Death Review Policy, Tab # 95*; *Sentinel Event Policy, Tab # 143*. The Director, PID continues to work with the Performance Improvement Committee (PIC) to implement a feedback loop. Presently, findings are presented to the CEO and the Performance Improvement Committee, of which both the Risk Manager and Director, Performance Improvement Department, are members. In December 2009, the Hospital hired a new PID Director and Risk Manager. The Risk Manager was formerly the Director of Consumer Affairs for the Hospital. The Risk Manager is registered to complete training in investigations in April 2010. An additional staff member continues to assist the Risk Manager in conducting investigations. The Investigation training certification for that individual was provided during the previous site survey. **Compliance: Substantial**
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 result of investigations.	**Findings:** See XII.B.3. Changes were made in how razors are handled through out the hospital. JHP implemented a Razor Log in November 2009 to track an individual's possession and use of a razor. RMB is not using a razor log. However, individuals are not allowed to use razors unsupervised. The practice on the civil units is that the individuals are monitored in the bathroom during shaving time and the monitor retrieves the razor immediately after the person has finished shaving. The practice in JHP is that shaving occurs daily in the

No	Requirement	Progress/Findings
		morning. Razors are distributed to individuals, which is logged into the Razor Log. They then proceed to a designated shaving area where they are monitored by staff. Once the individual is finished shaving they return the razor to staff in the nursing office. Staff will then update the Razor Log that the razor was returned. Nursing supervisors monitor the Razor Log to ensure that all razors are returned to staff. The Hospital also is implementing a "recommendations tracking log" that will track all recommendations that affect systems issues. It will be presented to PIC each month to address implementation of recommendations. *See tab # 139, PI Projects.* **Compliance: Partial**
XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Findings:** The *Patient Death Review* policy establishes a review process that includes investigation by the Risk Manager or Office of Accountability, review by the Hospital's Mortality Review Committee, and for unanticipated deaths, a review by the Sentinel Event Review Committee. *Patient Death Review Policy*, *Tab # 95, tab # 143 Sentinel Event policy*. The policy was modified to include a requirement that abuse, neglect or exploitation be considered in every death review investigation. Further, the policy specifically provides that the Medical Director is a member of the Sentinel Review Committee, which reviews not only unanticipated deaths but other serious incidents at the Hospital. PID is implementing a system for identifying and monitoring recommendations from investigations. **Compliance: Partial**
XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	**Findings:** Prior practice continues. The UI form continues to be in use hospital wide, and data is available that reflects staff and patient involvement. The UI database was enhanced with a data verification tool in addition to other checks and balances utilized by the Risk Manager to ensure UI reports contain all mandated data as well as accuracy of data. Each UI continues to be identified by a unique tracking number. The Risk Manager utilizes the information obtained from data verification and other checks and balances of the UI database to inform additional UI training to staff by way of presenting additional UI trainings at Senior Staff Meetings, Hospital intranet postings, emails and one-on-one trainings. **Compliance: Substantial**

No	Requirement	Progress/Findings
XII.E	By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:	**Findings:** See XII.D; see also *Unusual Incident Form Tab # 141.* The database permits tracking and trending of each field of the UI form, including individual in care, date, type of incident, unit, time, location, role in incident and action taken . A summary report is prepared each month reflecting trends in UIs; information is available by ward as well as shift although that information is not published each month. *Unusual Incident Monthly Report, Tab # 142.* Recent data shows that since August 2009, there has been a slight decline in the timeliness of reporting UIs but that trend was reversed in February, 2010. The number of UIs reported increased while the census has decreased, perhaps suggesting better reporting, but in recent months, the number of individual in care assaults/altercations decreased as did the number of falls, medical emergencies and unauthorized leaves compared with levels in Spring, 2009. All UIs are reviewed by the Risk Manager, numbered and coded, assigned a severity level and information is checked for accuracy. Monthly, the Risk Manager and the Director, Office of Monitoring Systems, review the incident management database to identify errors or discrepancies that need correction or follow up, and is working closely with Nurse Managers on improving the accuracy and completeness of the UI forms. The Risk Manager also initiates investigations of major incidents, and ensures, if appropriate, staff are placed on administrative leave. Once completed, his findings (including cause and/or contributing factors) and recommendations will be forward to the Division director and to PIC for review. The Office of Quality Improvement also tracks the implementation of recommendations made during investigations. **Compliance: Substantial**
XII.E.1	Track trends by at least the following categories:	**Findings:** See XII.E **Compliance: Substantial**
XII.E.1.a	type of incident;	**Findings:** See XII.E **Compliance: Substantial**

