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

Saint Elizabeths Hospital Compliance Report 7

April 18, 2011

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Janet Maher
Chief Compliance Officer

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.	**INTEGRATED TREATMENT PLANNING**	
	By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in. a single, integrated plan.	
V.A	**Interdisciplinary Teams**	
	By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	
V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Recommendation:** 1. Same as in V.A.2 to V.A.5. SEH Response: Same as in V.A.2 to V.A.5. 2. Same as in V.B., V.C., V.D., and V.E. SEH Response: Same as in V.B., V.C., V.D. and V.E. 3. Implement SEH Corrective Action Plan (CAP) of October 7, 2010 relative to Section V.A. SEH Response: Ongoing. The Hospital, through its Chief of Staff, is implementing the CAP sections that address Section V.A of the Agreement. Discipline attendance at IRP conferences is monitored through the IRP observation audit tool as set forth in the CAP. ***Tab # 8 IRP observation audit tool***. Also, as provided in the CAP, the IRP manual was revised substantially prior to the November 2010 visit and again in early March 2011. Changes to the Manual include adding more examples of goals, objectives and interventions, especially around medical issues. The revised Manual also provides more examples of discharge criteria, barriers to discharge and discharge plans. In part due to results of the clinical chart audits, refresher training around writing goals, objectives and interventions was provided to clinical administrators and nurse managers, and refresher training around discharge planning was provided to all treatment team members. Clinical administrators also

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>were provided additional training on completing the “Present Status” section of the Clinical Formulation and presenting it at the IRP conference. See Tab # 1, IRP training outlines and data. See also V.A.3. Coaching on both IRP process and IRP content continues for all units, and IRP observation audits and clinical chart audits are also occurring.</td></tr>
<tr><td>V.A.2</td><td>be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:</td><td>Recommendation:

Maintain current level of practice.

SEH Response: Psychiatrists/treatment team leader psychologists continue to lead team and clinical administrators continue to co-facilitate. See also V.A.2.a below.</td></tr>
<tr><td>V.A.2.a</td><td>assume primary responsibility for the individual's treatment;</td><td>Recommendation:

Maintain current level of practice.

SEH Response: Practice maintained.

Facility’s Findings: See below. See Tab # 8 (Table of Attachments), IRP Observation Audit tool. Please note that the “Mean” from the prior period is based only upon three months of data, as the tool was modified in June 2010. [1]

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>122</td><td>140</td><td>158</td><td>208</td><td>186</td><td>188</td><td>212</td><td>167</td></tr>
<tr><td>n</td><td>19</td><td>15</td><td>12</td><td>16</td><td>22</td><td>23</td><td>22</td><td>18</td></tr>
<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C Indicator #1. The team is led by the treating psychiatrist or licensed clinical psychologist who shall assume primary responsibility for the individual’s treatment</td><td>100</td><td>100</td><td>94</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited (Audit sample plan provides for 2 audits per unit per month)
* The mean for the previous period reflects only three months data.
See Tab # 9 IRP OBSERVATION AUDIT RESULTS.

Analysis/Action Plans: Data show consistent high levels of compliance on this requirement. No corrective actions are required.</td></tr>
</table>

[1] Throughout this report, we will be using weighted means. Each table includes weighted mean for the previous review period (Mar-10~Aug-10) under ‘Mean-P’ column wherever data is available and weighted mean for the current review period (Sep-10~Feb-11) under Mean-C.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>V.A.2.b</td><td>require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;</td><td>
Recommendation:

Continue with identified corrective action plan.

SEH Response: The Hospital continues to monitor whether family members or community workers were invited to the IRP conferences through the IRP observation audits. In September 2010, the social work supervisors advised social work staff that it was their responsibility to ensure family and community workers were invited. During their monthly audits, social work supervisors are reviewing records each month to determine if social workers are noting invitations for IRP conferences. This is monitored through the IRP Observation audits.

Facility's Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
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<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C Data fields: Family Member invited?</td><td>21</td><td>42</td><td>90</td><td>78</td><td>91</td><td>85</td><td>30</td><td>60</td></tr>
<tr><td>%C Data fields: Community support worker invited</td><td>37</td><td>58</td><td>91</td><td>92</td><td>100</td><td>95</td><td>47</td><td>77</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month)
* The Mean for the prior review period reflects only three months of data.
See Tab # 9 for IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data show significant improvement in performance related to inviting family members and community case workers since November 2010. Performance in each of the four months since that time shows that the Hospital is meeting this requirement in over 90% of the cases audits. Audits will continue, but, given the current level of performance, no additional actions are needed at this time.
</td></tr>
<tr><td>V.A.2.c</td><td>require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;</td><td>
Recommendations:

1. Continue with current corrective action plan.

SEH Response: Corrective action plan is being implemented. (It was updated on March 4, 2011, and a copy is provided with this report).

The IRP manual was revised substantially prior to the November 2010 visit, and again was updated in early March 2011 to add, inter alia, additional examples of goals, objectives and interventions, especially around medical issues. Other changes to the IRP manual include refining the discharge section of the clinical formulation. There are now more examples for the
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

four discharge sections in the clinical formulation (discharge criteria, discharge barriers, discharge plan and discharge plan review). Finally, the clinical chart audit and instructions have been updated and the newest version has been added to the manual. ***See IRP Manual.***

During the review period, additional training around writing goals, objectives and interventions (with a focus on medically related goals, objectives and interventions) was provided to clinical administrators and nurse managers and training around discharge planning was provided to all team members. ***See Tab # 1, IRP training outlines and data.*** The completion of the present status section of the clinical formulation and presentation of present status during the IRP conference also was reviewed with the Clinical Administrators and coaching provided. See also V.A.3 re training data. Coaching on both IRP process and content continues for all units, and clinical chart audits are also being conducted,

2. Analyze social worker attendance rate monthly and develop additional corrective action plans as necessary if data continues to show an unacceptable level of social worker attendance at scheduled IRP conferences.

SEH Response: SEH is auditing social work attendance at IRP conferences through monthly observations by a core group of coaches/observers. Results are shared with discipline chiefs for follow up. Social work attendance is significantly improved during this rating period, up to 88% mean from a mean of 65% for the prior review period.

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C Data fields: Social work Attendance	79	100	81	88	95	83	**65**	**88**

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C. #2. Each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatment	84	100	94	100	95	96	**88**	**95**

N = All IRPs scheduled in the review month
n = number audited per audit sample plan

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>* Mean for this period reflects only three months data
See Tab # 9 for IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data show high level of compliance with this requirement. The mean improved from 88% in the prior review period to 95% during this review period. IRP conference observations and discipline audits will continue.</td></tr>
<tr><td>V.A.2.d</td><td>require that the treatment team functions in an interdisciplinary fashion;</td><td>Recommendation:
1. Maintain current level of practice.

SEH Response: Maintained current level of practice.

Facility’s Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>122</td><td>140</td><td>158</td><td>208</td><td>186</td><td>188</td><td>212</td><td>167</td></tr>
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<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C. #3. The team functions in an interdisciplinary fashion</td><td>100</td><td>95</td><td>94</td><td>100</td><td>100</td><td>100</td><td>91</td><td>98</td></tr>
</table>
N = All IRPs scheduled in the review month
n = number audited
* Mean for this period reflects only three months data
Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data show high rates of compliance. Continue IRP observation audits.</td></tr>
<tr><td>V.A.2.e</td><td>verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and</td><td>Recommendations:
1. Continue to provide a summary of the aggregated monitoring data regarding the integration of psychiatric and behavioral modalities. The data should include the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: Completed. See facility’s findings below.

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

SEH Response: Completed. See facility’s findings below.

3. Ensure that documentation in the psychiatric updates regarding significant developments during the previous interval reflects integration of behavioral and psychiatric modalities, as clinically appropriate.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Ongoing. The Psychiatric Update form was modified when it went into AVATAR to better capture documentation related to this requirement. The Psychiatric Update form went live in October 2010, and some additional revisions were made effective in April 2011. The Avatar Psychiatric Update form includes a specific tab to address non-pharmacological interventions that are being used with an individual in care. Pre-identified choices include "PBS", "TLC", "behavioral guidelines", "individual therapy", and "other". The form *requires* the psychiatrist to describe the interventions (mandatory field) and also prompts the psychiatrist by asking, "Are there any specific behavioral and/or psychodynamic issues that are affecting the patient's lack of progress?" and, if answered yes, the description is a mandatory field. The Hospital is monitoring this through the psychiatric update audits. Data from the audits shows excellent performance on this requirement, with the mean 100% for this review period. *See data in the facility's findings section below*. Psychiatrists are periodically reminded at their monthly meetings of the need to ensure integration of behavioral and psychiatric modalities in their monthly updates. Finally, the PBS team leader continued to train psychiatrists; at the last review period, 75% of psychiatrists were trained on PBS, and as of February 28, 2011, that has risen to 100%. Updated PBS data show:

PBS Training to Date (3/1/10-2/28/11)

Discipline	# Required	# Attended	# Competent	% Attended	% Competent
Chaplain	6	6	6	**100**	**100**
Clinical Administrator	13	13	13	**100**	**100**
Dentistry	13	13	13	**100**	**100**
Dietary	4	4	4	**100**	**100**
Medical	11	11	11	**100**	**100**
Nursing - Nurse Manager	18	18	18	**100**	**100**
Nursing - RN	93	92	92	**99**	**99**
Nursing - LPN	32	32	32	**100**	**100**
Nursing - RA	202	201	197	**100**	**98**
Psychiatry	67	67	67	**100**	**100**
Psychology	29	28	28	**97**	**97**
Rehabilitation	21	21	21	**100**	**100**
Social Work	16	16	16	**100**	**100**
Treatment Mall	4	4	4	**100**	**100**
Clinical (Other)	7	7	7	**100**	**100**
Total	**536**	**533**	**529**	**99**	**99**

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

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

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

See Tab # 40 PBS Training curricula and data

Facility's Findings:

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 21 Does the psychiatric update include an appropriate plan that includes integration of behavioral and psychiatric interventions?</td><td>100</td><td>100</td><td>100</td><td>96</td><td>100</td><td>100</td><td>97</td><td>99</td></tr>
</table>

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data show high performance. The Hospital will continue to audit this through the psychiatric update audits.

</td></tr>
<tr><td>V.A.2.f</td><td>require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.</td><td>

Recommendation:
1. Maintain current level of practice.

SEH Response: Maintained level of practice.

Facility's Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
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<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C. #4. The team identified someone to be responsible for the scheduling and coordination of necessary progress reviews</td><td>100</td><td>100</td><td>100</td><td>100</td><td>91</td><td>96</td><td>95</td><td>97</td></tr>
</table>

N = All IRPs scheduled in the review month
n = number audited
* Mean for period reflects only two months data
Tab # 9 IRP OBSERVATION AUDIT RESULTS

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: Data show high performance. Continue to monitor through IRP observation audits.</td></tr>
<tr><td>V.A.3</td><td>provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;</td><td>
Recommendation:

1. Continue work with new consultant regarding treatment planning.

SEH Response: Work continues. Training on the four modules (clinical formulations, developing goals, objectives, and interventions, discharge planning and engagement) was held in September 2010; staff who were unable to attend those sessions have since been trained. See Tab # 1 IRP Training materials and training data. Subsequently, in February 2011, as a result of the data from the clinical chart and IRP observation audits, refresher training was provided to the clinical administrators on developing the present status section of the clinical formulation and presenting present status at the IRP conference. A second training on developing focus areas, objectives and interventions, with a specific focus on medical objectives and interventions, was held with clinical administrators and nurse managers. Finally all treatment teams were provided additional training on engagement of individuals, discharge planning, developing discharge criteria, and identifying discharge barriers. Consultants are also providing coaching around the writing of IRPs and are observing IRPs on each unit. Tab # 2 (IRP Consultant contract); Tab # 1, IRP Training data.

2. Provide re-training where necessary based on audits of written IRPs.

SEH Response: See response to recommendation # 1. Consultants are reviewing written IRPs and are providing feedback to IRP teams. This consultant training supplements the coaching provided by internal mentors who observe at least two IRPs per unit, and provide an average of 1 ½- 2 hours of coaching each month. Clinical chart audits continue, and a form was developed effective March 2011 for clinical chart audits for use by auditors to highlight areas of strength and areas in need of improvement that can be shared with the treatment team. See Tab # 1 IRP Data around review of IRPs; Tab # 10 Clinical Chart Audit Tools and Tab # 7 Clinical Chart Audit Feedback Form.

Facility's Findings: Additional training was provided during this review period through the contract with the IRP consultant. Data show:

Foci, Objectives, and Interventions in Treatment Planning (IRP Module I) 9/01/2010 ~ 3/15/2011
<table>
<tr><th>Discipline & Number Hours</th><th># Required</th><th># Attended</th><th># Competent</th><th>% Attended</th><th>% Competent*/ % of Attendees Competent**</th></tr>
<tr><td>Clinical Administrator (15 hours)</td><td>12</td><td>12</td><td>12</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Nurse Manager (12 hours)</td><td>16</td><td>16</td><td>16</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Psychiatry (12 hours)</td><td>21</td><td>21</td><td>21</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Psychology (12 hours)</td><td>14</td><td>14</td><td>14</td><td>100%</td><td>100%/100%</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Social Work (12 hours)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

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

Engagement Training – IRP Module II 9/01/2010 ~ 3/15/2011

Discipline & Number of Hours	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Clinical Administrator (2 hours)	12	12	12	100%	100%/100%
Nurse Manager (1 hour)	16	16	16	100%	100%/100%
Psychiatry (2 hours)	21	21	21	100%	100%/100%
Psychology (1 hour)	14	14	14	100%	100%/100%
Social Work (1 hour)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

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

Clinical Formulation – IRP Module III 9/01/2010 ~ 3/15/2011

Discipline & Number of Hours	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Clinical Administrator (14 hours)	12	12	12	100%	100%/100%
Nurse Manager (12 hours)	16	16	16	100%	100%/100%
Psychiatry (12 hours)	21	21	21	100%	100%/100%
Psychology (12 hours)	14	14	14	100%	100%/100%
Social Work (12 hours)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

Discharge Planning - IRP Module IV					9/01/2010 ~ 3/15/2011
Discipline & Number of Hours	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator (15 hours)	12	12	12	100%	100%/100%
Nurse Manager (15 hours)	16	16	16	100%	100%/100%
Psychiatry (15 hours)	21	21	21	100%	100%/100%
Psychology (15 hours)	14	14	14	100%	100%/100%
Social Work (15 hours)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

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

Engagement and Community Integration II (1 and ½ hours all disciplines)			09/01/10 ~ 03/15/11
Discipline	**# Required**	**# Attended**	**% Attended**
Clinical Administrator	12	12	100%
Nursing - Nurse Manager	16	8	50%
Psychiatry	22	21	96%
Psychology	14	14	100%
Social Work	13	13	100%
Total	**77**	**68**	**88%**

Writing Focus Areas, Objectives and Interventions/Medical Goals, Objectives and Interventions (2 hours all disciplines)				09/01/10 ~ 03/15/11
Discipline	**# Required**	**# Attended**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator	12	11	92%	92%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nursing - Nurse Manager	16	13	81%	81%/100%
Total	**28**	**24**	**86%**	**86%/100%**

Present Status of Clinical Formulation (1 ½ hours)- Clinical Administrators			09/01/10 ~ 03/15/11
Discipline	**# Required**	**# Attended**	**% Attended**
Clinical Administrator	12	10	83%
Total	**12**	**10**	**83%**

SUMMARY OF COACHING HOURS	
1A - Allison House	12
1B - Barton House	7
1C - O'Malley House	12
1D - Dix House	6
1E - Haydon House	12
1F - Shields House	4
1G - Howard House	7
2A - Gorelick House	7
2B - Nichols House	8
2C - Blackburn House	10
2D - Franz House	11
Annex A	7
Annex B	11

Finally, the consultants have reviewed 48 IRPs and clinical formulations to date.

See Tab # 1 IRP Training data and outlines

Analysis/Action Plans: Training by consultants is ongoing and will continue as needed and funded. Training will be led by in-house trainers as the Hospital builds capacity.

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

Recommendation:
See V.A.2.c.

SEH Response: See V.A.2.c.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	**Facility's Findings:**

IRP OBSERVATION MONITORING AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C. # Data fields Attendance data core team members: Clinical Administrator	95	95	94	88	95	100	**93**	**95**
Psychiatrist	95	95	94	100	95	100	**98**	**97**
Social Worker	79	100	81	88	95	83	**65**	**88**
RN	84	79	81	94	91	91	**88**	**87**
Individual	95	100	100	100	100	96	**95**	**98**

N = All IRPs scheduled in the review month
n = number audited
* Mean from prior period is based upon three months data
Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data show high levels of compliance. Social work attendance improved significantly, and will continue to be tracked. Continue to monitor through audits.

V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Recommendations:** 1. Continue auditing as per the instructions in Cell V.B.9. SEH Response: Audits are continuing. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See below. 3. Utilize plan presented in Hospital's compliance report to ensure that managers have access to this data in a timely manner and can follow up appropriately with those teams having trouble achieving compliance. SEH Response: The IRP related timeliness reports are the next in the queue for Avatar development. In the meantime, performance on this requirement is tracked through the clinical chart audits. Audit findings are now reviewed during the clinical administrators meetings and at the clinical leadership meetings. In addition, as PID implements the new house

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>support project, PID staff will include this data in their unit based data discussions and will work with staff to identify strategies for improvement. See Tab # 139 Performance Improvement Projects, House Support Project

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #2. The IRP was reviewed and revised as per IRP required schedule (at day 30, day 60 and every 60 days thereafter)</td><td>50</td><td>86</td><td>94</td><td>88</td><td>73</td><td>94</td><td>86</td><td>81</td></tr>
</table>
N = Total number of IRP reviews scheduled
n = number audited
Targeted sample size is 26 reviews per month (2 per unit)
* Mean for prior period is calculated based upon two months data
Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data show slightly lower performance on this indicator. This is likely due to September's audit result, which was impacted by treatment teams being in IRP training for a full week, thereby delaying IRPs during that month. Audits will continue and the trend monitored. A new management report to track this will be in development beginning in April 2011.</td></tr>
<tr><td>B</td><td>Integrated Treatment Teams</td><td></td></tr>
<tr><td></td><td>By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:</td><td></td></tr>
<tr><td>V.B.1</td><td>where possible, individuals have input into their treatment plans;</td><td>Recommendations:

1. Provide a summary of all mentoring activities provided to the IRP teams during the review period relative to the engagement of individuals. Specify the participating disciplines in mentoring the teams and the mentoring process (didactic, observation, feedback to teams).