No	Requirement	Progress/Findings
XII.E.1.b	staff involved and staff present;	**Findings:** See XII.E **Compliance: Substantial**
XII.E.1.c	individuals involved and witnesses identified;	**Findings:** See XII.E.; XIII.B.1.; V.C.1.; X.A. The Risk Manager Investigation Report has been updated to include a "Prior Incident Section". In this section, the Risk Manager/Investigator provides the incident history for the preceding twelve months of the victim, aggressor, and involved Staff member(s) as well as the involved Individual(s). See *Investigation Report Template Tab # 159.* Review of investigation reports show that the prior incident history of involved Individual and involved staff member were incorporated into the investigation report. The investigation reports have been provided to Ms. Chura's Advance Document Request materials. The Hospital modified its system of tracking the current high risk indicators (3 or more unusual incidents of any type) to improving tracking of implementation of corrective actions, if appropriate. The revised process is as follows: ▪ Risk Management/Assistant sends notification to the respective Assistant Medical Director. ▪ The appropriate Assistant Medical Director will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification. ▪ The Assistant Medical Director will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations in the next IRP. ▪ PID will track the recommendations. *See tab # 56, Process of Tracking of High Risk indicators and reports.* While it is true that the Hospital is currently only monitoring three or more UIs in a thirty day period as high risk indicators, this system captures repeated use of restraint or seclusion, assaultive behavior, falls, psychiatric emergencies, medical emergencies etc, since any type of 3 UIs in a rolling thirty day period will trigger the notification and monitoring process.

No	Requirement	Progress/Findings
		In addition, the Hospital's PIC is considering which additional high risk indicators will be tracked beginning in a phased manner. In the March, 2010 PIC meeting, PID's Director presented a list of potential high risk indicators to monitor, and proposed both method of monitoring and what interventions would be expected in the event a risk indicator was triggered. The list includes behavioral and medical risks. *See Tab # 139, Performance Improvement Projects, Roadmap to High Risk Indicator Notification and Tracking.* The Committee is reviewing the full list of indicators and it is expected that at the April meeting additional indicators will be selected and forwarded to Executive staff for consideration. Implementation will then be phased in over several quarters. In addition, PID created a database to capture all recommendations resulting from any investigation or other PI activity and to track implementation and outcomes. It currently includes recommendations starting from January 1, 2010. **Compliance: Substantial**
XII.E.1.d	location of incident;	**Findings:** See XII.E. The Hospital continues to track incidents by unit. *UI Monthly Report, Tab # 142* and *PRISM Report, Tab # 53*. RMB-6 continues to have the highest occurrences of UIs which one might expect of a civil admissions ward. **Compliance: Substantial**
XII.E.1.e	date and time of incident;	**Findings:** See XII.E. See *Risk Management and Safety Committee Minutes, Tab # 145.* **Compliance: Substantial**
XII.E.1.f	cause(s) of incident; and	**Findings:** See XII.E The Hospital complied with its review policies around deaths. The Unusual Incident database was enhanced to now capture Follow-up/Investigation Findings. This feature