SEH Response: Each team has been provided training and mentoring during the review period, September 2010 to February 2011. Mentors pursuant to the IRP consultation contract include Nirbhay Singh, Ph.D; Ramasamy Manikam, Ph.D; and Rachel Myers, Ph.D, RN; (A. Adkins, A. Singh, Ph.D, A. Van Wysnsberghe Ph.D and Chandni Patel, Behavioral Specialist participated in the September 2010 training but not the February 2011 sessions). Internal mentors are Beth Gouse, Ph.D;</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Haylee Bernstein, LICSW; Nicole Rafanello, Ph.D; Robert Benedetti, Ph.D; Susan Bergmann, LICSW; Yolanda Williams, professional counselor ; Richard Gontang, Ph.D, Shirley Quarles, RN, Tyler Jones, M.D., Clotilde Vidoni- Clark, RN, and Robert Morin, Psy.D. Dr. Manikam and/or internal Hospital mentors have observed and provided coaching to all treatment teams during the review period. In addition to the September 2010 training on the four main modules, the consultants in February 2011, provided intensive, focused didactic training around writing focus statements, objectives and interventions for IRPs using examples involving medical conditions and a second training on developing discharge criteria, identifying discharge barriers and writing discharge plans and reviews. During the discharge training, the consultants again focused on engagement of individuals, using discharge planning as the framework. A third refresher training was held in February 2011 with clinical administrators only on completing the present status section of the clinical formulation and presenting present status at the IRP conferences. In addition, the consultants and mentors are reviewing the written IRPs and clinical formulations, and providing comments on them; to date, 48 clinical formulations and IRPs have been reviewed and feedback provided. ***Tab #1 IRP Training Materials and Training Data***

New employees are provided an overview of the IRP process during the week long orientation. Rather than review all four IRP related training modules - - engagement; developing clinical formulations; developing and writing focus areas, objectives and interventions; discharge planning - - during the orientation, the Hospital elected to train new direct care employees as a group after they have had some exposure to IRP conferences and process. Thus, each quarter, the Chief of Staff will train direct care employees hired during the preceding quarter on each of the four modules.

The internal mentors are expected to observe at least two IRP conferences each month per unit, and provide feedback to the treatment teams in accordance with guidelines developed jointly by the Chief of Staff and the Performance Improvement Department. ***Tab #1 Feedback guidelines; IRP meetings, Phase II Icebreakers***. An average of 1 ½ to 2 hours of coaching through IRP observations is provided. Mentors are working with their assigned teams on how to engage individuals during Phase II. Mentors are guided by the IRP-Phase II icebreakers guidelines. ***Tab #1 Feedback guidelines; IRP meetings, Phase II Icebreakers*** All observers/mentors have received the full complement of IRP training including developing foci, objectives and interventions, engagement, developing clinical formulations and discharge planning as well as the targeted training completed in February 2011.

Clinical chart audits continue, (2 per unit), and the results are shared with clinical staff. During the review period, a form was developed through which the mentors/auditors can provide written comments and suggestions to the treatment teams about specifics from the audits. The form allows auditors to provide examples of what was particularly good in a clinical formulation or IRP and what could be improved, and why. ***Tab # 10 Clinical chart audit, Tab # 7 Clinical Chart Audit Feedback Form.*** Below is a chart of individuals who are providing coaching/mentoring to treatment teams. Please note that the individuals highlighted in blue provided mentoring in 2010 but are no longer providing mentoring.

TREATMENT TEAM	CONSULTANT MENTORS/INTERNAL MENTOR/IRP OBSERVER
1A	Manikem/Benedetti & Bernstein/Jones
1B	Manikem & Myers/Arena/Quarles
1C	Manikem & Adkins/Maher/Morin
1D	Manikem & Van Wysnsberghe /Arena/Benedetti
1E	Manikem & Van Wysnsberghe /Maher/Rafanello/Vidoni-Clark

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

1F	Manikem & A. Singh/Morin/Bernstein
1G	Manikem & A. Singh/Rafanello/Walden-Yeager/Gaswirth
2A	Manikem & N. Singh/Rafanello/Bergmann
2B	Manikem & N. Singh/Bernstein/Gouse
2C	Manikem & Adkins/Gouse/Gontang
2D	Manikem & Adkins/Walden-Yeager/Rafanello

See V.A.3 for training data.

2. Ensure that team mentors address the process deficiencies outlined in other findings above.

SEH Response: Mentors reinforce the training principles during coaching sessions, and provide ongoing support to teams as needed. In addition, during this review period, clinical administrators were provided additional coaching around completion and presentation of present status and treatment teams were also provided additional coaching around discharge planning to address related findings from the last visit. IRP observation data and clinical chart audit data is shared with mentors as well as with the management of Clinical Operations, to whom clinical administrators report.

3. Continue to provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.

SEH Response: See below. Please note that the data reflects training of those individuals who missed the previous training. In addition, there was some additional coaching around engagement during the discharge related training and the training around development of focus areas, objectives and interventions.

Engagement Training – IRP Module II					9/01/2010 ~ 3/15/2011
Discipline & Number of Hours	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator (2)	12	12	12	100%	100%/100%
Nurse Manager (1)	16	16	16	100%	100%/100%
Psychiatry (2)	21	21	21	100%	100%/100%
Psychology (1)	14	14	14	100%	100%/100%
Social Work (1)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Engagement and Community Integration II (1 and ½ hours)			09/01/10 ~ 03/15/11
Discipline	**# Required**	**# Attended**	**% Attended**
Clinical Administrator	12	12	100%
Nursing - Nurse Manager	16	8	50%
Psychiatry	22	21	96%
Psychology	14	14	100%
Social Work	13	13	100%
Total	**77**	**68**	**88%**

4. Continue to monitor the individual's attendance and participation in the IRP conferences using process observation data based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: SEH is monitoring IRP conferences through observation. Its goal is to monitor two IRP conferences per unit per month. ***Tab # 36 (Audit Plan)***. Please note that the Annex closed during this rating period, so there are now only 11 units. See data below.

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

SEH Response: See below.

6. Implement the facility's CAP of October 7, 2010 relative to section V.B.

SEH Response: Ongoing.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. Data Fields: Individual attends the IRP conference	95	100	100	100	100	96	**95**	**98**
%C. #5. Individuals have input into their treatment plans	59	82	94	92	86	84	**90**	**83**

N = IRPs scheduled in the review month
n = number audited
* Mean for the prior period reflects only three months of data
Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: Data show performance is below the previous review period, but show a generally improving trend since September 2010's performance. Training on engagement was started in September 2010 and is reinforced through coaching. Additional training around engagement provided during the review period (described above in V.A.3) appears to have a positive impact on performance. This will continue to be monitored through IRP observation audits and corrective actions will be implemented if performance declines.

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;

Recommendations:

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

SEH Response: Timeliness of initial assessments is being monitored through discipline specific audits. Data is presented below.

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

SEH Response: See data below.

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

SEH Response: See VI.A.1 to VI.A.5.

Facility's Findings:

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # Data fields -CIPA completed within 24 hours of admission	100	100	100	100	100	100	**100**	**100**

N = Admissions during the month
n = number audited- target is 20% sample per month
Tab # 16 CIPA AUDIT RESULTS

COMPREHENSIVE INITIAL NURSING ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	8	3	8	8	4	**7**	**6**
%S	19	24	9	23	24	14	**17**	**19**
%C. #2. Initial nursing assessments are completed within 8 hrs of admission	67	88	100	88	89	67	**72**	**85**

N = Number of admissions during the month
n = number audited
Tab # 4 (CINA audit results)

INITIAL PSYCHOLOGICAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	6	2	6	6	2	**5**	**5**
%S	23	18	6	17	18	7	**12**	**15**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	43	33	100	67	67	0	**50**	**52**
%C # 1 (Part B) If Part B completed within 12 days of admission?	14	50	50	83	33	50	**64**	**45**

N = Number of admission
n = number audited-target is 20% sample (Audit sample plan)
Tab # 21, IPA audit results

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	7	7	7	7	6	**8**	**7**
%S	19	21	22	20	21	21	**20**	**21**
%C # Completed within 5 days of admission	83	57	86	86	71	83	**60**	**78**

N= Number of admissions

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n = number audited-target is 20% of admissions(Audit sample plan) ***Tab # 33 SOCIAL WORK AUDIT RESULTS*** **Analysis/Action Plans:** The data show that psychiatric initial assessments are being completed in virtually all cases within the first 24 hours but that other discipline assessments are not as timely in completing their initial assessments. However, both nursing and social work have improved in timeliness (nursing improved to 85% from 72% and social work improved to 78% from 60%). Nursing also is addressing timeliness by modifying its initial assessment form; it is dividing the form into a Part A and Part B. In the past, nurses were unable to complete the form within 8 hours in a number of cases due to the circumstances of admission – at times the individual was uncooperative or sleeping, so the form was not completed and could not be saved as final in Avatar. With the new two part form, which is in development in Avatar, nursing will be able to complete part A within 8 hours but will have up to 24 hours to finish Part B. With respect to the timeliness of social work initial assessment, the supervisors are continuing to audit this requirement and address issue with individual social workers as they arise. Psychology continues to struggle with timely completion of IPAs. The Hospital has not been permitted to fill the three psychology vacancies due to budget limitations, but the closing of the Annex has allowed one and one half psychologists to be assigned to provide backup to the psychologists assigned to the admissions unit. Psychology will continue to monitor this through audits. The Hospital is continuing also to work on the issue of staff inadvertently saving documents in "draft" when in fact they mean to save the document as final. (Generally, an assessment in draft is not considered timely in the audits.) Reports are available to managers to review those assessments that remain in draft status and data show that the number of assessments in draft status is decreasing. Further, audit instructions were revised by some disciplines so that assessments that remain in draft status would be rated as timely ***if*** the assessment specifically reflects that the reason the assessments could not be completed was due to the unavailability/uncooperativeness of the individual in care.
V.B.2.b	initial treatment plans are completed within 5 days of admission; and	**Recommendations**: 1. Continue to monitor the timeliness of the comprehensive IRPs based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average mean. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: Audits are ongoing, see below. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). SEH Response: See data below. **Facility's Findings:**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #1. The Comprehensive IRP was developed on the 7th ± 3 calendar days from the day of admission</td><td>67</td><td>100</td><td>100</td><td>100</td><td>80</td><td>75</td><td>83</td><td>83</td></tr>
<tr><td>%C. #2. The IRP was reviewed and revised as per IRP required schedule (at day 30, day 60 and every 60 days thereafter)</td><td>50</td><td>86</td><td>94</td><td>88</td><td>73</td><td>94</td><td>86</td><td>81</td></tr>
</table>
N = Total number of IRP reviews scheduled
n = number audited
* Mean reflects only two months of audit data from the prior period
Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The clinical chart audit shows a slight decline in the rate of performance from a mean of 86% in the prior review period to a new mean of 81% (although the mean for this period was affected by a particular low performance in September, 2010 when teams received a week long training and thus IRPs were late). This will continue to be monitored through the clinical chart audit to identify any adverse trends. Further the development of management reports to monitor timeliness of IRPs is expected to begin in Spring, 2011.
</td></tr>
<tr><td>V.B.2.c</td><td>treatment plan updates are performed consistent with treatment plan meetings.</td><td>
Recommendations:
1. Continue to monitor the treatment plan reviews based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See below.

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

SEH Response: See below.

Facility's Findings: See V.A.5.

Analysis/Action Plans: See V.A.5.
</td></tr>
<tr><td>V.B.3</td><td>individuals are informed of the purposes and</td><td>Recommendations:</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	major side effects of medication;	1. Continue the process of Consumer Satisfaction Surveys and provide a summary of results. SEH Response: The consumer satisfaction survey is completed annually, and was not completed during the review period. It will be completed during the next review period. However, as noted below, the psychiatric update audit began tracking whether individuals are informed of the purposes and major side effects of medication in October 2010. Further, during this review period, Consumer Affairs conducted as series of surveys around food services. ***See Tab # 50, Food Survey Materials.*** 2. Provide information regarding medication education groups provided during the interval, including number of groups scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education. SEH Response: Below is a comparison of capacity relating to medication groups. Note the census declined from 330 and 292 between March 2010 and February 2011.

Medication Groups Mar~Aug10		Medication Groups Sept 10~ Feb 11		Medication Groups Feb 11~ present	
Sessions per week	**Capacity**	**Sessions per week**	**Capacity**	**Sessions per week**	**Capacity**
69	494	79	462	72	376 (293 Enrolled. All who need intervention are receiving it.)

The TLCs continue to evolve, and revised programming was implemented effective September 20, 2010. The programming has four key components. These include more comprehensive cognitive programming, which includes an online cognitive skill building program for those with mild cognitive impairments, a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. In addition, there is expanded dosing of groups, which allows for material to be presented in a more in depth manner. TAMAR groups (trauma informed care groups) will begin in April 2011, and there are more basic social skills/living with people groups that will include videotaping and role playing. Schedules are built based upon the individual's diagnosis, level of functioning, IRP group guide and the needs and choices of the individual.

As of February 2011, medication groups include "Understanding Your Illness and Treatment" (psychiatry) (capacity 94, enrolled 64), "What's Up Doc?" (psychiatry) (capacity 16, enrolled 13); "Mental Health Teaching/Illness Recovery" (psychiatry) (capacity 88, enrolled 59); and "Understanding Your Illness and Treatment" (nursing) (capacity 20, enrolled 13), Medication Education (nursing) (capacity 158, enrolled 131), and Understanding Treatment (nursing) (capacity 10, enrolled 10). ***See Tab # 69 for TLC Schedule; Tab #163 for Medication Group Capacity Data.***

Facility's Findings:

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 14 Does the update reflect that medication benefits, risks and side effects were explained to the individual in care?</td><td>*</td><td>*</td><td>*</td><td>100</td><td>100</td><td>100</td><td>*</td><td>100</td></tr>
</table>
N = Last day monthly census less month’s admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
* No indicator in tool used during this period
Tab # 11, PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Psychiatric Update was modified in Avatar effective October 2011 and, in the Pharmacological section, includes the following as required fields: “How is medication being given” – voluntarily or involuntarily and describe; “has the individual had any side effects from medication” and describe if yes; “have any medications been changed in last month” and if so, describe; and “have benefits of treatment prescribed and any risks or possible side effects been discussed with patient” with a discussion summary. This was revised in the Psychiatric Update effective in April 2011 so that psychiatrists now must address whether “there are medication changes made in response to any of the following: STAT medications, Seclusion or restraint, side effects or no changes”, and a description of side effects is required. Psychiatry also slightly modified the question concerning side effects of medication discussion so it now reads “Have the risks and benefits of current treatment been discussed with the patient, and it still includes a mandatory section for a “discussion summary”. ***See Tab # 17 Psychiatric Update Forms.*** This item was only audited beginning with December 2010, so there are only three months of data available. This will continue to be monitored through psychiatric update audits and corrective actions will be taken as needed.</td></tr>
<tr><td>V.B.4</td><td>each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;</td><td>
Recommendations:

1. Same as in V.D.1, V.D.2 and V.D.3.

SEH Response: See V.D.1, V.D.2 and V.D.3.

2. Same as in V.D.4 and V.D.5.

SEH Response: See V.D.4 and V.D.5.

3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>documents should be provided.

SEH Response: Audits are continuing.

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

SEH Response: See below.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #3. Each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported and documented</td><td>64</td><td>91</td><td>83</td><td>78</td><td>91</td><td>88</td><td>95</td><td>83</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit data for the prior period
See Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data from the clinical chart audits show a compliance rate lower than in the prior review period (which was only a two month period), but probably is more indicative of performance. The Hospital provided additional training in February 2011 targeting the writing of focus statements, objectives and interventions in the IRP and completion of present status and discharge related sections of the clinical formulation. In addition, each treatment team had at least three clinical formulations and IRPs reviewed by the consultant who provided comments and coaching. Audits will continue.</td></tr>
<tr><td>V.B.5</td><td>the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;</td><td>Recommendations:

1. Continue to provide data regarding documentation of the review and assessment by the Director of Psychiatric Services of individuals who reach high risk triggers/thresholds.

SEH Response: Ongoing. During this rating period, the Director of Psychiatric Services continues to review the cases of many of those individuals who reach high risk indicators, although with a slightly modified process. See Tab #56, Tracking Reports for High Risk Indicators. Under the process used during the review period, the Hospital's Risk Manager continues to monitor unusual incident reports and identifies those cases where an individual in care is involved in three or more</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		incidents of any type within a 30 day period on a weekly basis. In addition to notifying the treatment team, the Risk Manager notifies the Director of Psychiatric Services when an individual meets this indicator. The treatment team is expected to meet and address the issues within a week, and the Director of Psychiatric Services follows up to review the team's response, makes any additional recommendations, and writes a progress note in Avatar. The Risk Manager updates a spread sheet with the Director of Psychiatric Services recommendations and the information is returned to the original recipients. In addition, beginning in March 2011, with the implementation of the High Risk Indicator Tracking and Review Policy, the Psychiatric Services Director will review as a level two review when the high level thresholds (two or more episodes of restraint/seclusion in 24 hour period, three or more episodes in a rolling 30 day period, any restraint/seclusion episode lasting more than 12 hours, three or more UIS in 30 day period, three or more emergency involuntary medication administrations in a 24 hour period) are reached. This will be tracked by PID, and a database is being developed to help track this. 2. Same as in XII.E.2. SEH Response: See XII.E.2.
V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	**Recommendation:** 1. Maintain current level of practice. SEH Response: Current practice maintained.
V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Recommendations:** 1. Same as in V.E.3, V.E.4 and V.E.5. SEH Response: See V.E.3, V.E.4 and V.E.5. 2. Same as in VIII. SEH Response: See VIII. 3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by comparative data to the last review and analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See below.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's Findings: *Please note that while this requirement was included in the clinical chart audits the question was confusing to auditors and thus data collected is not reliable. As indicate below, the question has been clarified, and data will be available beginning March, 2011*.

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	182	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. #4. Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition and changing needs.	**	**	**	**	**	**	**64**	**

N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit data from the prior period
* * Data analysis suggested that auditors had differing interpretations of the question and thus results were invalid. The question has been revised effective with March clinical chart audits
Tab # 3, CLINICAL CHART AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C #10 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	100	100	100	100	100	100	**98**	**100**
%C # 11 Does the diagnosis reflect current clinical data or was it changed or updated based upon change in current clinical data?	100	100	100	96	100	100	**98**	**99**
%C # 18 Does the pharmacological plan of care reflect the diagnoses, mental status assessment and individual's response to treatment?	97	100	100	96	100	100	**99**	**99**
%C # 22 Does the update adequately analyze the risks and benefits of the chosen treatment interventions?				96	100	100		**99**

N = Census as of end of month, less month's admissions
n = number audited
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: The Hospital modified the Psychiatric Update in Avatar in an effort to improve documentation around response to treatment and progress. The Psychiatric Update now requires psychiatrists to address medication response, assess whether the psychiatric condition is generally improving, unchanged or worsening, include a narrative describing their overall assessment/changes in symptoms and functional condition since the last assessment, document whether the individual is progressing toward treatment goals and to describe that progress. The Psychiatric Update audits show high levels of compliance on this requirement. These audits will continue.

As noted, data from the clinical chart audits relating to this requirement are not available. There were issues with interpretations with this indicator, making the data not reliable. These were resolved with some modification to the language of the instructions and data will be available beginning with March 2011 audits.</td></tr>
<tr><td>V.B.8</td><td>an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and</td><td>Recommendations:

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

SEH Response: The Hospital continues to monitor inter-unit transfers using the same tool as used in the prior review period, which is mostly focused on presence or absence of documentation by disciplines, although there is some focus on content and quality. Audits were completed for each month during the review period, and the data are set out below. See Tab # 60 Transfer audit tool/instructions

Please note that the high number of inter-unit transfers in January and February were due to the closure of all units in the Annex.

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

SEH Response: See data below.

Facility's Findings:

<table>
<tr><th colspan="9">INTER-UNIT TRANSFER AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>9</td><td>2</td><td>1</td><td>3</td><td>15</td><td>22</td><td>11</td><td>9</td></tr>
<tr><td>n</td><td>4</td><td>2</td><td>1</td><td>3</td><td>3</td><td>5</td><td>5</td><td>3</td></tr>
<tr><td>%S</td><td>44</td><td>100</td><td>100</td><td>100</td><td>20</td><td>23</td><td>47</td><td>35</td></tr>
<tr><td>%C #I.11 Transfer summary form completed by psychiatrist</td><td>50</td><td>100</td><td>100</td><td>67</td><td>100</td><td>80</td><td>n/a</td><td>78</td></tr>
<tr><td>%C #I.8.a Psychiatric acceptance note present</td><td>100</td><td>100</td><td>100</td><td>33</td><td>100</td><td>60</td><td>71</td><td>78</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C	#I.7.b SW transfer note present	50	100	100	67	100	100	**19**	**83**
%C	#I.8.b SW acceptance note present	50	100	0	67	0	20	**19**	**39**
%C	#I.7.c Nursing transfer note present	50	100	100	67	100	40	**65**	**67**
%C	#I.8.c Nursing acceptance note present	100	100	0	100	33	100	**77**	**83**
%C	#I.7.d GMO transfer note present	50	100	100	67	100	60	**58**	**72**
%C	#I.8.d GMO acceptance note present	100	100	100	100	100	60	**52**	**89**
%C	#I.13.b Rationale for transfer	100	100	100	100	100	80	**n/a**	**94**
%C	#1.13.c Current behavior, treatment and response	75	50	100	100	100	80	**65**	**82**
%C	#I.13.e Anticipated benefit of transfer	100	50	100	50	100	80	**71**	**82**
%C	#I.13.g Brief course of treatment	75	100	100	50	100	80	**65**	**82**
%C	# I.13.h Risk factors	100	100	100	50	100	80	**68**	**88**
%C	#1.13.i Current diagnosis	100	100	100	100	100	80	**74**	**94**
%C	#1.13.j Discharge barriers	100	100	100	50	100	40	**71**	**76**
%C	#I.13.k Recommended plan of care	100	100	100	50	100	80	**61**	**88**
%C	2.II.2 IRP completed within 7 days of transfer	0	100	100	100	100	80	**58**	**72**

N= number of inter-unit transfers in the month
n= population monitored
* Because the transfer summary that was added to Avatar serves the same purpose as the note, this question was removed from the audits.
Tab # 61 TRANSFER AUDIT RESULTS, March through August

Analysis/Action Plans: The above data show that the Hospital's performance in completing its transfer notes or in fully documenting information about the individual in making or receiving the transfer significantly improved during this review period; all indicators showed improvement. Data further show that it is meeting the timeliness standard around treatment planning also more frequently than during the prior review period. Documentation around transfers at the time of the transfer will continue to be monitored by the Office of Clinical Operations and audits will continue.

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.	**Recommendation:** 1. Present an outline of all current self-assessment tools, including sample sizes, status of implementation during the review period, any modifications made during the review period or planned for next review period. SEH Response: The Hospital is currently monitoring through a variety of tools. Audits continuing or beginning during this review period include IRP observation audits, clinical chart audits, therapeutic progress note audits, CIPA audits, psychiatric update audits, TD audits, IPA (Psychology) audits, psychology risk assessment audits, psychology evaluation audits, PBS audits, Initial rehabilitation services audits, SWIA audits, SW update audits, CINA audits, nursing update audits, seclusion and restraint audits, discharge record review audits, transfer audits, substance abuse Intervention audits, and the post - discharge services audits completed by MHA. An audit of the use of Emergency Involuntary Medication began in October as did audits of group facilitators. Below is a summary table.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		AUDIT RESULTS	**AUDIT STATUS**	**CHANGES IN AUDIT TOOLS SINCE LAST REVIEW**
		IRP observation audits	Ongoing throughout review period. Target is 2 per unit per month. There are 11 units.	No change to tool since last review.
		Clinical chart audit	Began for IRPs completed in July 2010. No data for March through June 2010 so prior period mean is based upon two month sample. Target is 2 per unit per month. Audits were completed for each of the months during this review period.	Tool was modified in January 2011 to combine questions relating to timeliness and to clarify instructions after inter-rater reliability issues were identified. Additional changes to instructions in indicator 4 were made in March 2011. Changes were also made in early April 2011. All versions of tools are provided in Tab # 10, in both clean versions and track changes versions for ease of review.
		Therapeutic progress note audit	Ongoing for two months of Jan and Feb for psychology, psychiatry, social work, nursing and rehabilitation services. None for nursing. Target is 1 note per group leader and individual therapist per month.	Tool was slightly modified in September 2010 to clarify instructions but indicators are the same. In November, based upon input from DOJ consultants, tool was modified to remove specific questions. Tool revised again in February 2011 to break down some of the questions into more discrete indicators. Final change was made in March to correct grammar in question 6. All versions of the tool are provided.
		CIPA audit	Ongoing throughout review period. Target is 20%.	Tool was modified in December 2010 to incorporate recommendations by DOJ consultant. Several questions were removed, and questions were reordered to improve flow. A question was added concerning whether appropriate labs and consultations were ordered and whether the audit results were discussed with psychiatrist. The changes to the tool are reflected in the audit results.
		Psychiatric Update audit tool	Ongoing through the review period. Target is 2 reviews per unit psychiatrist.	Tool was modified in December 2010 to improve clinical flow and reflect new psychiatric update form in Avatar. Questions were added around high risk medication practices (i.e. use of benzodiazepines for more than 90 days) as the medication monitoring audit was stopped. Changes to the tool are reflected in the audit results.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Psychiatry TD audit tool	Ongoing for review period. Target is each case of TD diagnosis every six months.	Tool updated January 2011. New question was added as to whether psychiatric update reflects TD status.
		Psychology IPA audits	Ongoing for review period. Target is 20%.	No change to tool
		Psychology Risk Assessment	Ongoing for review period. Target is 1 per psychologist who completes them.	Tool revised to eliminate specific questions and to add additional questions. Audit results indicate which questions were added and deleted.
		Psychology Evaluation	Ongoing for review period. Target is 1 per psychologist who completes them.	Tool revised to eliminate specific questions and to add additional questions. Audit results indicate which questions were added and deleted.
		PBS audit tool	Ongoing for review period. Target is 50% of plans and guidelines.	No change in tool.
		Neuropsychology assessment audits	Ongoing during review period.	Tool revised to eliminate specific questions and to add additional questions. Audit results indicate which questions were added and deleted.
		Initial Rehabilitation Assessment audit tool	Ongoing for review period. Target is 20%.	Small changes in tool and instructions beginning with September 2010 audits.
		SWIA audit tool	Ongoing for review period. Target is 20%.	Small changes in tool and instructions beginning with September 2010 audits to include tracking of whether family was invited to IRP conference. Tool was modified effective March 2011 to better reflect IRP process.
		SW Update audit tool	Ongoing review period. Target is 1 per social worker.	Small changes in tool and instructions implemented with September 2010 audits to include tracking of whether family was invited to IRP conference. Tool was modified effective March 2011 to better reflect IRP process.
		Medication Monitoring audits (Pharmacy)	Discontinued during this rating period per DOJ recommendation.	Questions around high risk medication practices were added to Psychiatric Update audits as this audit was discontinued.
		Emergency Involuntary medication audits	Audits began in October 2010. Target is 20%.	No change in tool.
		CINA audits	Ongoing for review period. Target is 20%.	No change to tool. Will be modified during this upcoming review period to reflect CINA two part form.
		Nursing Update audits	Ongoing for period. Target is 4 per unit.	New tool was used beginning in November 2010. Audit results show new questions. New tool required due to change in progress update form.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Seclusion and restraint audit</td><td>Target is 50% of cases.</td><td>Tool was completely rewritten to track the requirements of the Settlement Agreement.</td></tr>
<tr><td>Discharge record audit tool</td><td>Ongoing. Target is 10%.</td><td>Two new questions added in December 2010 around providing copy of discharge plan of care to individual in care and signature.</td></tr>
<tr><td>Inter-unit transfer audit tool</td><td>Ongoing. Target is 20%.</td><td>No change in tool during this review period.</td></tr>
<tr><td>Group facilitator observation audit tool</td><td>Audits begun in November. Target is one per group leader per 4 months.</td><td>Implemented tool provided during last review.</td></tr>
<tr><td>DMH post discharge audits</td><td>Monthly</td><td>Tool modified beginning for September 2010 audits to include whether DMH received discharge plan of care.</td></tr>
</table>

2. Consolidate and simplify some of the auditing tools that address overlapping areas and that contain redundant indicators (e.g. Medication Monitoring Audit can be discontinued in favor of a more complete Psychiatric Update Audit and the Therapeutic Progress Notes tool can be simplified).

SEH Response: The Hospital discontinued the medication monitoring audits and incorporated specified topics into the Psychiatric Update audit tool. Monitoring of polypharmacy, use of new generation anti-psychotics, use of anti-cholinergics in high risk groups, long term use of benzodiazepines in high risk populations and some medication practices involving geriatric individuals is now completed through the Psychiatric Update audits. Other tools were modified as indicated in the above chart. Audits are continuing and data are published at regular intervals.</td></tr>
<tr><td>V.C.</td><td>By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:</td><td></td></tr>
<tr><td>V.C.1</td><td>be derived from analyses of the information gathered including diagnosis and differential diagnosis;</td><td>Recommendations:

1. Continue to provide aggregated data regarding competency-based training of IRP team core members regarding the Interdisciplinary Case Formulation.

SEH Response: See V.A.3 and V.B.1 for training information and data. See Tab # 1 for IRP training materials and data.

2. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH response: See data below.

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

SEH response: See data below.

4. Implement SEH CAP of October 7, 2010 relative to section V.C.

SEH response: The Psychiatric Update, CIPA, IRP and clinical formulation forms were modified to incorporate specific DOJ recommendations and to improve the flow of the documents. The Hospital no longer uses a clinical formulation update, but only a single clinical formulation form. ***See Tab # 5 IRP form, # 6 Clinical Formulation form, # 14 CIPA form, # 17 Psychiatric Update form.*** Audits by all disciplines of the initial assessments and updates continue, as do the IRP observation and clinical chart audits. Audit results are shared by disciplines with their staff, discipline chiefs are providing individualized coaching as needed, and IRP and clinical chart audit related data are shared with clinical leadership. In addition, the Hospital through its consultants provided targeted training with clinical administrators on completion of present status in the clinical formulation and presentation of present status. Training was also provided to clinical administrators and nurse managers on developing goals, objectives and interventions for medical needs, and with the entire treatment teams in developing discharge criteria, plans and identifying discharge barriers.

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	182	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. #5. The clinical formulation should be derived from analyses of the information gathered including diagnosis and differential diagnosis	48	74	70	89	77	88	**71**	**74**

N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit data from the prior review period
** Sample size 2 per unit (22)
See Tab# 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data reflect marginal improvement from the prior review period, although the trend in the last several months of the current review period shows that performance is nearing the 90% mark. Additional training with

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>clinical administrators was provided around developing and presenting the present status section of the clinical formulation and at least three clinical formulations and IRPs per team have been reviewed by consultants with feedback provided. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. In addition, clinical chart auditors will be using a newly implemented feedback form to provide specific comments based upon their audits. See Tab # 10 Clinical chart audit tool, Tab # 7 Clinical Chart Audit Feedback Form.

Finally, the clinical formulation was modified to reflect the new IRP manual and the clinical formulation update deleted, so only one form is used for the original clinical formulation and for updates.</td></tr>
<tr><td>V.C.2</td><td>include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;</td><td>Recommendations:
1. Same as above.

SEH Response: Same as above.

Facility’s Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #6. The clinical formulation includes a review of clinical history; predisposing, precipitating and perpetuating factors; present status and previous treatment history</td><td>50</td><td>78</td><td>75</td><td>82</td><td>79</td><td>87</td><td>49</td><td>75</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit data for the prior review period
** Sample size 2 per unit (22)
See Tab# 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data suggest that the Hospital is improving in addressing the six Ps as part of the clinical formulation. This likely reflects that the training provided to date has been effective. To further strengthen performance, the Hospital, through its consultants, provided targeted coaching with clinical administrators on presentation of present status, which was designed to address deficiencies noted by DOJ in its report and exit conference. Coaching through review of at least three IRPs and clinical formulations per team also began in late 2010, so additional improvement should be evidenced during the upcoming review period. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. The Clinical Chart Audit Feedback Form will be used by the clinical chart auditors.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>V.C.3</td><td>include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;</td><td>
Recommendations:
1. Same as above.

SEH Response: Same as above.

2. Same as in VI.A.5

SEH Response: Same as VI.A.5.

Facility's Findings:

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 18 Does the psychopharmacological plan of care reflect the diagnoses, mental status assessment, and individual's response to treatment?</td><td>97</td><td>100</td><td>100</td><td>96</td><td>100</td><td>100</td><td>99</td><td>99</td></tr>
</table>
N = Last day monthly census less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11, PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital's audit of psychiatric updates shows high performance on this requirement and no additional steps are required. The Hospital will continue to audit the psychiatric update.
</td></tr>
<tr><td>V.C.4</td><td>consider biochemical and psychosocial factors for each category in Section V.C.2., supra;</td><td>
Recommendations:
1. Same as above.

SEH Response: See above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
</table>
</td></tr>
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<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C. #7. The clinical formulation considers biochemical and psychosocial factors as clinically appropriate</td><td>89</td><td>95</td><td>100</td><td>89</td><td>90</td><td>91</td><td>85</td><td>92</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit results from the prior review period
** Sample size 2 per unit (22)
See Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data reflect high performance of this requirement. Clinical chart audits will continue.
</td></tr>
<tr><td>V.C.5</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;</td><td>
Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility’s Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #8. The clinical formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</td><td>88</td><td>95</td><td>100</td><td>100</td><td>95</td><td>96</td><td>74</td><td>96</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects two months of audit data from the prior review period
** Sample size 2 per unit (22)
See Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data reflect improved, and high performance for this requirement. Clinical chart audits will continue.
</td></tr>
<tr><td>V.C.6</td><td>enable the treatment team to reach determinations about each individual's treatment needs; and</td><td>
Recommendations:

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

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

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
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<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #9. The clinical formulation enables the interdisciplinary team to reach determinations about each individual's treatment needs</td><td>15</td><td>43</td><td>40</td><td>56</td><td>55</td><td>58</td><td>37</td><td>45</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects two months of audits for the prior review period
** Sample size 2 per unit (22)
See Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: While improved from the last review period, the data show significant improvement is still needed in completing a clinical formulation in a manner that enables the treatment team to reach determinations about each individual's treatment needs. The Hospital provided additional training in February 2011 to address some issues around completion of the present status section of the clinical formulation and also is providing coaching around the writing of the clinical formulation and IRPs. Finally, a clinical chart audit feedback form is now being used by which auditors can provide specific comments directly to the teams – what was good and what could be improved, with suggestions on how to improve the IRP related documents. See Tab # 7 Clinical Chart Audit Feedback Form
</td></tr>
<tr><td>V.C.7</td><td>make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.</td><td>
Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
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<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #10. The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge, whenever possible</td><td>26</td><td>74</td><td>61</td><td>67</td><td>45</td><td>68</td><td>52</td><td>57</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of audit results for the prior review period
** Sample size 2 per unit (22)
See Tab# 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: The data show modest improvement from the last review period in addressing discharge related issues in the clinical formulation. Based upon this, in February 2011, the Hospital provided intensive training to each treatment team, as a team on developing the parts of the clinical formulation related to discharge – those sections addressing discharge criteria, discharge plans and discharge barriers. With the consultant's assistance, each team took a case and reviewed the specific discharge related issues and redrafted the clinical formulations. Staff were trained on the differences between discharge criteria, discharge plans and discharge barriers. See Tab # 1, IRP training data and materials. In addition, the IRP manual was revised to provide additional examples and guidance in completing the discharge sections of the clinical formulation. Finally, a minimum of three clinical formulations and IRPs from each unit have been reviewed by the training consultants and comments were provided to treatment teams. These three initiatives are expected to result in improvement over the upcoming review period; the clinical chart audits will continue and the data will be monitored to determine if additional actions are needed.
</td></tr>
<tr><td>V.D.</td><td>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:</td><td></td></tr>
<tr><td>V.D.1</td><td>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;</td><td>Recommendations:

1. Develop and implement corrective actions to address the process deficiencies in medical and nursing care outlined above. Include an update regarding the status of implementation of the facility's policies and procedures regarding provision of medical care and seizure management.

SEH Response: The Hospital, through its consultants, provided additional training focusing on IRP planning for those with medical needs. Training was held with clinical administrators and nurse managers around developing goals, objectives and interventions for those with medical needs. See Tab # 1 for training materials and training data. The Hospital also made some slight modifications to the general medical services policy to reflect the closure of the RMB Annex and address some changes to practice. The seizure management policy was updated and is being implemented; nursing began using the</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

approved seizure observation form. However under current practice, only the staff witnessing the seizure (often a Recovery Assistant) documents the seizure on the Seizure Observation Form. A Registered Nurse (RN) does not routinely review and document on the form. In addition, the form does not adequately capture all required documentation elements (as outlined in the policy). Therefore, nursing revised the Seizure Observation Form and process to include two parts: one part completed by the staff witnessing the seizure and the other part completed by the RN. This revision should be completed no later than May 2011 visit.

In addition, audit tools were developed for reviewing the quality and timeliness of the History and Physicals as well as documentation around medical transfers, and audits were begun in January, 2011. ***See Tab #s 65 (History and Physical Audit form and instructions), # 66 (History and Physical Audit Results); # 75 (Medical Transfer Audit Form), # 78 (Medical Transfer Audit Results).*** Audit results for the history and physical audits show high performance on all indicators. Audit results for the medical transfer audits show high compliance on most indicators, but improvement is needed on indicators relating to completion of all subsections of basic information, accuracy/completeness of diagnoses and inclusion of a brief description of current behavior and response to treatment.