No	Requirement	Progress/Findings
		allows the Risk Manager to update and track follow-up activity for each major unusual incident. This activity includes tracking the recommendations from QI and the date reviewed by QI. See *UI Database Follow-up/Investigation Findings Screenshots, Tab # 160.* **Compliance: Substantial**
XII.E.1.g	actions taken.	**Findings:** See XII.E The PIC is in the process of developing an ongoing recommendations log that will track committee recommendations, progress of recommendations and outstanding recommendations. **Compliance: Substantial**
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:** See XIII.B.1.; V.C.1.; X.A. The Hospital modified its system of tracking the current high risk indicators (3 or more unusual incidents of any type) to improving tracking of implementation of corrective actions, if appropriate. The revised process is as follows: ▪ Risk Management/Assistant sends notification to the respective Assistant Medical Director. ▪ The appropriate Assistant Medical Director will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification. ▪ The Assistant Medical Director will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations in the next IRP. ▪ PID will track the recommendations. *See Tab # 56, Tracking of High Risk Indicators.* While it is true that the Hospital is currently only monitoring three or more UIs in a thirty day

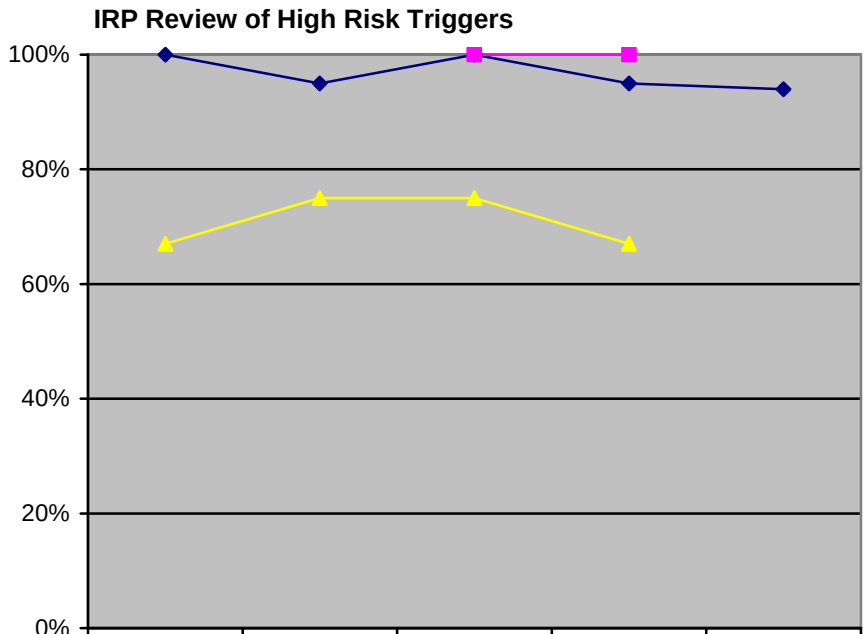
No	Requirement	Progress/Findings
		period as high risk indicators, this system captures repeated use of restraint or seclusion, assaultive behavior, falls, psychiatric emergencies, medical emergencies etc, since any type of 3 UIs in a rolling thirty day period will trigger the notification and monitoring process. In addition, the Hospital's PIC is considering which additional high risk indicators will be tracked beginning in a phased manner. In the March, 2010 PIC meeting, PID's Director presented a list of potential high risk indicators to monitor, and proposed both method of monitoring and what interventions would be expected in the event a risk indicator was triggered. The list includes behavioral and medical risks. *See Tab # 139, Performance Improvement Projects, Roadmap to High Risk Indicator Notification and Tracking.* The Committee is reviewing the full list of indicators and it is expected that at the April meeting additional indicators will be selected and forwarded to Executive staff for consideration. Implementation will then be phased in over several quarters. In addition, PID created a database to capture all recommendations resulting from any investigation or other PI activity and to track implementation and outcomes. It currently includes recommendations starting from January 1, 2010. **Compliance: Partial**
XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Findings:** Risk assessment for suicide is included in psychiatric, nursing and psychological assessments and their updates. *Comprehensive Initial Psychiatric Assessment, Tab # 14 ; Psychiatric Update, Tab # 17; Initial Nursing Assessment, Tab # 26; Nursing Assessment Update, Tab # 28; Initial Psychological Assessment, Part A, Tab # 19.* See VI; XII.E.2.; XIII.B.1.; V.C.1; X.A. The Hospital modified its system of tracking the current high risk indicators (3 or more unusual incidents of any type) to improving tracking of implementation of corrective actions, if appropriate. The revised process is as follows: ▪ Risk Management/Assistant sends notification to the respective Assistant Medical Director. ▪ The appropriate Assistant Medical Director will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification. ▪ The Assistant Medical Director will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations in the next