HISTORY AND PHYSICAL AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N					33	29		**31**
n					26	17		**22**
%S					79	59		**69**
%C. # Timely completion					96	94		**95**
%C. # 1 Subsections on basic information completed					100	100		**100**
%C. # 2 Part II of H & P includes completed past medical history					100	100		**100**
%C. # 3 Immunization section is complete					100	100		**100**
%C. # 4 H & P includes complete and appropriate description of review of systems					100	100		**100**
%C. # 5 PE section of H & P includes results of PE, including all vital signs and pertinent physical findings					100	100		**100**
%C. # 6 Neurological section is completed					100	100		**100**
%C. # 7 Cranial nerve section is completed					100	100		**100**
%C. # 8 Assessment section is completed and includes synthesis of relevant findings					100	100		**100**
%C. # 9 Plans section is completed and reflects appropriate plan and includes orders as needed.					100	100		**100**

N = Total monthly admissions
n = number audited
* No audits in prior period
See Tab# 66 HISTORY AND PHYSICAL AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

MEDICAL TRANSFER AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N				16	24	21		**20**
n				1	5	**		**2**
%S				6	21	**		**10**
%C. # 1 Subsections on basic information completed				100	50	**		**60**
%C. # 2 Part II of medical transfer included accurate and complete diagnoses				100	75	**		**80**
%C. # 3 Reason for medical transfer is clearly indicated on the form				100	100	**		**100**
%C. # 4 The transfer form includes a complete and appropriate description of relevant history.				100	100	**		**100**
%C. # 5 The PE section includes the results of the physical examination that preceded the transfer including vital signs and pertinent physical findings				100	100	**		**100**
%C. # 6 All the most recent lab results were provided				100	100	**		**100**
%C. # 7 A list of the current medications is provided and recent changes to medication are noted				100	100	**		**100**
%C. # 8 The allergy section is completed fully and accurately				100	100	**		**100**
%C. # 9 The form includes a brief description of current behavior and responses to treatment				100	25	**		**40**
%C. # 10 There is a diagnostic impression that makes clear the reasons for the transfer				100	100	**		**100**
%C. # 11 There is a progress note upon the individual's return that includes an analysis of information from the medical facility and an appropriate response by the physician/nurse practitioner.				100	100	**		**100**

N = Total number of medical transfers
n= number audited
* No audits in prior period
** Audits were underway for February transfers but were not completed in time for data to be included in this report.
See Tab # 78 MEDICAL TRANSFER FORM AUDIT RESULTS

2. Continue to provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/ Interventions.

SEH Response: New employees are provided with an overview of IRP process during orientation, and then each quarter, employees who started during the quarter are trained by the Chief of Staff on each of the four modules, including

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

developing focus areas/objectives and interventions. In addition, during this review period, clinical administrators and nurse managers were provided additional training on developing focus statements, goals, objectives and interventions. The training, which covered basic principles as well, focused on development of goals, objectives and interventions for those with medical needs, in part to address the prior recommendation. Staff members were provided with examples of possible objectives and interventions for those with medical needs and were asked to develop their own. These additional examples have been incorporated into the IRP manual. Finally, extensive coaching in writing focus statements, objectives and interventions was provided to staff through review of 48 IRPs and clinical formulations by consultants and coaches. ***See Tab # 1 for IRP training materials and data.*** See also V.A.3.

3. Continue to monitor each requirement in V.D.1 to V.D.6 based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates and weighted average compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

5. Ensure that the self-report contains a summary outline of the following:
   a. Number and types of Cognitive remediation interventions that are currently provided and plans to increase these interventions and
   b. Specific information regarding the assignment of Mall groups to individuals based on initial cognitive screening of the individuals.

SEH Response: See chart below and ***Tab # 163 for additional information***

Cognitive Remediation Therapies/ Groups Mar~Aug10		**Cognitive Remediation Therapies/Groups Sept 10~ Feb 11**		**Cognitive Remediation Therapies/Groups Feb 11~ present**	
Sessions per week	Capacity	Sessions per week	Capacity	Sessions per week	Capacity
104	521	251	994	252	1024 (857 currently enrolled as of Feb 2011)

The TLCs continue to offer comprehensive cognitive programming, which includes an online cognitive skill building program for those with mild cognitive impairments, a “pen and pencil” cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. ***See Tab # 163 Cognitive Groups Capacity comparison.*** Groups for those with cognitive impairments are provided by rehabilitation services, co-occurring disorders, nursing, TLC staff, social work, psychiatry,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

consumer affairs, chaplaincy, and psychology. Schedules are built based upon the individual's diagnosis, IPA results, level of functioning, clinical formulation summary, IRP group guide, observations of TLC staff made during the weeklong orientation, and the needs and choices of the individual.

6. Implement the facility's CAP of October 7, 2010 relative to section V.D.

SEH Response: Training on development of focus statements, objectives and interventions was provided (for additional information see response to Recommendation # 2), as provided for in the CAP. In addition a significant sample (48) of IRPs and clinical formulations were reviewed by consultants or coaches and comments on ways to improve them were provided to clinical administrators. Clinical chart audits were completed for each month during the review period, and a feedback form was developed to provide specific feedback to clinical administrators and treatment teams based upon the audit results. ***See Tab # 10 Clinical chart audit and Tab # 7 Clinical Chart Audit Feedback Form***. Weekly meetings with TLC staff and clinical administrators to review the progress of individuals whose IRPs are upcoming continue, and discipline chiefs are now conducting group observations to assess the quality of group leaders. ***Tab # 124 Group Facilitator Monitoring Form and Instructions and Group Facilitator Audit Results***. Assignment to groups in the TLCs continue to reflect individual's cognitive functioning and as relevant stage of change (substance abuse groups).

Facility's Findings:

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	182	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. #11. The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs	65	96	74	72	68	80	**68**	**76**

N = All IRP reviews scheduled in the review month
n = number audited
* Mean reflects only two months of data for the prior review period
** Sample size 2 per unit (22)
Tab # 3, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data show some improvement in the quality of the goals and objectives during this rating period. As noted, in February 2011, additional training was provided to clinical administrators and nurse managers around developing goals and objectives, with a focus on medical needs. In addition, beginning in late December 2011, consultants started the review of clinical formulations and IRPs and the Hospital believes these interventions will improve performance. Audits will continue and additional steps will be identified if needed.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>V.D.2</td><td>provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);</td><td>
Recommendations:
1. Same as above.

SEH Response: Same as above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #12. The goals/objectives address treatment (e.g., for a disease or disorder), and rehabilitation (e.g., skills/supports and quality of life activities)</td><td>78</td><td>70</td><td>73</td><td>78</td><td>68</td><td>76</td><td>80</td><td>74</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period reflects only two months of data
** Sample size 2 per unit (22)
Tab # 3, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data suggest that performance is not improving as expected, although auditors reported difficulty in understanding the instructions (which have since been modified). Trainings offered in February 2011 that target development of goals and objectives and individual engagement were designed to address these findings. Coaching in writing IRPs and clinical formulations also is continuing. This requirement will be monitored through the ongoing clinical chart audits and additional action steps will be identified and implemented if needed.
</td></tr>
<tr><td>V.D.3</td><td>write the objectives in behavioral and measurable terms;</td><td>
Recommendations:

1. Same as above.

SEH Response: Same as above.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
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<table>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #13. The IRP includes objectives written in behavioral and measurable terms</td><td>65</td><td>57</td><td>57</td><td>72</td><td>80</td><td>76</td><td>61</td><td>67</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period reflects only two months of audits
** Sample size 2 per unit (22)
Tab # 3, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data suggests that performance is not improving as expected, although it shows some improvement since December 2010 with performance consistently over 70% since that time. Trainings offered in February 2011 that target development of goals and objectives and individual engagement were designed to address these findings. Coaching in writing IRPs and clinical formulations also is continuing. This requirement will be monitored through the ongoing clinical chart audits and additional action steps will be identified and implemented if needed.
</td></tr>
<tr><td>V.D.4</td><td>provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;</td><td>
Recommendations:
1. Same as above.

SEH Response: Same as above.

2. Continue to monitor this requirement using the Clinical Chart Audit and the Therapeutic Progress Notes Audit. Present aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted averages of %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

4. Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. Present auditing data for this instrument according to instructions in Cell V.B.9.

SEH Response: Question 20 from the clinical chart audit was moved to the group facilitator chart audit. Data should be available for the next review period. See Tab # 124 Group Facilitator Monitoring Form and Instructions.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	182	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. #14. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective	35	91	78	83	77	84	**84**	**75**

N = All IRP reviews scheduled in the review month
n = number audited
* The mean for the prior review period reflects only two months of audits.
** Sample size 2 per unit (22)
Tab # 3, CLINICAL CHART AUDIT RESULTS

THERAPEUTIC PROGRESS NOTE AUDIT RESULTS (ALL DISCIPLINES)*								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N					269	279	**279**	**266**
n total notes audited					39	61	**41**	**50**
Psychiatry					8	8	**2**	**8**
Psychology					3	11	**11**	**7**
Nursing*					0	18	**12**	**9**
Social work					10	5	**4**	**8**
Rehab/chaplain					18	19	**13**	**19**
%S					14	23	**15**	**19**
%C. #1 Completed timely (all disciplines)					97	85	**67**	**90**
%C #2 Is the number of session scheduled indicated?					100	100		**100**
%C #3 Is the number of sessions attended indicated?					100	100		**100**
%C #4 Is the number of sessions attended equal to the number of sessions scheduled?					87	58		**69**
%C #5 If applicable, is there a specific reason why numbers (attended versus scheduled) are not identical					100	69	**96**	**74**
%C #6 Is the intervention (group name or individual therapy noted and is description of individual's participation level present and informative					100	93	**95**	**96**

N= 90% of average daily census
n= total therapeutic progress notes audited
*The therapeutic progress note tool went through various iterations over the Fall, so the Hospital is presenting only two

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		months of data. Not all disciplines completed audits in each month. See Tab 41 for discipline specific results. ***Tab #41 THERAPEUTIC PROGRESS NOTE AUDIT RESULTS*** **Analysis/Action Plans:** Clinical chart audit data suggest that performance is not improving as expected. Trainings offered in February 2011 that target development of goals and objectives and individual engagement were designed to address these findings. Coaching in writing IRPs and clinical formulations also is continuing. In addition, the audit tool instructions are being revised on this indicator due to confusion among auditors on how to interpret it. This will be monitored through the ongoing clinical chart audits and additional action steps will be identified and implemented if needed. Similarly, the therapeutic progress note audit tool was modified as a result of questions posed by the auditors and to incorporate recommendations by DOJ. ***See Tab # 45 Therapeutic Progress Note Audit Tool and Instructions and Tab # 41 Therapeutic Progress Note Audit Results.*** The revised tool tracks whether the progress note is timely, tracks the individual's attendance, reflects the group name, assesses whether the reasons for nonattendance (if applicable) reflected in the note and assesses whether the note is descriptive and informative concerning the individual's participation level. Data show overall high levels of compliance with most indicators, including those relating to the quality of the note. The only indicator showing improvement concerns explaining reasons for absence.
V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and	**Recommendations:** 1. Track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. SEH Response: This is now tracked through a monthly management report. Dedicated data entry personnel have been identified and are entering scheduling and attendance data. ***Tab # 46 Treatment hours report*** Data from house based groups is now included, although there remains some underreporting due to some group leaders failure to return attendance sheets. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's Findings:** The Hospital during this review period created a management report that tracks hours scheduled and hours attended based upon information in Avatar and looks at individuals with a LOS of 14 days or greater. The data reflect TLC and some unit based groups. Because the Hospital anticipates that it could take up to 60 days for someone to be engaged in as many as 20 hours of treatment each week, the Hospital is developing additional reports to track certain cohorts of individuals (i.e, LOS of 30 days, LOS 60 + days, geriatric etc). Some of these reports will be available by the May visit. However, data based on a 14 day LOS show:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Hours Of Groups Scheduled

	10/31/10~11/27/10*		11/28/10~1/1/11 **		1/2/11~1/29/11*		1/30/11~2/26/11*		Mean # 10/31~ 2/26/11	Mean % 10/31~ 2/26/11
Hours	Mean #	Mean %	Mean #	Mean %	Mean #	Mean %	Mean #	Mean %		
N=	296	100%	294	100%	293	100%	288	100%	293	100%
0 Hours	33	11%	37	13%	34	12%	31	11%	34	11%
0>5 Hours	7	2%	7	2%	6	2%	8	3%	7	2%
6>10 Hours	14	5%	14	5%	21	7%	14	5%	16	5%
11>15 Hours	38	13%	37	13%	36	12%	37	13%	37	13%
16>19	16	5%	21	7%	69	24%	28	10%	33	33%
20+	189	64%	179	61%	128	44%	171	59%	166	11%

N= Individuals with LOS 14 days or more
* At least one holiday
** Mall closed for two weeks over Christmas holiday

Hours Of Groups Attended

	10/31/10~11/27/10		11/28/10~1/1/11		1/2/11~1/29/11		1/30/11~2/26/11		Mean # 10/31~ 2/26/11	Mean % 10/31~ 2/26/11
Hours	Mean #	Mean %	Mean #	Mean %	Mean #	Mean %	Mean #	Mean %		
N=	296	100%	294	100%	293	100%	288	100%	251	100%
0 Hours	28	10%	33	11%	29	10%	20	7%	24	9%
0>5 Hours	57	19%	61	21%	58	20%	55	19%	50	20%
6>10 Hours	63	21%	58	20%	57	20%	58	18%	50	20%
11>15 Hours	67	23%	67	23%	72	25%	49	17%	55	22%
16>19	39	13%	51	17%	53	18%	50	17%	41	16%
20+	42	14%	24	8%	24	8%	61	21%	32	13%

N= Individuals with LOS 14 days or more
* One holiday
** Mall closed for two weeks over Christmas holiday

Tab # 46 TREATMENT HOURS REPORT (this includes more specific data by week during this period)

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

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P*	Mean-C
N	196	191	194	219	183	182	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #14. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective</td><td>35</td><td>91</td><td>78</td><td>83</td><td>77</td><td>84</td><td>84</td><td>75</td></tr>
</table>
N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period reflects only two months of audits.
** Sample size 2 per unit (22)
Tab # 3, CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: As noted, the Hospital continues to review data now available and is developing additional reports by various cohorts since the above presented data looks at all individuals with a length of stay of 14 days or more, and special populations. What the data show however, is that about 60% of individuals in care are scheduled for 20 or more hours of treatment per week, and that only about a third of those at the hospital for 14 days or more are attending groups as scheduled.

The clinical chart audit shows that improvement is needed in formulating objectives and in tying the interventions to objectives, but training underway should continue to strengthen performance on this requirement. See V.D.4. However, the data may be affected by confusion among auditors in interpreting the instructions which were then modified in early April 2011, for audits beginning in the next review period. In addition, there was additional training on writing focus statements, objectives and interventions in February, 2011, supplemented by coaching and review of written IRPs and clinical formulations.

Effective September 2010, the TLCs introduced a new catalogue of groups and a new method of providing therapies. These changes, which include more dosing of groups, more cognitive therapies, more social skills groups and more community integration groups are designed to more closely reflect the needs of the population served by the Hospital. The groups were rolled out to clinical administrators, and the catalogue is available on the intranet so treatment teams can select groups that better meet the individual's needs.

The Hospital is continuing to analyze data and expects to have additional information available during the visit.</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>Recommendations:
Same as in V.D.1 through V.D.5.

SEH Response: Same as in V.D.1 through V.D.5.</td></tr>
<tr><td>V.E.</td><td>By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide</td><td></td></tr>
</table>

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

Recommendations:

1. Continue to monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: IRP observations and clinical chart audits continued throughout the review period. ***See Tab # 8 IRP Observation Monitoring tools/instructions and Tab # 10 Clinical chart audit tool/instructions.*** The Hospital's monitoring target for both instruments is 2 per unit per month. ***See Tab # 36 Audit Sample Plan.***

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

SEH Response: See data below.

3. Implement the facility's CAP of October 7, 2010 relative to section V.E.

SEH Response: As previously noted, consultants continue to review IRPs and provide feedback to teams. During the review period, at least 3 plans per team were reviewed and feedback was provided. In addition, clinical administrators and nurse managers were provided training around developing and revising objectives as needed, with a focus on medical needs and related objectives. Chart audits are continuing and this requirement is assessed as part of those audits.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #15 The team revised the objectives as appropriate to reflect the individual's changing needs.</td><td>15</td><td>81</td><td>41</td><td>60</td><td>35</td><td>52</td><td>59</td><td>48</td></tr>
</table>

N = All IRP reviews scheduled in the review month
n = number audited
* Mean for the prior review period indicated reflects only two months of audits
** Sample size is two per unit

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

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

Tab # 3, CLINICAL CHART AUDIT RESULTS

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>122</td><td>140</td><td>158</td><td>208</td><td>186</td><td>188</td><td>212</td><td>167</td></tr>
<tr><td>n</td><td>19</td><td>15</td><td>12</td><td>16</td><td>22</td><td>23</td><td>22</td><td>18</td></tr>
<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C. # 7 Team bases progress reviews/revisions recommendations on clinical observation and data.</td><td>53</td><td>68</td><td>88</td><td>79</td><td>95</td><td>87</td><td>86</td><td>79</td></tr>
</table>

N = IRP reviews scheduled
n = number audited
* Mean for the prior review period reflects three months of audits

Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: The data show improvement is needed in revising objectives as an individual's needs changes although the trend is improving. Based on the data, in February 2011, additional training was provided to staff around developing goals, objectives and interventions, completing and presenting the present status section of the clinical formulation and developing discharge criteria, plans and identifying discharge barriers. It is anticipated that this training will positively impact performance on this indicator.
</td></tr>
<tr><td>V.E.2</td><td>monitor, at least monthly, the goals; objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;</td><td>

Recommendations:
1. Same as in V.E.1.

SEH Response: Same as in V.E.1

2. Continue to monitor this requirement using the Psychiatric Update Audit based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 10 Does the psychiatric update accurately reflect the individual’s response to treatment/progress?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td><td>100</td></tr>
</table>
N = Census as of end of month, less month’ admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data show high performance on this indicator. The Hospital also modified the Psychiatric Update when it became “live” in Avatar to better capture information about the individual’s progress and response to treatment. Under the revised Psychiatric Update, psychiatrists must now assess whether the medication has been effective, describe the psychiatric condition generally, provide a narrative describing the doctor’s overall assessment and changes in the individual’s symptoms and functional condition since the last assessment, indicate whether the individual is progressing toward his treatment goals, and finally, describe the progress in a narrative form. The Hospital will continue the audits to identify areas and or units in which additional training or coaching may be needed.
</td></tr>
<tr><td>V.E.3</td><td>review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;</td><td>
Recommendations:
1. Same as in V.E.1.

SEH Response: See V.E.1.

Facility’s Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>182</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #16. Review the goals, objectives and interventions more frequently if there are clinical relevant changes in the individual’s functional status or risk factors.</td><td>100</td><td>80</td><td>83</td><td>100</td><td>50</td><td>86</td><td>86</td><td>86</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
* The mean for the prior review period indicated reflects only two months of audit data
** Sample size target is 2 per unit per month
Tab # 3, CLINICAL CHART AUDIT RESULTS
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: The data show good performance on this requirement, and, but for January's data, would be at the 90% mark. The Hospital implemented its High Risk Tracking and Review policy in March, 2011. Under the policy, treatment teams are required to monitor individuals in care and notify the PID where an individual meets one of 16 categories of behavioral or medical risk indicators. Among the expectations in the policy is for teams to update the risk factors as part of the present status section of the clinical formulation as well as to develop interventions to address the risks. In addition, the Hospital is continuing the monitoring of three or more UIs in a thirty day period. The Risk Manager continues to notify treatment teams and the Director of Psychiatric Services, among others, when an individual has three or more major unusual incidents in a thirty day period. The Director of Psychiatric Services consults with the treatment team, reviews the chart and actions of the treatment team, and makes recommendations in the chart concerning actions for the team to consider.</td></tr>
<tr><td>V.E.4</td><td>provide that the review process includes an assessment of progress related to discharge; and</td><td>Recommendations:

1. Continue to provide aggregated data regarding competency-based training of all core members of the IRP teams relevant to this requirement.

SEH Response: Treatment teams were provided additional training during this review period around discharge planning. The didactic training included a one and one half hour module on development of discharge criteria, discharge plans and review, including identifying discharge barriers. In addition, the discharge related parts of the clinical formulation and IRPs are being reviewed by consultants and coaches. Data show:

<table>
<tr><th colspan="3">Engagement and Community Integration II (1 and ½ hours)</th><th>09/01/10 ~ 03/15/11</th></tr>
<tr><th>Discipline</th><th># Required</th><th># Attended</th><th>% Attended</th></tr>
<tr><td>Clinical Administrator</td><td>12</td><td>12</td><td>100%</td></tr>
<tr><td>Nursing - Nurse Manager</td><td>16</td><td>8</td><td>50%</td></tr>
<tr><td>Psychiatry</td><td>22</td><td>21</td><td>96%</td></tr>
<tr><td>Psychology</td><td>14</td><td>14</td><td>100%</td></tr>
<tr><td>Social Work</td><td>13</td><td>13</td><td>100%</td></tr>
<tr><td>Total</td><td>77</td><td>68</td><td>88%</td></tr>
</table>

2. Monitor this requirement using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.</td></tr>
</table>

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

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

SEH Response: See data below.

Facility's Findings:

<table>
<tr><th colspan="9">IRP OBSERVATION MONITORING RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>122</td><td>140</td><td>158</td><td>208</td><td>186</td><td>188</td><td>212</td><td>167</td></tr>
<tr><td>n</td><td>19</td><td>15</td><td>12</td><td>16</td><td>22</td><td>23</td><td>22</td><td>18</td></tr>
<tr><td>%S</td><td>16</td><td>11</td><td>8</td><td>8</td><td>12</td><td>12</td><td>10</td><td>11</td></tr>
<tr><td>%C. #6. The review process includes an assessment of progress toward discharge</td><td>74</td><td>89</td><td>93</td><td>79</td><td>86</td><td>95</td><td>79</td><td>86</td></tr>
</table>
N = All IRPs scheduled
n = number audited
* Mean for indicated prior review period reflects only three months of audit data
Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: The data for this requirement reflect improving performance during the rating period. All teams received additional training in February 2011 around discharge planning, identification of discharge criteria and discharge barriers. In addition, a second quarterly training with community case managers and Hospital staff was held in February 2011, which among other things, reviewed with staff the new process for securing housing in the community. See Tab # 164 Community-Hospital Training

The Hospital will continue the IRP observation audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.</td></tr>
<tr><td>V.E.5</td><td>base progress reviews and revision recommendations on clinical observations and data collected.</td><td>Recommendations:

1. Same as in Section V.A.1 to V.A.1.5.

SEH Response: See Section V.A.1 to V.A.1.5.

2. Same as in V.B.1.

SEH Response: See Section V.B.1

3. Same as V.E.4.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See Section V.E.4

4. Monitor this requirement using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C. #7. Team bases progress reviews and revision recommendations upon clinical observation and data	53	68	88	79	95	87	**86**	**79**

N = All IRPs scheduled in the review month
n = number audited
* Data only reflects three months of audit results for the prior review period
Tab # 9 IRP OBSERVATION AUDIT RESULTS

Analysis/Action Plans: The data show that performance in meeting this requirement is not consistent and needs improvement overall. The Hospital in February 2011, based upon audit results, provided additional training to clinical administrators around updating present status in the clinical formulation and at the IRP conference, and with clinical administrators and nurse managers around developing and revising goals, objectives, and interventions. See Section V.A.3above for training data, and ***Tab # 1 for IRP training materials and data.*** In addition, the Hospital updated the format for the Psychiatric Update, effective January 2011. Under the new format, the psychiatrist now provides, among other things, an overall narrative of the current assessment and changes in symptoms and functional condition since the most recent update, indicates if the individual is progressing toward treatment goals, and describes the progress in a narrative. ***Tab # 17, Psychiatric Update form.*** This is expected to impact positively the updating of the IRP.

The Hospital will continue the monthly IRP observation audits to identify areas and or units in which additional training or

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		coaching may be needed and may identify additional actions during the upcoming review period if indicated.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.	**MENTAL HEALTH ASSESSMENTS**	
	By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible' for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	
A	**Psychiatric Assessments and Diagnoses**	
VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Recommendations:** 1. Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. SEH Response: See VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. 2. Continue to monitor the timeliness and content of psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided SEH Response: The Hospital is completing monthly audits of the Comprehensive Initial Psychiatric Assessment (CIPA) and the Psychiatric Update. ***See Tab # 36 Audit Sample Plan, Tab # 15 CIPA Audit Tool/instructions and Tab # 18 Psychiatric Update Audit Tool/instructions.*** Both audit tools were revised slightly in January, 2011 as reflected in section V.B.9 and in the audit results. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period). SEH Response: See data below. 4. Implement SEH CAP of October 7, 2010 relative to the requirements in VI.A.2. SEH Response: The Hospital modified the forms for the CIPA and the Psychiatric Update (the latter went live in Avatar

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

effective 10/31/11, with some revisions live in April, 2011, to improve the instrument even more) and the respective audit forms to track the changes to the CIPA and Psychiatric Update forms and to improve the focus on the quality of the assessments. Both types of psychiatric assessments now flow better; the Psychiatric Update now requires more narrative in key areas such as the individual's progress, his/her response to medication and other types of interventions, rationale for medication changes and integration of psychiatric and behavioral interventions, which should improve the overall quality as well. In addition, the issue with Avatar that resulted in the thought content sections of the assessments to not fully populate the report was resolved. ***See Updated Corrective Action Plan (March 4, 2011) for additional information.***

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # Data fields -CIPA completed within 24 hours of admission	100	100	100	100	100	100	**100**	**100**
%C # 4 History of presenting illness	100	100	100	100	100	100	**100**	**100**
%C #6 Medical History obtained	100	100	83	100	100	100	**91**	**98**
%C #7 Information about medication obtained	60	71	83	100	43	100	**56**	**76**
%C #8 Information about allergies obtained	86	100	83	100	86	100	**90**	**93**
%C # 9 Substance abuse assessment completed, or reason provided	100	86	100	100	100	100	**98**	**98**
%C # 10 Family history includes	100	100	83	86	100	100	**79**	**95**
%C # 11 Social and development history included	100	100	100	100	100	100	**79**	**100**
%C # 12 MSE completed	100	100	100	*	*	*	**100**	**100**
%C #12a MSE section completed (physical appearance)	100	100	100	100	100	100	**98**	**100**
%C #12b MSE section completed (eye contact)	100	100	100	100	100	100	**98**	**100**
%C #12c MSE section completed (psychomotor activity)	100	100	100	100	86	100	**98**	**98**
%C #12d MSE section completed (attitude/behavior)	100	100	100	100	100	100	**98**	**100**
%C #12e MSE section completed (speech)	100	100	100	100	100	100	**100**	**100**
%C #12f MSE section completed (Mood)	100	100	100	100	100	100	**98**	**100**
%C #12g MSE section completed (Affect)	100	100	100	100	100	100	**100**	**100**
%C #12h MSE section completed (Perception)	100	100	100	100	100	100	**88**	**100**
%C #12i MSE section completed (Thought Processes)	100	100	100	100	100	100	**98**	**100**
%C #12j MSE section completed (Thought Content)	100	29	100	100	71	100	**95**	**83**
%C #12k MSE section completed (Sensorium)	100	100	100	100	100	84	**100**	**98**
%C #12l MSE section completed (Orientation)	100	100	100	100	86	83	**98**	**95**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #12m MSE section completed (Memory)	100	100	100	100	100	83	**93**	**98**
%C # 16 Diagnosis reflects clinical presentation	100	100	100	100	100	100	**91**	**100**
%C # 17 Individual's strengths noted	86	100	100	100	100	100	**86**	**98**
%C # 18 Appropriate pharmacological plan present	100	100	100	100	100	100	**86**	**100**
%C # 19 Risk/benefits associated with medication regimen addressed	86	100	100	100	100	100	**86**	**97**
% C # 21 Labs/consultations ordered as clinically indicated	*	*	*	100	86	100	*	**95**
%C # 20 AIMS test administered	43	100	83	71	100	100	**77**	**83**

N = Admissions during the month
n = number audited- target is 20% sample per month
* No data collected for this indicator

Tab # 16 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C. #Data fields. Psychiatric update completed every 30 days	97	100	100	96	100	100	**97**	**99**
%C #3a MSE section completed (physical appearance)	100	100	100	100	100	100	**100**	**100**
%C #3b MSE section completed (eye contact)	100	100	100	100	100	100	**100**	**100**
%C #3c MSE section completed (psychomotor activity)	100	100	100	100	100	100	**100**	**100**
%C #3d MSE section completed (attitude/behavior)	100	100	100	100	100	100	**100**	**100**
%C #3e MSE section completed (speech)	100	100	100	100	100	100	**98**	**100**
%C #3f MSE section completed (Mood)	100	100	100	100	100	100	**97**	**100**
%C #3g MSE section completed (Perception)	100	100	96	96	100	96	**94**	**98**
%C #3h MSE section completed (Thought Processes)	97	100	100	100	100	100	**96**	**99**
%C #3i MSE section completed (Thought Content)	97	100	100	100	100	96	**100**	**99**
%C #3j MSE section completed (Sensorium)	100	100	100	100	100	100	**100**	**100**
%C #3k MSE section completed (Orientation)	100	100	96	100	100	100	**95**	**99**
%C #3l MSE section completed (Memory)	100	100	96	100	100	100	**96**	**99**
%C #4 Addresses significant developments since last update	*	*	*	100	100	100	*	**100**
%C # 5 Explanation for the STAT medication's benefits that outweigh their risks	*	*	*	n/a	100	100	*	**100**
%C # 6 Benefits and risks of restraint/seclusion explained	*	*	*	n/a	n/a	n/a	*	**n/a**
%C # 7 Adverse reactions noted as appropriate	81	94	100	86	88	100	**88**	**91**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 8 Specifics and rationale for two or more anti-psychotics	67	100	100	100	100	92	**89**	**94**
		%C # 9 Risk assessment sections accurately completed	100	100	100	100	100	100	**95**	**100**
		%C #10 Psychiatric update reflects response to treatment/progress	100	100	100	100	100	100	**99**	**100**
		%C # 11 Diagnosis reflects current clinical data	100	100	100	96	100	100	**98**	**99**
		%C # 12 Axes completed in dx section	100	100	96	100	100	100	**97**	**99**
		%C # 13 Documented justification for R/O or NOS diagnosis	75	78	100	100	100	75	**82**	**86**
		%C # 14 Medication side effects, benefits and risks are explained	*	*	*	100	100	100	*	**100**
		%C # 15 Justification for using anti-cholinergics with dx of cognitive disorder	100	100	88	n/a	100	100	**84**	**97**
		%C # 16 Psych Update reflects lab levels obtained at appropriate interval	88	100	100	100	100	100	**92**	**99**
		% C # 17 Follow up abnormal lab levels	97	100	100	100	96	100	**95**	**99**
		%C # 18 Pharmacological plan of care reflects diagnosis, MS assessment and response to treatment	97	100	100	96	100	100	**99**	**99**
		%C # 19 Pharmacological plan addresses monitoring of FGA or SGA for adverse reactions/side effects	100	100	100	100	100	100	**90**	**100**
		%C # 20 Rationale for use of benzodiazepines in high risk categories	100	100	100	100	100	100	**88**	**100**
		%C # 21 Update includes integration of behavioral and psychiatric interventions	100	100	100	96	100	100	**97**	**99**
		%C # 22 Psychiatric update adequately analyzes risks and benefits of chose treatment interventions.	*	*	*	96	100	100	*	**99**
		%C #23 Note by attending doctor if update completed by trainee	100	100	100	75	100	100	**83**	**98**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
* No data collected for this indicator during the month
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data show that the CIPA and the Psychiatric Updates continue to be completed in a timely manner and show high performance in most indicators. In the CIPA audits, the following indicators show progress since the last review period but further improvement is needed in several; information about current medication being obtained improved from 56% to 76%, inclusion of family history improved from 79% to 95%, social and developmental history improved from 79% to 100%, identification of strengths improved from 86% to 98%, presence of an appropriate psychopharmacological plan improved from 86% to 100%, analysis of risk/benefits of medication improved from 86% to 97% , and AIMS test administration improved from 77% to 83%. The only area of decline includes thought content of the mental status examination, but it believed that the decline is due to issues with the report function in Avatar, which was

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>resolved and the failure to use of language line for a non-English proficient individual. Similarly, the audits show improvement in the content of Psychiatric Update especially once it went live in Avatar. Thirty-two of thirty-three indicators were rated at 90% of higher.

In an effort to sustain high performance and improve performance in those areas where needed, the Hospital will continue its monthly audits of the CIPA and the Psychiatric Update. In addition, as previously mentioned, the Psychiatric Update has been revised to improve the clinical flow as part of the form's Avatar development, and "went live" in Avatar at the end of October 2010. The revised form includes additional mandatory fields, provides more prompts that focus the psychiatrist on analyzing changes since the last update in a broader range of categories and also expands the narrative for psychiatrists to address items such as progress since last update. The Psychiatric Update was modified again (slightly) in early April1` 2011, to address issues that had been identified once the form was implemented in Avatar.

See also VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.</td></tr>
<tr><td>VI.A.2</td><td>By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;</td><td>Recommendations:

1. Same as VI.A.1.

SEH Response: See VI.A.1.

2. Continue to monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: Ongoing. Risk Assessment is monitored through the CIPA audits and the IPA audits, consistent with the Audit Sample plan. See Tab # 36, Audit Sample plan; Tab # 15 CIPA Audit tool, indicator # 18 a-e; Tab # 20, IPA Audit tool/Instructions, indicators # 7a, #7b, #8a, #8b.

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

SEH Response: See below data.

Facility's findings:

<table>
<tr><th colspan="9">COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>n</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td></tr>
<tr><td>%S</td><td>23</td><td>21</td><td>19</td><td>20</td><td>21</td><td>21</td><td>19</td><td>21</td></tr>
</table></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 13 Were the following specific subsections of the risk assessment completed	100	100	100	*	*	*	**100**	**100**
a. risk of self injury	100	100	100	100	100	100	**98**	**100**
b. risk of completed suicide	100	100	100	100	100	83	**98**	**98**
c. risk of physical aggression	100	100	100	100	100	83	**100**	**98**
d. risk of sexual aggression	100	100	100	100	100	83	**100**	**98**
e. risk of elopement	100	100	100	100	100	83	**100**	**98**
%C # 14 Were appropriate precautions noted for each type of risk identified	100	100	100	100	100	100	**95**	**100**

N = Number of admissions in the month
n = number audited- target is 20% sample per month
* Data not collected for this indicator during these months
Tab # 16 CIPA AUDIT RESULTS

INITIAL PSYCHOLOGY ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	6	2	6	6	2	**5**	**5**
%S	23	18	6	17	18	7	**12**	**15**
%C #A7a Assess (screen) violence risk	100	100	100	83	100	100	**100**	**97**
#A7b Assess (screen) suicide risk	100	100	100	100	100	100	**96**	**100**
#A8a Findings violence risk	86	100	100	83	100	50	**86**	**90**
#A8b Findings suicide risk	86	100	100	100	100	100	**89**	**97**

N = Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 21 IPA AUDIT RESULTS

Analysis/Action Plans: CIPA audits continue to show excellent performance on completion of risk assessments with a mean above 90 for all sub-indicators. Similarly the audits show high levels of performance around assessing risk in the IPA, with a mean in all categories above 90%. However timeliness of the IPAs continues to be an issue – Part A is timely only 52% of the time. With the closure of the Annex, a psychologist has been assigned to provide support to three admissions units (1F, 1G and 1D) and students also now work to assist the two psychologists assigned to 1E, the civil admissions unit.

VI.A.3	By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics an Statistics Manual ("DSM") for reaching psychiatric diagnoses;	**Recommendations:** 1. Same as in VI.A.1 and VI.A.6. SEH Response: See VI.A.1 and VI.A.6. 2. Continue to monitor diagnostic accuracy in psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

4. Provide an outline of the average number of individuals in each of the following categories (during the review period compared with the previous period):
   a) All individuals in care;
   b) Individuals with "no diagnosis" on Axis I;
   c) Individuals receiving Axis I diagnosis listed as Deferred for 90 or more days;
   d) Individuals receiving Axis I diagnosis listed as R/O for 90 or more days; and
   e) Individuals receiving Axis I diagnosis listed as NOS for 90 or more days.

SEH Response: The Hospital is not yet able to provide averages for each of these categories, but continues to work on developing a report that will allow us to do so. Below is a table that provides a point in time comparison between early in the review period and at the end of the review period.

Type	September 23, 2010	April 5, 2011
Total individuals in care	314	276
Individuals with "no diagnosis" on Axis I	1	2
R/O for more than 90 days	4	0
NOS for more than 90 days	34	21
Deferred diagnosis longer than 90 days	0	0

See Tab # 157 Summary Data reports relating to Diagnoses and Medications

5. Ensure timely updates of diagnoses on AVATAR.

SEH Response: The Medical Director and/or Director of Psychiatric Services continue to monitor regularly diagnoses through management reports, with a focus on use of NOS diagnoses, R/O diagnosis or deferred diagnoses.