No	Requirement	Progress/Findings
		IRP. ▪ PID will track the recommendations. *See Tab # 56, Tracking of High Risk Indicators.* While it is true that the Hospital is currently only monitoring three or more UIs in a thirty day period as high risk indicators, this system captures repeated use of restraint or seclusion, assaultive behavior, falls, psychiatric emergencies, medical emergencies etc, since any type of 3 UIs in a rolling thirty day period will trigger the notification and monitoring process. In addition, the Hospital's PIC is considering which additional high risk indicators will be tracked beginning in a phased manner. In the March, 2010 PIC meeting, PID's Director presented a list of potential high risk indicators to monitor, and proposed both method of monitoring and what interventions would be expected in the event a risk indicator was triggered. The list includes behavioral and medical risks. *See Tab # 139, Performance Improvement Projects, Roadmap to High Risk Indicator Notification and Tracking.* The Committee is reviewing the full list of indicators and it is expected that at the April meeting additional indicators will be selected and forwarded to Executive staff for consideration. Implementation will then be phased in over several quarters. In addition, PID created a database to capture all recommendations resulting from any investigation or other PI activity and to track implementation and outcomes. It currently includes recommendations starting from January 1, 2010. **Compliance: Partial**

XIII. Quality Improvement

No	Requirement	Progress/Findings
	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.	**Summary of Progress:** 1. The Hospital continues to conduct numerous audits, some led by the Performance Improvement Department (PID) and others led by the disciplines, but supported by PID through data analysis. Audits include IRP observations, record review of discharges, transfers and seclusion and restraint episodes; audits of discipline initial assessments and updates by the disciplines among others. A substance abuse audit around IRP interventions and objectives is set to begin in April and nursing is beginning audits of some particular nursing issues. These audits have influenced hospital performance in the functioning of IRP teams, protections surrounding the use of restraint and seclusion and in ensuring the safe transfer of individuals within the hospital and to outside hospitals. 2. The Hospital continues to publish its PRISM report monthly and a yearly Trend analysis. Unit data is available and is provided to each unit for more detailed information. Data around staff injury was added to the PRISM report, and will be trended once a few more months of data is available. 3. The Hospital's Mortality and Morbidity Committee is conducting reviews of all deaths, and the SERC review process is implemented for unexpected deaths and for serious incidents. 4. The Hospital is implementing a process for tracking high risk indicators through monitoring unusual incidents (3 or more of any type involving an individual in care). In addition PID is working with the Performance Improvement Committee to identify additional indicators from among a list. It is expected that PIC will vote on additional indicators in April to be presented to Executive staff for monitoring. 5. The Hospital, under the direction of PID, is embarking on a Violence Reduction Initiative. 6. A new Risk Manager and PID director were appointed in December, 2009.
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 monthly PRISM Report and provide data from the report to individual units. *Tab #53.* The report tracks data on key indicators and reports on the Hospital's performance compared with the national average in a number of key areas, including for example, patient injury rate, elopement rate and rates of seclusion and restraint. The Hospital modified its system of tracking the current high risk indicators (3 or more unusual incidents of any type) to improving tracking of implementation of corrective actions,