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # 15 Are all axes completed	100	100	100	100	100	83	**93**	**98**

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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C #16 Does the diagnosis reflect the clinical presentation</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>91</td><td>100</td></tr>
</table>
N = Number of admissions
n = number audited- target is 20% sample per month
Tab # 16 CIPA AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C #11 Diagnosis reflects current clinical data</td><td>100</td><td>100</td><td>100</td><td>96</td><td>100</td><td>100</td><td>98</td><td>99</td></tr>
<tr><td>%C #12 Are all axes completed in the diagnosis section</td><td>100</td><td>100</td><td>96</td><td>100</td><td>100</td><td>100</td><td>97</td><td>99</td></tr>
<tr><td>%C # 13 If there is a R/O or NOS diagnosis, is there an adequate justification</td><td>75</td><td>78</td><td>100</td><td>100</td><td>100</td><td>75</td><td>82</td><td>86</td></tr>
</table>
N = Census as of end of month, less month’s admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

See also Sections VI.A.1, VI.A.4 and VI.A.6

Analysis/Action Plans: CIPA audit data show the means across both relevant indicators as well above 90%. The Psychiatric Update audit shows good performance generally around diagnosis, but suggests that further improvement is needed in documenting the basis for rule/out, NOS and deferred diagnoses. However, it is clear that the Hospital continues to make good progress on diagnosis – improvement is seen in the number of individuals with a R/O diagnosis for more than 90 days, from 7 to 4; in the number with NOS diagnoses for more than 90 days (from 46 to 21) and in Axis II deferred for more than 90 days (from 7 to 0). The Hospital will continue to monitor these indicators through CIPA and the Psychiatric Update.</td></tr>
<tr><td>VI.A.4</td><td>By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;</td><td>Recommendations:
1. Same as in V.A3.

SEH Response: Same as above. See V.A.3 for related data.

Analysis/Action Plans: Same as above.</td></tr>
<tr><td>VI.A.5</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;</td><td>Recommendations:

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

SEH Response: See VI.A.1 to VI.A.3.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>2. Develop and implemented corrective actions to address the deficiencies outlined in findings above.

SEH Response: See VI.A.1 to VI.A.3.

Analysis/Action Plans: See VI.A.1 to VI.A.3.</td></tr>
<tr><td>VI.A.6</td><td>By 12 months from the Effective Date hereof, SEH shall ensure that:</td><td></td></tr>
<tr><td>VI.A.6.a</td><td>Clinically supported, and current assessments and diagnoses are provided for each individual</td><td>Recommendations:
1. Same as in VI.A.1 and VI.A.3.

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

Analysis/Action Plans: See VI.A.1 to VI.A.3.</td></tr>
<tr><td>VI.A.6.b</td><td>all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments:</td><td>Recommendations:
1. Continue to monitor implementation of this requirement in psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>n</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td></tr>
<tr><td>%S</td><td>23</td><td>21</td><td>19</td><td>20</td><td>21</td><td>21</td><td>19</td><td>21</td></tr>
<tr><td>%C # 22 Was the CIPA signed by the attending psychiatrist?</td><td>86</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td></tr>
<tr><td>%C #23 If the assessment was completed by the resident, is there a note from the attending psychiatrist?</td><td>86</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td></tr>
</table>
N = Number of admissions each month</td></tr>
</table>

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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
n = number audited- target is 20% sample per month
Tab # 16 CIPA AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 23 If completed by a resident, is there documented evidence that the Psychiatric Update was reviewed by the attending psychiatrist?</td><td>100</td><td>100</td><td>100</td><td>75</td><td>100</td><td>100</td><td>83</td><td>98</td></tr>
<tr><td>%C #24 Is there a note by the attending psychiatrist?</td><td>97</td><td>100</td><td>96</td><td>89</td><td>98</td><td>100</td><td>85</td><td>97</td></tr>
</table>
N = Census as of end of month, less month’s admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The data show much improved performance on this requirement overall and a mean above 90% for both relevant indicators. The Medical Director will continue to monitor this through monthly audits of both the CIPA and Psychiatric Updates.
</td></tr>
<tr><td>VI.A.6.c</td><td>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</td><td>
Recommendations:
1. Same as in VI.A.3.

SEH Response: See VI.A.3.

2. Continue to provide documentation of CME training during the review period, including dates and titles of courses and names of instructors and their affiliation.

SEH Response: The following Grand Rounds were held between Sept 2010 and February 2011:

<table>
<tr><th>Grand Rounds</th><th>Presenter</th><th># of Attendees</th></tr>
<tr><td>Genetic Neuropathology in Human Brain Development And Schizophrenia The Shape Of Things to Come

11/03/2010</td><td>Joel Kleinman, M.D., Ph.D.
Associate Clinical Professor,
Department of Psychiatry and Behavioral Sciences and Department of Neurology
GWU School of Medicine</td><td>Psychiatry- 18
Psychology- 0
RN- 0
Residents- 10
NP- 1</td></tr>
<tr><td>Integrating Behavioral Health and Medical Care</td><td>Andrew Kolbasovsky, PsyD, MBA
Director, Behavioral Health Strategic Planning and Disease</td><td>Psychiatry- 9
Psychology- 2
RN- 1</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

12/01/2010	Management Emblem Health	GMOs- 6 Residents- 13 Social Workers- 1 Medical Students- 5
Meeting the Needs of Families: A randomized Trial of the NAMI's Family to Family Education Program 1/05/2011	Lisa Beth Dixon, M.D., M.P.H. Professor with Tenure Department of Psychiatry University of Maryland	Psychiatry-11 Psychology- 2 Residents- 20 GMO's- 1 Medical Students -2
Psychoeducational Groups for Psychiatric Inpatients 2/2/2011	Nina W Brown Ed.D., LPC, NCC, FAGPA Professor and Eminent Scholar Old Dominion University Counseling and Human Services	Psychiatry- 11 Psychology- Residents- 17 GMO's- 2 RN-2 OT- 2
Chronic Mental Illness and Metabolic Syndrome 3/2/2011	Gloria Reeves, M.D. Assistant Professor, Psychiatry Department University of Maryland School of Medicine	Psychiatry- 21 Psychology- 1 Residents-25 GMO's-4 RN-4 Social Workers- 3 NP- 2 Medical Students- 3

See Tab # 84, Grand Rounds Training Schedule

Facility's findings:

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 13 If there is a R/O or NOS diagnosis, is there an adequate justification?	75	78	100	100	100	75	**82**	**86**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: The Hospital improved in documenting rationale for deferring diagnoses or carrying a R/O or NOS diagnosis, from 82% during the prior review period to 86% during the current review period. The Psychiatric Update was added to Avatar in October 2010, and likely contributed to this improvement, which is expected to continue with refinements made to the Update form in early April 2011. The Psychiatric Update now includes a specific prompt to address deferred or R/O diagnosis. Further, the Medical Director and Director of Psychiatric Services continue to monitor through management reports and follow those individuals with deferred Axis II or long term R/O or NOS diagnoses. While the documentation in the Psychiatric Update continues to need some improvement, it should be noted that as of March 31, 2011 no one had a R/O for longer than 30 days, and only 21 individuals have an NOS diagnosis for longer than 90 days, down from 4 and 34 respectively in March 2010. See VI.A.3 for additional information. The Hospital will continue to monitor this through the audits and management reports. The Medical Director and Director of Psychiatric Services will continue to work with individual psychiatrists on improving the documentation as indicated by the audit results.
VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Recommendations:** 1. Same as in VI.A.1 through VI.A.6.a and VI.6.c. SEH Response: See VI.A.1 through VI.A.6.a and VI.6.c. **Analysis/Action Plans:** See VI.A.1 through VI.A.6.a and VI.6.c.
VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	**Recommendations:** 1. Implement corrective actions to improve the review of clinical developments during the interval and the clinical flow of data in the Psychiatric Update. SEH Response: The Hospital implemented corrective action to address the review of clinical developments and the clinical flow of data in the Psychiatric Update. ***See Tab # 17, Psychiatric Update Form.*** The form, which went live in Avatar in late October 2010, and was refined in April 2011, was reorganized from the paper version to improve the clinical flow, incorporating the recommendations of DOJ's consultant. In addition, the section around the individual's progress was modified. A dedicated tab titled "Vital Signs" to include Weight Loss or Gain and BMI is now included. Within the tab titled "Interim History", the following information prompts are included;, *Medication Response* (Full, Partial Response, Non Response to be selected), *Psychiatric condition generally* (Improving, Unchanged, Worsening to be selected), *Overall hospital course since the last assessment* (requires a narrative); *Does IRP support goals/objectives given current condition* (yes/no) and *Describe and if no, why doesn't the IRP support goals and objectives*; *Pertinent Las/serum levels; Relevant labs; Recent Consults; Describe Recent Consults; Clinical Rating Scale (Yes/No); Clinical Rating Scales if applicable; Mental Status examination* . In addition, in the Pharmacological tab, there is a question as to whether medication changes made in response to use of *STAT medications, restraint or seclusion or medication side effects and rationale*. These changes are designed to improve the quality of the psychiatric report on progress and clinical developments. Further, the Psychiatric update now has "lightbulbs" which provide guidance to practitioners in expectations of what should be addressed in the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

various sections. Additional lightbulbs may be added.

2. Same as in VI.A.1.

SEH Response: Same as in VI.A.1.

3. Continue to monitor this requirement using the Psychiatric Update and Medication Monitoring Audits based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

Facility's findings:

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C Data fields Timeliness (every 30 days)	97	100	100	96	100	100	**97**	**99**
%C #1 Are all sections of the Subjective Findings section completed and consistent with the relevant progress notes?	100	100	100	100	98	100	**100**	**99**
%C # 5 Explanation for the STAT medication's benefits that outweigh their risks	*	*	*	n/a	100	100	*	**100**
%C # 6 Benefits and risks of restraint & seclusion explained	*	*	*	n/a	n/a	n/a	*	**n/a**
%C # 8 Specification and rationale for two or more anti-psychotics	67	100	100	100	100	92	**89**	**94**
%C # 10 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	100	100	100	100	100	100	**99**	**100**
%C #11 Does the diagnosis reflect current clinical data or was it changed or updated based upon in current clinical data	100	100	100	96	100	100	**98**	**99**
%C # 15 If the medication regimen includes use of	100	100	88	n/a	100	100	**84**	**97**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

anti-cholinergics in an individual with a dx of cognitive disorder, is there adequate justification										
%C # 16 Psych Update reflects lab levels obtained at appropriate interim	88	100	100	100	100	100	**92**	**99**
%C # 17 Evidence of appropriate follow up for abnormal results	97	100	100	96	100	100	**95**	**99**
%C # 18 Appropriate pharmacological plan present	97	100	100	96	100	100	**99**	**99**
%C # 19 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects	100	100	100	100	100	100	**90**	**100**
C% # 20 Does the psychopharmacological plan of care adequately address the use of benzodiazepines in high risk populations	100	100	100	100	100	100	**88**	**100**

N = Census as of end of month, less month's admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
* No data collected for this indicator for this month
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The data show generally excellent performance during this review period in all indicators. The Hospital took a number of actions to address deficient findings from the prior review period. The Psychiatric Update was revised and reorganized to provide a better clinical flow as well as to identify all key mandatory fields and to incorporate recommendations made by DOJ's psychiatric consultant and the new form was added to Avatar in October 2010; refinements were effective April 2011. Further, the audits continue each month, and the Medical Director and the Director of Psychiatric Services are able to address deficiencies on an individual basis and work with a particular psychiatrist if needed. Psychiatrists also participated in training around discharge criteria and discharge planning, which provided a better framework for their assessments and the relationship to the development of the clinical formulation and IRP.

Finally it should be noted that there were two cases identified during the review period where at first blush, there appeared to be a PRN order for psychiatric medications. However, upon examination those orders were only written to permit an injection if the individual declined oral medications, and in both cases, the guardian consented to that practice.

B.	Psychological Assessments (these assessment may be completed by psychologists or graduate students, in psychology under the supervision of psychologists.)	
VI.B.1	By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk	**Recommendations:** 1. Determine the barriers to the timely completion of IPAs, both Part A and Part B and the timely completion of neuropsychological assessments and implement appropriate corrective action plan. SEH Response: The Department of Psychology continues to address timeliness issues in completing IPAs. Currently, the civil admissions unit is staffed with two full time psychologists, and each admissions unit serving forensic admissions has an

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	assigned psychologist. In addition, with the closure of the Annex, the Director of Psychology has assigned two psychologists to assist the three admission units primarily serving forensic individuals, and also assigned a number of trainees to provide additional support to the admission unit that serves civil admissions as needed in completing the IPAs. He continues to monitor this and will make further assignments as needed. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's findings:**

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	6	2	6	6	2	**5**	**5**
%S	23	18	6	17	18	7	**12**	**15**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	43	33	100	67	67	0	**50**	**52**
%C # 1 (Part B) If Part B completed within 12 days of admission?	14	50	50	83	33	50	**64**	**45**

N = Number of admissions
n = number audited-target is 20% sample (Audit sample plan)
Tab # 21, IPA AUDIT RESULTS

RISK ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	3	3	4	2	3	7	**3.3**	**3.7**
n	1	1	2	1	1	4	**1.2**	**1.8**
%S	33	67	50	50	33	57	**35**	**50**
%C # 1 Completed within 30 days of receipt of referral?	0	0	50	0	0	25	**40**	**18**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	9	13	10	9	5	11	**33**	**57**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	3	5	n/a	11	40	18	**24**	**23**
%S	33	38	n/a	11	40	18	**24**	**23**
%C # 1 Completed within 30 days of receipt of referral?	0	60	*	100	100	50	**100**	**54**

N= Number of referrals in the month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

NEUROPSYCHOLOGICAL AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	4	8	2	1	4	6	**7**	**4.2**
n	2	2	2	1	2	1	**2**	**1.7**
%S	50	25	100	100	50	17	29	**40**
%C # 1 Completed within 45 days of receipt of referral?	0	50	100	100	100	100	**33**	**70**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital is providing the full range of psychological evaluations and the quality remains high. See VI.B generally for additional data reflecting other indicators from audits. Some modifications to the audit tools for the Risk Assessment and the Psychological Evaluations peer review tools were introduced in October 2010, as a result of the audit experiences and were revised again in March 2011. ***See Tab # 20 IPA Audit Tool, Tab # 22 Neuropsychological, Psychological Evaluation, and Risk Assessment Audit or Peer Review Tools.***

The primary issues in meeting this requirement is not quality, but are in the timely completion of the IPAs, risk assessment evaluations and psychological evaluations (neuropsychology has made significant improvement in timely completion of assessments), and in ensuring that completed evaluations remain in the medical record. The Hospital has undertaken several steps to address these issues. First, to address the latter issue, beginning in late January 2011, the Hospital began phasing in the FILENET, a system by which all non-electronic records are forwarded to Medical Records for scanning into the medical record; as scanned records, the evaluations will be accessible through a link and will not be able to be removed.

There are multiple strategies around improving the timeliness of psychological evaluations. With the closure of the Annex, the Director of Psychology has assigned two psychologists as “floaters” to assist the forensic admission units, and several trainees provide additional support to the civil admission unit as needed in completing the IPAs. He continues to monitor this and will make further assignments as needed. Unfortunately, there have not been sufficient resources available to fill the psychology positions previously identified, although the closure of the Annex has freed up one unit based psychologist.

VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments, shall:	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Recommendations:** 1. Change the audit form for neuropsychological assessments to include an audit of the referral question/purpose of the assessments. SEH Response: Completed as of November 2010. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's findings:**

RISK ASSESSMENT PEER REVIEW RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	3	3	4	2	3	7	**3.3**	**3.7**
n	1	1	2	1	1	4	**1.2**	**1.8**
%S	33	67	50	50	33	57	**35**	**50**
%C # 3a. Referral question is clearly stated	100	100	100	100	100	100	**86**	**100**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	9	13	10	9	5	11	**33**	**57**
n	3	5	n/a	11	40	18	**24**	**23**
%S	33	38	n/a	11	40	18	**24**	**23**
%C # 3a Referral question, purpose of evaluation and what information is to be provided is clearly stated?	100	100	*	0	100	100	**63**	**92**

N= Number of referrals during the month
n = number audited-target is 1 per psychologist who completes them (Audit sample plan)
* No data collected for this indicator during this month
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Audits will continue and psychology will monitor data and trends. Psychologists are being

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>reminded of the standards for completion of the evaluations. No other actions required.</td></tr>
<tr><td>VI.B.2.b</td><td>be based on current, and accurate data;</td><td>

Recommendations:

1. Maintain current level of practice.

SEH Response: Level of practice maintained.

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

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">RISK ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>3</td><td>3</td><td>4</td><td>2</td><td>3</td><td>7</td><td>3.3</td><td>3.7</td></tr>
<tr><td>n</td><td>1</td><td>1</td><td>2</td><td>1</td><td>1</td><td>4</td><td>1.2</td><td>1.8</td></tr>
<tr><td>%S</td><td>33</td><td>67</td><td>50</td><td>50</td><td>33</td><td>57</td><td>35</td><td>50</td></tr>
<tr><td>%C # 6a Lists psychological tests, specific risk assessment tools, interview and duration and collateral interviews?</td><td>100</td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>86</td><td>91</td></tr>
<tr><td>%C # 6b Lists records reviewed?</td><td>100</td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>100</td><td>91</td></tr>
<tr><td># 6c Uses multiple sources of information from each area that is being assessed</td><td>100</td><td>100</td><td>*</td><td>100</td><td>100</td><td>*</td><td>100</td><td>100</td></tr>
</table>

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* No data collected for this indicator during this month
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>9</td><td>13</td><td>10</td><td>9</td><td>5</td><td>11</td><td>33</td><td>57</td></tr>
<tr><td>n</td><td>3</td><td>5</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%S</td><td>33</td><td>38</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%C #6a Lists interviews, record reviews, structured clinical inventories, observational methods and tests administered?</td><td>100</td><td>100</td><td>*</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 6b Tests chosen are appropriate to referral question and patient characteristics	100	100	*	0	50	100	**63**	**85**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* No data collected for this indicator during this month
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Data show high or improving practice. Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations. No other actions required.

VI.B.2.c provide current assessment of risk for harm factors, if requested;

Recommendations:

1. Maintain current level of practice.

SEH Response: Level of practice maintained.

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

SEH Response: See data below.