No	Requirement	Progress/Findings
		if appropriate. The revised process is as follows: ▪ Risk Management sends notification to the respective Medical Director; ▪ The appropriate Medical Director/designee will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification; ▪ The Medical Director/designee will enter recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations into the next IRP. ▪ PID will track the recommendations. *See tab # 56, Tracking of High Risk indicators.* While it is true that the Hospital is currently only monitoring three or more UIs in a thirty day period as high risk indicators, this system captures a number of events, including repeated use of restraint or seclusion, assaultive behavior, falls, psychiatric emergencies, medical emergencies etc, since ***any*** type of 3 UIs in a rolling thirty day period will trigger the notification and monitoring process. In addition, the Hospital's Performance Improvement Committee (PIC) is considering which additional high risk indicators will be tracked beginning in a phased manner. In the March, 2010 PIC meeting, PID's Director presented a list of potential high risk indicators to monitor, and proposed both method of monitoring, outcomes and what interventions would be expected in the event a risk indicator was triggered. The list includes behavioral and medical risks from which PIC can choose and identifies methods of tracking performance. *See tab # 139, Performance Improvement Projects, Roadmap to High risk indicator notification and tracking.* The Committee is reviewing the full list of indicators and it is expected that at the April meeting additional indicators will be selected and forwarded to Executive staff for consideration. Implementation will then be phased in over several quarters. With respect to the some of the current high risk indicators, IRP observers now are monitoring treatment team response. Prior to IRP conferences, observers are reviewing 1) the UI database to see if the individual was involved in any type of UI, 2) the STAT/PRN medication report and 3) use of seclusion or restraint. At the IRP conference, observers then track if the team identified this during presentation of present status and adjusted interventions if needed to address the high risk trigger. Data show that teams are addressing these indicators in their IRP development.

No	Requirement	Progress/Findings
		 Aug / Sept / Oct / Dec / Jan Risk factors addressed: 100% / 95% / 100% / 95% / 94% Seclusion/restraint used: n/a / n/a / 100% / 100% / n/a STAT/PRN meds use: 67% / 75% / 75% / 67% / n/a *See Tab # 9 IRP Monitoring Observation Audits (n/a, no applicable cases reviewed).* **Compliance: Partial**
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:** The Hospital is implementing the monitoring system described in the prior report and PID continues to improve data tracking. Currently, the Hospital remains in the middle of Avatar implementation and thus some new reports are available through Avatar. However, additional staff is needed to assist in Avatar report development; positions have been approved and are in active recruitment. As more assessments, notes, orders and IRPs are added to Avatar, it will be used to track timeliness, completion of mandatory fields, etc. The Hospital continues to publish the Monthly PRISM report, and also provides unit based data to the units. In addition, data is available monthly from the IRP observations, the

No	Requirement	Progress/Findings
		transfers, discharge, and restraint/seclusion audits as well as the discipline audits. It modified the IRP observation tool substantially beginning with the December, 2009 audits to address inter-rater reliability issues. The seclusion/restraint audit tool and instructions were also modified, and currently, one individual is conducting all audits. Results of the audits are discussed in the specific chapters of this report (Discharge Chapter VII, Restraint and Seclusion chapter X). The Hospital is also implementing the Patient Death Review Policy and the Sentinel Event policy. *See tab # 143 and 153.* **Compliance: Partial**
XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Findings:** The Hospital is beginning to implement a structure to monitor recommendations from any of the Hospital committees or recommendations from investigations that involve the organization as a whole or a broad systems issue. A data base was created and recommendations made since January 1, 2010 are now included. *Tab 139, Performance Improvement projects.* The database generally does not yet capture recommendations prior to January 1, 2010 or recommendations that do not have a system or organization implication but rather is designed to capture those key recommendations that affect the system as a whole. The database includes identification of a person responsible as well as outcome measures. It is expected that this database will be shared with PIC each month for monitoring. **Compliance: Partial**
XIII.B.2	the anticipated outcome of each step; and	**Findings:** See XIII.B.1 **Compliance: Partial**
XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	**Findings:** See XIII.B.1 **Compliance: Partial**