Facility findings:

RISK ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	3	3	4	2	3	7	**3.3**	**3.7**
n	1	1	2	1	1	4	**1.2**	**1.8**
%S	33	67	50	50	33	57	**35**	**50**
% C # 13 a Summary/discussion that integrates all the data gathered into a clear clinical picture is present	100	100	100	100	100	100	**100**	**100**
%C #13 b Referral question is answered	100	100	100	100	100	100	**100**	**100**
%C # 13c Conclusions about the patient's risk status are stated?	100	100	100	100	100	100	**100**	**100**
%C # 13 d Conclusions and risk management (including and treatment) recommendations flow naturally from the risk factors identified in the report	100	100	100	100	0	100	**100**	**90**
%C #13e Clinician distinguishes between strategies for addressing stable and acute risk factors?	100	100	100	100	100	100	**67**	**100**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS **Analysis/Action Plans:** Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations. No other actions required.
VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment, and	**Recommendations:** 1. Identify barriers to providers directly addressing the referral question in focused psychological assessments and institute a corrective action plan. SEH Response: The Hospital is monitoring this through audits and improvement is noted, particularly in regard to psychological evaluations. The Director of Psychology is providing feedback as needed and is reminding staff during departmental meetings. 2. Identify barriers to IPA providers recommending specific groups and institute a corrective action plan. SEH Response: Guidelines for the IPA have been revised, effective October 1, 2010, and staff are now expected to recommend specific groups as part of completion of the IPA. This is tracked through the IPA audits, part B. ***Tab #20 IPA audit instructions.*** Results from the IPA audits, Part B suggest improvement has been made. ***See Tab # 21 IPA Audit Results*** 3. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's findings**

RISK ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	3	3	4	2	3	7	**3.3**	**3.7**
n	1	1	2	1	1	4	**1.2**	**1.8**
%S	33	67	50	50	33	57	**35**	**50**
%C #4a First sentence provides any bottom line recommendations	100	100	100	100	100	100	**67**	**100**
%C #4b Paragraph summarizes conclusions and recommendations sections	100	100	100	100	100	100	**50**	**100**
% C #13b Referral question is answered	100	100	100	100	100	100	**100**	**100**
N= Number of risk assessment referrals in month								

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>9</td><td>13</td><td>10</td><td>9</td><td>5</td><td>11</td><td>33</td><td>57</td></tr>
<tr><td>n</td><td>3</td><td>5</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%S</td><td>33</td><td>38</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%C #4a First sentence provides any bottom line recommendations</td><td>33</td><td>100</td><td>*</td><td>0</td><td>100</td><td>50</td><td>0</td><td>69</td></tr>
<tr><td>%C #4b Paragraph summarizes conclusions and recommendations sections</td><td>67</td><td>100</td><td>*</td><td>0</td><td>100</td><td>50</td><td>0</td><td>77</td></tr>
</table>
N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* No data collected for this indicator during this month
Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations. No other actions required.</td></tr>
<tr><td>VI.B.2.e</td><td>include a summary of the empirical basis for all conclusions, where possible.</td><td>Recommendations:

1. Maintain current level of practice.

SEH Response: Level of practice maintained.

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

SEH Response: See VI.B.2.b.

Analysis/Action Plans: Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations and the Chief Psychologist will also work with staff in selecting the appropriate tests and instruments. No other actions required.</td></tr>
<tr><td>VI.B.3</td><td>By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and,</td><td>Recommendation:
1. None needed.

SEH Response: None needed.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>if indicated, referred for additional psychological assessment.</td><td></td></tr>
<tr><td>VI.B.4</td><td>By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.</td><td>Recommendations:

None needed.

SEH Response: None needed.</td></tr>
<tr><td>VI.B.5</td><td>By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.</td><td>Recommendations:

1. Determine barriers to completing the acknowledgement sheet and institute corrective action plan.

SEH Response: This continues to be an issue for the Hospital. Treatment team members seem reluctant to sign the acknowledgment before reading the results, even though it is clear it is just a receipt acknowledgment. The Hospital is considering eliminating this form, as the increased participation of psychologists in the IRPs is improving communication, and as psychological evaluations will now be scanned into the record through FILENET, and thus their availability to teams will be ensured.

2. Develop a method for auditing these sheets for completeness.

SEH Response: See response to Recommendation # 1.

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

SEH Response: See data below.

Facility’s findings:

<table>
<tr><th colspan="9">RISK ASSESSMENT PEER REVIEW RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>3</td><td>3</td><td>4</td><td>2</td><td>3</td><td>7</td><td>3.3</td><td>3.7</td></tr>
<tr><td>n</td><td>1</td><td>1</td><td>2</td><td>1</td><td>1</td><td>4</td><td>1.2</td><td>1.8</td></tr>
<tr><td>%S</td><td>33</td><td>67</td><td>50</td><td>50</td><td>33</td><td>57</td><td>35</td><td>50</td></tr>
<tr><td>%C # 16a Acknowledgement of receipt of report and recommendations is attached as last page of the evaluation</td><td>100</td><td>50</td><td>50</td><td>100</td><td>100</td><td>75</td><td>80</td><td>73</td></tr>
</table>
N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)</td></tr>
</table>

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

Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

<table>
<tr><th colspan="9">PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>9</td><td>13</td><td>10</td><td>9</td><td>5</td><td>11</td><td>33</td><td>57</td></tr>
<tr><td>n</td><td>3</td><td>5</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%S</td><td>33</td><td>38</td><td>n/a</td><td>11</td><td>40</td><td>18</td><td>24</td><td>23</td></tr>
<tr><td>%C #14a Acknowledgement of receipt of report and recommendations is attached to the last page of evaluation and fllled out.</td><td>67</td><td>100</td><td>*</td><td>0</td><td>100</td><td>100</td><td>33</td><td>85</td></tr>
</table>

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
* No data collected for this indicator during this month

Tab # 30 PSYCHOLOGICAL AND RISK ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Upon completion of each psychological assessment, the psychologist usually meets with the clinical administrator to review the results, and the clinical administrator should be signing the acknowledgement of receipt of the report and recommendations. In addition, each treatment team is supported by a psychologist who is available on an ongoing basis to provide further guidance to teams about the results of various assessments. Psychologists attended over 77% of IRP conferences, (***see Tab # 9 IRP Observation results)*** and were available to meet with teams about evaluation results. It should be noted that the 77% attendance rate reflects that during the review period, two psychologists were out on maternity leave.

</td></tr>
<tr><td>VI.C</td><td>Rehabilitation Assessments</td><td></td></tr>
<tr><td>VI.C.1</td><td>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.</td><td>

Recommendations:

1. Continue with present corrective action plan.

SEH Response: Corrective action plan implemented.

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

SEH Response: See data below.

Facility's findings:

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">REHABILITATION ASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>3</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td></tr>
<tr><td>%S</td><td>45</td><td>41</td><td>44</td><td>40</td><td>42</td><td>48</td><td>36</td><td>43</td></tr>
<tr><td>%C # Completed within 5 days of admission</td><td>93</td><td>93</td><td>100</td><td>100</td><td>100</td><td>86</td><td>84</td><td>95</td></tr>
<tr><td>%C # 2 Level of functioning - leisure</td><td>93</td><td>93</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td></tr>
<tr><td>%C # 3 Level of functioning - perceptual</td><td>93</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
<tr><td>%C # 4 Level of functioning – cognitive</td><td>93</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td></tr>
<tr><td>%C # 5 Level of functioning - psychosocial</td><td>79</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>96</td></tr>
<tr><td>%C # 6 Level of functioning – motor skills</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C # 7 Level of functioning - behavior</td><td>86</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td><td>98</td></tr>
</table>
N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 25 REHABILITATION SERVICES ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Staff were redeployed to ensure timely completion of the initial rehabilitation assessment and data show a high level of performance. Training was held with rehabilitation services staff on new guidelines and the quality and consistency of the assessments improved. Audits also show strong performance in all indicators. Audits will continue, and if a trend appears (i.e. specific staff struggle with portions of the Assessment), additional support will be provided. See also Corrective Action Plan.
</td></tr>
<tr><td>VI.C.2</td><td>By 24 months from the Effective Date hereof, all rehabilitation assessments shall:</td><td></td></tr>
<tr><td>VI.C.2.a</td><td>be accurate as to the individual's functional abilities;</td><td>Recommendation:
1. Maintain current level of practice.

SEH Response: Level of practice maintained. See data in VI.C.1.</td></tr>
<tr><td>VI.C.2.b</td><td>identify the individual's life skills prior to, and over the course of, the mental illness or disorder;</td><td>Recommendation:

Maintain current level of practice.

SEH Response: Level of practice maintained. See data below.

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

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">REHABILITATION ASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>3</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td></tr>
<tr><td>%S</td><td>45</td><td>41</td><td>44</td><td>40</td><td>42</td><td>48</td><td>36</td><td>43</td></tr>
<tr><td>%C # 9 Were the individual's life skills perspectives prior to and over the course of mental illness/disorder identified?</td><td>93</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>98</td><td>99</td></tr>
</table>
N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 25 REHABILITATION SERVICES ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The data show excellent performance. Audits will continue. No further actions required.
</td></tr>
<tr><td>VI.C.2.c</td><td>identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and</td><td>
Recommendation:
1. Maintain current level of practice.

SEH Response: Practice level maintained.

Facility's findings:

<table>
<tr><th colspan="9">REHABILITATION ASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>3</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td></tr>
<tr><td>%S</td><td>45</td><td>41</td><td>44</td><td>40</td><td>42</td><td>48</td><td>36</td><td>43</td></tr>
<tr><td>%C # 10 Does the assessment include the individual's self-reported interests and activities?</td><td>79</td><td>93</td><td>100</td><td>93</td><td>100</td><td>100</td><td>96</td><td>94</td></tr>
</table>
N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 25 REHABILITATION SERVICES ASSESSMENT AUDIT RESULTS

See also VI.C.2.a.

Analysis/Action Plans: The data continue to show excellent performance. Audits will continue. No further actions required.
</td></tr>
<tr><td>VI.C.2.d</td><td>provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.</td><td>
Recommendations:
Continue to present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>correction. Supporting documents should be provided.

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">REHABILITATION ASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
<tr><td>n</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td><td>14</td></tr>
<tr><td>%S</td><td>45</td><td>41</td><td>44</td><td>40</td><td>42</td><td>48</td><td>36</td><td>43</td></tr>
<tr><td>%C # 11 Were specific rehabilitative strategies identified to engage the individual in appropriate activities that are viewed as personally meaningful and productive?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>93</td><td>95</td><td>99</td></tr>
</table>
N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 25 REHABILITATION SERVICES ASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The data continue to show excellent performance. Audits will continue. No further actions required.</td></tr>
<tr><td>VI.C.3</td><td>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.</td><td>Recommendation:
1. None needed.</td></tr>
<tr><td>VI.D</td><td>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.</td><td>Recommendations:

1. Continue with current corrective action plan.

SEH Response: The corrective action plan submitted in October 2010 was implemented by social work, but based upon the audit results, it was modified when audits suggested additional strategies were needed. See CAP dated March 3.2011.

Audit results over the six months raised a number of issues that social work leadership is addressing. First, they reviewed audit results for inter rater reliability issues, and determined that instructions for the initial assessment and update forms and audit tools were in need of modification. See Tab # 31 Social Work Initial Assessment Form Instructions (prior and updated version), # 34 Social Work Update Form Instructions (prior and updated versions), Tab # 32 SWIA audit tool</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

(prior and updated versions), and # 35 Social Work Update Audit Tool (prior and updated versions). In addition, all social work staff participated in training on completion of an initial assessment, led by supervisors and supported by the consultants. This was followed by social work and clinical administrators jointly working on a clinical formulation around discharge planning and discharge criteria and the relationship between this part of the clinical formulation and the social work updates. This training was in addition to the training the social workers attended with their entire teams around discharge planning and described in V.A.3.

Social worker attendance at IRPs is improved, although not consistently at expected levels.

While audit results are shared with individual workers, they will also be presented at the monthly social worker meetings.

The Hospital currently has one social work vacancy, although with the closing of the Annex, all units have one dedicated social worker, except for the civil admissions unit which has two social workers.

2. Specify in the directions for the SWIA that the section on discrepancies must contain an entry, even if the entry is "No discrepancies were identified."

SEH Response: Completed. This was also discussed in the training on completion of the SWIA in which all social workers participated.

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

SEH Response: See data below.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	7	7	7	7	6	**8**	**7**
%S	19	21	22	20	21	21	**20**	**21**
%C # Completed within 5 days of admission	83	57	86	86	71	83	**60**	**78**
%C # 2 Discrepancies in social history and efforts to resolve them	n/a	0	0	0	100	n/a	**50**	**20**
%C # 3 Explanation for conclusion about discrepancies	n/a	0	0	0	100	n/a	**50**	**20**
%C # 4 Treatment goals and discharge plans reflect strengths and limitations	67	57	57	71	86	83	**80**	**70**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 5 Assessment includes discussion of individual's goals and whether they are realistic/achievable.	83	43	57	71	71	83	**76**	**68**
%C # 6 Social work interventions are specific and individualized, reflect frequency and are related to treatment goals and discharge planning	67	43	71	86	43	67	**78**	**63**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 33 SOCIAL WORK AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	267	271	265	266	246	**280**	**266**
n	13	11	13	11	11	14	**10**	**12**
%S	5	4	5	4	4	6	**4**	**5**
%C # 1 Progress note(s) indicate contact with family, significant others, and their support towards individual's progress and discharge plan.	85	64	82	70	100	64	**82**	**77**
%C # 2 Documentation of intervention is descriptive	77	91	77	91	64	50	**88**	**74**
%C # 3 Individual's expressed goals, concerns and perception of progress related to treatment and discharge goals (in individual's own words)	92	82	92	82	91	86	**98**	**88**
%C # 4 Description of progress toward discharge	69	45	69	82	55	79	**87**	**67**
%C # 5 Description of case manager's involvement in discharge planning and contact with individual	91	67	62	91	80	93	**86**	**81**
%C #6 Status of discharge barriers	62	91	85	82	91	71	**87**	**79**
%C # 7 Assessment of services needed for discharge planning	54	45	62	36	55	79	**65**	**56**
%C Timely completions	100	100	100	100	100	100	**100**	**100**

N= Census at end of month less admissions
n = number audited-target is 1 per social worker (Audit sample plan)
Tab # 33 SOCIAL WORK AUDIT RESULTS

See Also Chapter VII. For specific indicators around d/c planning.

Analysis/Action Plans: The social work initial assessment audits show a decline in performance in many key indicators, including identifying and resolving discrepancies in social history, identification of treatment goals and discharge plans that reflect the individual's strengths and limitations, and developing interventions that are specific, individualized and relate to goals and discharge planning. Improvement was noted in timeliness of social work initial assessments. In addition, the social work update audit also shows in most indicators a decline in performance. As noted, social work leadership has worked aggressively to address these issues. First, with line workers, supervisors reviewed the social work guidelines that should assist workers in completing the forms and determined significant changes to those guidelines/instructions were

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		needed; these were made and effective April 1, 2011. Second, the audit tools were reviewed and the two auditors reviewed several of the same cases to determine if inter-rater reliability issues existed; based upon that review, a decision was made to revise the audit tools and create instructions that better relate to the instructions used by the social workers in completing the forms. Third, social work staff, supported by the consultants, reviewed and completed a social work initial assessment. Fourth, social workers attended two trainings focused on their roles around discharge, and how their assessments and updates link to discharge planning in the IRP. One training was with the entire treatment team as a unit (and involved working on a case) and the second was with clinical administrators and focused on the clinical formulation development. Thus, social work has new instructions for the social work initial assessment and update (***tab ##s 31 and 34)***, new audit tools and instructions ***(tab ##s 32 and 35)*** and written examples that social workers and clinical administrators are able to use in developing discharge criteria, plans and identifying barriers. ***See Tab # 1 IRP Training documents***

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

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

SEH Response: IRP process monitoring continues. See Tab # 9 IRP OBSERVATION AUDIT RESULTS.

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

SEH Response: The Hospital provides an IRP overview that includes discussion around discharge planning as part of new employee orientation and recently also began training newly hired individuals on each module of the IRP training on a quarterly basis. The Hospital determined that the intensive training included in the IRP modules would make more sense to new staff after several months at the Hospital rather than including all the training in the new employee orientation. Data may be available on the quarterly trainings during the DOJ visit.

In addition, the Hospital in February 2011 provided a two hour training to all members of the treatment team around discharge planning. Taking an actual case, the teams developed discharge criteria, identified discharge barriers and reviewed discharge plans as part of the training. In addition, social workers and clinical administrators received an additional session when they jointly reviewed the clinical formulation around discharge planning as well as how the social work update complements that document.

<table>
<tr><th colspan="3">Engagement and Community Integration II (1 and ½ hours)</th><th>09/01/10 ~ 03/15/11</th></tr>
<tr><th>Discipline</th><th># Required</th><th># Attended</th><th>% Attended</th></tr>
<tr><td>Clinical Administrator</td><td>12</td><td>12</td><td>100%</td></tr>
<tr><td>Nursing - Nurse Manager</td><td>16</td><td>8</td><td>50%</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Psychiatry	22	21	96%
Psychology	14	14	100%
Social Work	12	12	100%
Total	**76**	**67**	**88%**

Discharge Planning - IRP Module IV					9/01/2010 ~ 3/15/2011
Discipline & Number of Hours	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator (15)	12	12	12	100%	100%/100%
Nurse Manager (15)	16	16	16	100%	100%/100%
Psychiatry (15)	21	21	21	100%	100%/100%
Psychology (15)	14	14	14	100%	100%/100%
Social Work (15)	12	12	12	100%	100%/100%
Total	**75**	**75**	**75**	**100%**	**100%/100%**

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

See Tab #1 for IRP Training Data and Materials

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	7	7	7	7	6	**8**	**7**
%S	19	21	22	20	21	21	**20**	**21**
%C # 7 All areas of discharge criteria are described in detail as to what is needed	50	57	57	71	86	67	**87**	**65**
%C # 8 Community support needs are addressed in all areas and are individualized	67	43	86	71	86	67	**98**	**70**
%C # 9 Description of discharge barriers	83	71	100	100	67	100	**98**	**87**
%C # 10 Identification of skills needed for discharge	50	57	57	71	71	50	**89**	**60**
%C # 11 Descriptive identification of discharge needs, i.e. housing, medical, financial, day program, employment, and aftercare needs	83	43	71	43	71	33	**93**	**58**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Tab # 33 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C # 8 SEH shall provide the individual the opportunity beginning at the time of admission and continuously throughout the individual's stay, to be an active participant in the discharge planning process, as appropriate	71	84	93	93	100	100	**86**	**90**

N = All IRP reviews scheduled in the month
n = number audited
* Mean during this audit period was based upon only three months of audits
** Sample size target is 2 per unit (Audit Sample plan)

Tab # 9 IRP OBSERVATION AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	184	**176**	**194**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C # 8 The clinical formulation considers such factors as age, gender, culture, treatment adherence and medication issues that may affect the outcomes of treatment and rehabilitation interventions.	88	95	100	100	95	96	**74**	**96**
%C. # 10 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?	26	74	61	67	45	68	**52**	**57**
%C # 11 The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.	65	96	74	72	68	80	**68**	**76**

N = IRP reviews scheduled during month
n = number audited
* Mean during the prior audit period was based upon only two months of audits

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

** Sample size target is 2per unit (Audit sample plan)

Tab # 3 CLINICAL CHART AUDIT RESULTS

DISCHARGE MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	17	17	20	22	15	22	**21**	**19**
n	4	4	5	5	4	5	**5**	**5**
%S	24	24	25	23	27	23	**24**	**24**
%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?	100	75	80	100	75	100	**78**	**89**
%C # 21 Identified individual to assist with interventions.	100	75	80	100	75	100	**67**	**89**
%C # 22 Timeframes and duration for completion of interventions	100	75	80	100	100	80	**11**	**89**

N = All discharges in the month

n = number audited

* March audits were excluded because findings were based upon prior audit tool that was substantially different than the current tool. A mean from the prior review period is not available due to the change in the tool.

n/a –These indicators were added to tool beginning for July audits

Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As the various audit results suggest, the Hospital improved its effective discharge planning from the time of admission but still has additional steps to take before it will consistently meet the Settlement Agreement's requirement. The Hospital provide training for the treatment teams around discharge planning in September 2010 which was a dedicated module in a weeklong training involving didactic, observation and coaching of all treatment teams. This was supplemented by an additional discharge related training completed in February 2011, in which each team presented a case and was trained in how to develop discharge criteria and discharge plans and to identify discharge barriers. In addition, in March 2011, social workers and clinical administrators were trained on the linkages between social work updates and the discharge piece of the clinical formulations. Social workers also, as a discipline, participated in a training specifically addressing completion of the SWIA. Finally, the Social Work department partnered with the DMH Division of Integrated Care on a second training, a half day workshop for social workers and community case managers/clinical directors. ***See Tab # 164 Community Hospital Joint Trainings.*** Similarly workshops will occur at least three times per year.