No	Requirement	Progress/Findings
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Findings:** See XIII.B.1. The Hospital modified its system of tracking the current high risk indicators (3 or more unusual incidents of any type) to improving tracking of implementation of corrective actions, if appropriate. The revised process is as follows: ▪ Risk Management sends notification to the respective Medical Director. ▪ The Medical Director/designee will review the record, meet with the treatment team, and provide recommendations for addressing the risk issues within seven calendar days of notification. ▪ The Medical Director/designee will enter any recommendations into AVATAR with a notification to Risk Management that the review has been conducted. ▪ The Clinical Administrators will capture/consider the recommendations into the next IRP. ▪ PID will track the recommendations. *See tab # 56, Tracking of High Risk indicators.* While it is true that the Hospital is currently only monitoring three or more UIs in a thirty day period as high risk indicators, this system captures repeated use of restraint or seclusion, assaultive behavior, falls, psychiatric emergencies, medical emergencies etc, since any type of 3 UIs in a rolling thirty day period will trigger the notification and monitoring process. In addition, the Hospital's PIC is considering which additional high risk indicators will be tracked beginning in a phased manner. In the March, 2010 PIC meeting, PID's Director presented a list of potential high risk indicators to monitor, and proposed both method of monitoring and what interventions would be expected in the event a risk indicator was triggered. The list includes behavioral and medical risks. *See tab # 139, Performance Improvement Projects, Roadmap to High risk indicator notification and tracking.* The Committee is reviewing the full list of indicators and it is expected that at the April meeting additional indicators will be selected and forwarded to Executive staff for consideration. Implementation will then be phased in over several quarters. In addition, PID created a database to capture all recommendations resulting from any investigation or other PI activity and to track implementation and outcomes. It currently includes recommendations starting from January 1, 2010. See XIII. B.

No	Requirement	Progress/Findings
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	**Findings:** See XIII.A. and XIII.B. **Compliance: Partial**
XIII.C.2	monitoring and documenting the outcomes achieved; and	**Findings:** With the development of the PIC recommendations database, PIC will identify and monitor outcomes from implementation of recommendations. *See tab # 139.* **Compliance: Partial**
XIII.C.3	modifying corrective action plans, as necessary.	**Findings:** See XIII. B. 1. **Compliance: Partial**
XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Findings:** See XIII.B and C. **Compliance: Partial**

XIV. Environmental Conditions

No	Requirement	Progress/Findings
	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:	**Summary of Progress:** 1. The date for move to the new hospital building is set for May 3 and 4th, 2010. SEH will operate a total of 13 units, 11 in the new facility and 2 in the RMB annex. There will be two Therapeutic Learning Centers (TLCs) programs in the new building, and various recreational areas for individuals in care. Medical clinics are relocating there as well. The new hospital building is designed with the capacity on each unit of 27 (except one unit that has a capacity of 23), and many individuals will have their own rooms. Meals will be served on the unit or at the TLCs. The RMB annex is undergoing some renovations of the lobby area to reorient it to the new hospital building. RMB infrastructure has been upgraded, including the electrical and HVAC systems. 2. The Hospital continues to track contraband and requests of the Solution Center (formerly trouble desk). 3. The consumer survey, initiated in 2009, provides the hospital with a basis from which to identify issues that require further inquiry from individuals in care. This also provides the opportunity to work on issues in concert with a council of individuals. The survey is planned for Spring, 2010. 4. The Hospital completed its first quarter environmental survey. In addition, the Safety Officer completes monthly inspections of units.
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:** Air vents were installed in JHP to replace those that were identified as a suicide risk. The new hospital is a state of the art psychiatric facility that is designed to minimize or eliminate risk of suicide. **Compliance: Substantial**
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:** The Hospital continues to track incidents of contraband. For the twelve month period of March 2009 through February, 2010, there were 55 incidents of contraband, including 39 incidents over the last six months. Of the 39 incidents, 33 related to discovery of smoking related materials such as cigarettes, lighters or matches. *See Tab # 150, report on contraband*

No	Requirement	Progress/Findings
		The Hospital continues to implement the contraband and search policies. **Compliance: Substantial**
XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	**Findings:** See VIII.D.11. Since January 1, 2010, all units, all shifts had an RN assigned and on duty. PRISM data shows significant improvement in the incidence of individuals in care eloping from the Hospital, with only four incidents per month in the months of November 2009 through February 2010. *Tab # 53, PRISM report.* This trend is expected to continue upon relocation to the new building, as there will be much less movement of individuals in care outside the building. There was one recent incident in which a fire was started by an individual in care who had matches, and wanted to be transferred to JHP so he set the fire. The Hospital is continuing to conduct regular searches for contraband, especially matches and lighters. *See Tab # 150, report on contraband* **Compliance: Partial**
XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.	**Findings:** Elevators are generally operable. In the new hospital building, geriatric individuals will be housed on the first floor. **Compliance: Substantial**
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:** The Hospital continues to have a current fire and evacuation plan for all buildings. A new plan is in development for the new building, (which is equipped with sprinkler system) and it is in the final stages of development. It will be provided during the site visit. The Hospital Fire Protection Specialist conducts quarterly fire drills in all occupied buildings. These drills are logged the same day that the drills occur. Logs will be available for review during the site visit. **Compliance: Substantial**

No	Requirement	Progress/Findings
XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	**Findings:** The Hospital continues to make monthly safety inspections and to complete quarterly environmental surveys. *Tab # 147, Environmental Checklist, Tab # 148 Environmental Survey results.* Results are shared with the Risk Management Safety Committee and the Infection Control Committee. *Tab # 145.* The Hospital developed systems to ensure adequacy of clothing. Nurse Managers or their designees conduct weekly inventories on their units to get an idea of the personal needs of each individual in care as it relates to undergarments and personal hygiene supplies. An ad-hoc committee that consist of Nursing's program analyst, the hospital's supplies coordinator, a nurse manager, two administrative officers and a housekeeping supervisor is addressing the ordering and storing of bulk items to ensure availability. This group is working with nurse managers to conduct an inventory and will submit recommendations to hospital leadership to ensure supplies are available. In addition, there are a number of individuals who discard clothing, and this will be included in their IRP. The consumer satisfaction survey also includes a question about whether the consumer felt the environment was clean and appropriate. *Tab # 50 Consumer satisfaction survey.* Data will be available once the survey is concluded. The Hospital conducted its first quarter environmental survey and also completes a monthly safety inspection. *Tab # 147.* The environmental survey shows a slight decline in environmental conditions although performance remains in the acceptable range. The distribution of percentage of units rated as acceptable declined from 96% to 92%; those units rated as problematic increased from 3% to 5%. Units rated as unacceptable increased from 1% to 3%. For the RMB units, the average rating of units decreased from 3.8 for FY09-Q4 to 3.7 for FY10-Q1. Treatment Mall unit average ratings decreased from 3.9 for all areas for FY09-Q4 to 3.7 for FY10-Q1. JHP unit average ratings also decreased from to 3.8 in the fourth quarter to the FY-10 first quarter average rating of 3.7. The overall average rating for all indicators Hospital-wide decreased from 3.8 to 3.7 from the 4th quarter, 2009 to the 1st quarter 2010. Individual average ratings for each category showed slight decreases while at the same time other areas remained the same or slightly improved in their in ratings during this period. Although the monitoring of refrigerators was discontinued during the second quarter survey the Safety Officer reinstituted the monitoring of refrigerators since food and drinks for individuals were being kept in the Treatment Mall refrigerators. The Hospital wide average rating scores within each of the fifteen categories

No	Requirement	Progress/Findings
		indicated that six of categories declined slightly, seven of the categories remained unchanged and two of the categories improved from the 4th quarter FY-09 to the 1st quarter FY-10. The number of units rated as acceptable in the General Unit Cleanness and General Unit Maintenance indicators declined to 95% for this quarter where as they were 100% for the previous survey. Also Nursing Station and Linen Handling indicators were rated as acceptable 100% of the time in the previous survey and in the current survey. All units maintained their average ratings in the acceptable range in all 15 survey standards for the fourth quarter and first quarter of Fiscal Year 2009 and Fiscal Year 2010 respectively. In summary, SEH hospital wide average rating was 3.9 and all 19 units were found to be in acceptable condition for all indicators. In the previous survey, again all units were found to be in an overall acceptable condition. The Hospital's trouble desk continues to monitor on a monthly basis the completion of work order requests. Data is available at *tab # 151, Trouble desk reports.* **Compliance: Substantial**