Social work also modified its instructions for social workers on how to complete the SWIA and Social Work Updates to provide additional clarity, and modified its audit tools and developed instructions to complement each of the revised form instructions. Finally social work also developed examples of discharge criteria and plans to assist workers and teams in addressing discharge issues. ***See Tab # 1 IRP Training material Discharge Documentation examples.***

The Hospital will continue with its discipline and discharge audits to identify areas of strengths and areas in need of

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>improvement.</td></tr>
<tr><td>VII.A.1</td><td>those factors that likely would result in successful discharge including the individual's strengths, "preferences, and personal goals;</td><td>Recommendation:
1. See VII.A

SEH Response: See VII.A

Analysis/Action Plans: See VII.A.</td></tr>
<tr><td>VII.A.2</td><td>the individual's symptoms of mental illness or psychiatric distress;</td><td>Recommendation:
1. See VII.A. and VII.A.1

SEH Response: See VII.A. See also additional data below.

2. The IRP process can be improved by better integrating a comprehensive assessment and diagnosis, including symptoms of mental illness, into identifying specific behavioral and clinical interventions that ready individuals for transitioning to the community and discharge planning.

SEH Response: The Hospital provided each treatment team with additional training around discharge planning. Using a real case, treatment teams, with the consultant trainers, were provided training on developing discharge criteria, discharge plans and identifying discharge barriers. Teams focused on learning how to better identify the skills the individual needs to be discharged, the steps the staff need to take with the individual to effect discharge, and the systemic issues that must be addressed as part of discharge. All members of the team were trained together. See Tab # 1, Training data and materials. Clinical administrators also received additional training on developing the present status section of the clinical formulation, as well as writing the IRPs themselves – writing focus statements, goals, objectives and interventions. See Tab # 1, Training data and materials. Clinical administrators and social workers also were teamed and trained on the discharge related sections of the IRP, and how those link to the social work initial assessments and updates.

In addition the Psychiatric Update was modified to improve the clinical flow and also now includes a specific prompt which requires the psychiatrist to assess the individual’s progress toward treatment goals; it also includes a specific prompt as to whether the IRP supports the goals and objectives given the individual’s current condition. See Tab # 17, Psychiatric Update Form

Facility’s findings:

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C. # 10 Does the psychiatric update accurately reflect</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>99</td><td>100</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		the individual's response to treatment/progress N = Census minus monthly admissions n = number audited Target sample is 1 per unit based psychiatrist ***Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS*** **Analysis/Action Plans:** See VII.A,, VII.A.1 and VII.A.3. See also cells at sections V.B.7, V.C.6, V.C.7 and V.D.1. The audit data show excellent performance, and audits will continue.
VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Recommendations:** 1. The hospital should implement the additional planned hospital/community seminars in order to increase understanding of community resources and the skills necessary for a consumer to be successful. SEH Response: A second joint hospital and community seminar was held in February 2011, and a third is planned for early June. ***See Tab # 164 Community/Hospital training materials.*** The February workshop focused on community housing to include voucher process, CRF applications and approval process, the elderly and physical disabilities waivered services, and the forensic process from A to Z. This supplemented the initial training provided in October 2010 which reviewed the range of options available for individuals upon their discharge The Hospital provided each treatment team with additional training around discharge planning. Using a real case, treatment teams were provided training on developing discharge criteria, discharge plans and identifying discharge barriers. Teams focused on learning how to better identify the skills the individual needs to be discharged, the steps the staff need to take with the individual to effect discharge, and the systemic issues that must be addressed as part of discharge. All members of the team were trained together. ***See Tab # 1, Training data and materials.*** 2. The hospital should consider implementing a process to review the clinical and discharge needs of individuals with multiple admissions. SEH Response: SEH and DMH reviewed the record of those individuals (total = 6) who have been admitted at least 3 times in the past year to examine the circumstances surrounding treatment in the community and the outplacement process from the hospital. All four civil individuals have been reviewed, as well as two other civil individuals. While specific issues related to each individual are addressed as both the hospital and community teams are present, the intent of the meeting is to identify any systemic issues that impact on length of stay in the community. 3. SEH Corrective Action Plan, Action Steps should be implemented and monitored. SEH Response: Ongoing. The Chief of Staff monitors implementation of all aspects of the CAP.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	7	7	7	7	6	**8**	**7**
%S	19	21	22	20	21	21	**20**	**21**
%C # 9 Description of discharge barriers	83	71	100	100	67	100	**98**	**87**

N= Number of admissions in the month
n = Target is 20% of admissions
Tab # 33 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	267	271	265	266	246	**280**	**266**
n	13	11	13	11	11	14	**10**	**12**
%S	5	4	5	4	4	6	**4**	**5**
%C # 6 Status of discharge barriers	62	91	85	82	91	71	**87**	**79**

N= Census at end of month less month's admissions
n = number audited-target is 1 per social worker(Audit sample plan)
Tab # 33 SOCIAL WORK UPDATE AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	184	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. # 10 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?	26	74	61	67	45	68	**52**	**57**
%C # 11 The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.	65	96	74	72	68	80	**68**	**76**

N = All IRPs scheduled in the review month
n = number audited. Target sample is 2 per unit

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
* The mean is based only upon two months of audits for the review period indicated
Tab # 3 CLINICAL CHART AUDIT RESULTS

<table>
<tr><th colspan="9">Census and 30-Day Readmissions*</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>Individuals in Care – Daily Average</td><td>313</td><td>308</td><td>303</td><td>300</td><td>299</td><td>292</td><td>319</td><td>302</td></tr>
<tr><td>Discharges</td><td>33</td><td>38</td><td>36</td><td>37</td><td>35</td><td>53</td><td>38</td><td>32</td></tr>
<tr><td># 30-day Readmissions</td><td>4</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2.3</td></tr>
<tr><td>% 30-day Readmissions</td><td>12.1%</td><td>5.3%</td><td>5.6%</td><td>5.4%</td><td>5.7%</td><td>3.8%</td><td>5.3%</td><td>7.2%</td></tr>
</table>
*National Public Rate (NPR) of 30-day readmission: 7.8%, NASMHPD Research Institute, December 2010
See Tab # 53 PRISM Report

Analysis/action steps: The Hospital has made significant strides in discharging individuals in care- - so much so that it was able to close the Annex by the end of February 2011. Average daily census declined in each month of the review period, and the average daily census in February 2011 was 292. This has been accomplished with a rehospitalization rate that generally falls below the national public rate.

In addition, psychiatric, social work and the clinical chart audits show an improving trend around identifying discharge barriers and improving IRPs to address these issues. Because it was recognized, however, that IRPs were not yet at the standard expected around ensuring discharge barriers were being addressed, additional discharge related training was provided to all treatment teams in February 2011 and extensive coaching has been provided to all teams around the content of the clinical formulation and IRPs. A follow up training for social workers and clinical administrators around discharge planning was also held with a focus on the linkages between the social work update and the completion of the discharge sections of the clinical formulation. This will continue to be monitored through the identified audits, and additional actions will be taken as needed.
</td></tr>
<tr><td>VII.A.4</td><td>the skills necessary to live in a setting in which the individual may be placed.</td><td>
Recommendations:

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

SEH Response: Ongoing. TLC group assignments are made utilizing the IPA, the clinical formulation, IRPs and progress notes, and the individual in care is observed during the week long orientation as part of the process in matching the individual to TLC groups. In addition, the TLC will be reviewing the curricula to ensure they reflect appropriate functional levels.

2. Working with DMH and community agencies, SEH should identify and expedite transitional activities in the community for individuals considered discharge ready. These activities should include attending day programs, public transportation training, visiting potential housing programs, visiting the community, establishing therapeutic relationships pre-discharge, etc. A specific community integration plan that increases the consumer's involvement in community services and supports over time could be developed to expedite successful discharge.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: The Hospital provides a full array of supports and activities to support transition to the community. There are a number of discharge related groups at the TLCs including:

- Travel Training (RT)
- Bridges (Transition specialists)
- WRAP (Consumer Action Network)
- Discharge Planning (social work)
- Principles of Recovery/ Recovery Process (Consumer Affairs)
- Art Therapy and Community Re-Entry
- Community Living Skills (OT)
- Community Awareness/Community Re-Entry (RT Trip)
- Community Outings (RT Trip)
- Takoma Park (RT Trip, occurs weekly)
- Exploring the Community (RT Trips)
- Vocational Skills Groups, such as resume writing, job seeking skills (Vocational rehab)
- Education/GED groups (educational rehab)
- Money Management (TLC)

Rehabilitation Services provides regular community based activities, both social (weekly day trips to museums, shopping malls etc, and learning activities such as using the subway or buses) and therapy based. Further twenty-nine individuals (10% of the overall census) attend day treatment programs in the community. ***See Tab # 79 List of individuals who attend community day programs.*** The Hospital also has a peer specialist program whereby peers work with individuals in the hospital to ease transition to the community. A key piece of this program is an apartment near the hospital, where peers take individuals for visits and learning community living skills such as cooking, cleaning and laundry. Outings include utilizing public transportation, grocery shopping, etc. Peer specialists also are paired 1:1 with identified individuals to assist in community skill building and to enhance self-confidence. Volunteer Services also take individuals on community trips at least monthly, where they have an opportunity to interact with community volunteers in normalized settings. Case managers also aid with the transition, visiting individuals in the hospital, attending treatment plan conferences and taking them to the community to look at housing, obtain benefits or identification, etc.

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

SEH Response: Ongoing

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	7	7	7	7	6	**8**	**7**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S	19	21	22	20	21	21	**20**	**21**
%C # 10 Identification of skills needed for discharge	50	57	57	71	71	50	**89**	**60**
%C # 11 Descriptive identification of discharge needs, i.e. housing, medical, financial, day program, employment, and aftercare needs	83	43	71	43	71	33	**93**	**58**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 33 SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	184	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. # 10 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?	26	74	61	67	45	68	**52**	**57**

N = All IRPs scheduled in the review month
n = number audited. Target sample is 2 per unit
* The mean is based only upon two months of audits for the review period indicated
Tab # 3 CLINICAL CHART AUDIT RESULTS

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

VII.B

By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.

Recommendations:
Continue to maintain this progress through ongoing monitoring.

SEH Response: Ongoing.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C. #8. SEH shall provide the individual the opportunity beginning at the time of admission and continuously throughout the individual's stay, to be an active participant in the discharge planning process, as appropriate: 71 | 84 | 93 | 93 | 100 | 100 | **86** | **90** N = All IRPs scheduled in the review month n = number audited Target sample size is two observations per unit per month ***Tab # 9 IRP OBSERVATION AUDIT RESULTS*** **Analysis/Action Plans:** Data show in general, improving performance in involving individuals in discharge planning. However to improve the quality of the involvement, all treatment teams and their members were provided additional training on discharge planning which included a component around engagement and clinical administrators were provided additional training on developing the written IRPs. Further, all teams are being provided coaching on an on-going basis. ***See Tab # 1 IRP training materials and data.*** There continue to be groups in the TLC that assist the individual in being more involved in treatment planning. ***See Tab # 69 TLC Group and Ward schedules.*** The Hospital will continue to monitor this through audits.
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:	**Recommendations:** 1. Continue to implement and monitor the Corrective Action Plan. SEH Response: Ongoing. The Chief of Staff monitors the implementation of the CAP. 2. Focus social work staff and individual social work supervision meetings on IRP participation and process. SEH Response: Social work staff are frequently reminded about the importance of attending the IRP and that their role is critical to timely effecting discharge. Attendance has improved during this review period (65% mean in prior review period to 88% mean for this review period), ***See Tab # 9 IRP Observation audit Results*** All teams have a dedicated social worker (the civil admissions unit has two assigned workers) who work with the team on discharge related issues. Further, through the discharge planning trainings completed by all teams, the role of social work at the IRPs was highlighted. In addition, social workers were also provided training on completion of the social work initial assessment, guidelines were updated and social workers and clinical administrators together were trained on completion of the discharge related sections of the IRPs.
VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Recommendations:** 1. See VII.C SEH Response: See VII.C. **Facility's findings:**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>17</td><td>20</td><td>22</td><td>15</td><td>22</td><td>21</td><td>19</td></tr>
<tr><td>n</td><td>4</td><td>4</td><td>5</td><td>5</td><td>4</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>24</td><td>24</td><td>25</td><td>23</td><td>27</td><td>23</td><td>24</td><td>24</td></tr>
<tr><td>%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?</td><td>100</td><td>75</td><td>80</td><td>100</td><td>75</td><td>100</td><td>78*</td><td>89</td></tr>
</table>
N = All discharges to the community in the month
n = number audited
Target sample is 20%
* Mean from prior review period was based upon 2 months of audits.
Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: Audit results suggest improved performance in ensuring measurable interventions regarding the individual's discharge considerations with a mean approaching 90%. In addition, in February 2011, teams were provided additional training around discharge issues in developing the IRP, and clinical administrators were provided training on writing the goals, objectives and interventions in an IRP, and this is expected to further improve performance. See V.A.3 and ***Tab #1*** for information about the training. Audits will continue to monitor performance on this requirement.
</td></tr>
<tr><td>VII.C.2</td><td>the persons responsible for accomplishing the interventions; and</td><td>
Recommendation:

Continue to monitor to ensure compliance.

SEH Response: Monitoring continues.
.
Facility's findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>17</td><td>20</td><td>22</td><td>15</td><td>22</td><td>21</td><td>19</td></tr>
<tr><td>n</td><td>4</td><td>4</td><td>5</td><td>5</td><td>4</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>24</td><td>24</td><td>25</td><td>23</td><td>27</td><td>23</td><td>24</td><td>24</td></tr>
<tr><td>%C. # 21 Was there an identified person(s) responsible for accomplishing the interventions?</td><td>100</td><td>75</td><td>80</td><td>100</td><td>75</td><td>100</td><td>67*</td><td>89</td></tr>
</table>
N = All discharges in the month
n = number audited
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Target sample is 20% of discharges
* Mean for prior period is based only upon two months of data
Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As previously noted, the Hospital provided additional training to treatment teams around discharge and treatment planning, with a focused module on developing discharge criteria, discharge plans and identifying discharge barriers. Among the topics covered were ensuring specific staff were identified to address criteria and work to remove barriers. See V.A.3 and Tab #1 for information about the training. It is expected that the training will improve the consistency in performance on this requirement.

Audits show improved performance on this requirement, with the mean improving from 67 in the prior period to 89 in this period. Audits will continue to monitor performance on this requirement.</td></tr>
<tr><td>VII.C.3</td><td>the time frames for completion of the interventions.</td><td>Recommendations:
1. Each intervention should be measurable with a specific timeline.

SEH Response: The Hospital disagrees with this recommendation. Unless otherwise indicated in the IRP itself, the time frame is the period covered by the IRP. Unless a specific time frame is specified in the IRP, plans are 7 days, 14 days (civil only), 30 days or every 60 days and therefore there is a time frame which is all the agreement requires. In addition, staff were provided additional training around discharge related IRP issues, and to the extent known, a date for completion of critical issues will be included in the clinical formulation if known. Finally, the Community Integration Team projects a date for discharge as well as monitors the status of key steps that must be taken in order to effect the discharge. This is reviewed with the teams at least monthly during the Monday CIT meetings.

2. Implement and monitor the Corrective Action Plan. The CAP should be modified to include “social workers to identify specific recommendations/interventions” that have specific timelines for completion.

SEH Response: See response to Recommendation Number 1.

Facility’s findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>17</td><td>17</td><td>20</td><td>22</td><td>15</td><td>22</td><td>21</td><td>19</td></tr>
<tr><td>n</td><td>4</td><td>4</td><td>5</td><td>5</td><td>4</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>24</td><td>24</td><td>25</td><td>23</td><td>27</td><td>23</td><td>24</td><td>24</td></tr>
<tr><td>%C. # 22 Were there time frames for the completion of the interventions?</td><td>100</td><td>75</td><td>80</td><td>100</td><td>100</td><td>80</td><td>11</td><td>89</td></tr>
</table>
N = All discharges in the month
n = number audited</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>* Mean for prior period is based only upon two months of data
Target sample is 20% of discharges
Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As previously noted, the Hospital provided additional training to treatment teams around discharge and treatment planning, with a focused module on developing discharge criteria, discharge plans and identifying discharge barriers. Among the topics covered were ensuring staff were identified to address criteria and to work to remove barriers. See V.A.3 and Tab #1 for information about the IRP training.

Audits show improved performance on this indicator with a mean of almost 90% and for several months, performance met the 100% mark. Audits will continue to monitor performance on this requirement.</td></tr>
<tr><td>VII.D</td><td>By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or.DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.</td><td>Recommendations:
Implement and monitor the Corrective Action Plan.

SEH Response: Corrective Action Plan is being implemented and monitored. See CAP, March 2011

Facility’s findings:

<table>
<tr><th colspan="9">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P*</td><td>Mean-C</td></tr>
<tr><td>N</td><td>17</td><td>17</td><td>20</td><td>22</td><td>15</td><td>22</td><td>21</td><td>19</td></tr>
<tr><td>n</td><td>4</td><td>4</td><td>5</td><td>5</td><td>4</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>%S</td><td>24</td><td>24</td><td>25</td><td>23</td><td>27</td><td>23</td><td>24</td><td>24</td></tr>
<tr><td>%C. # 23 Is there evidence of adequate assistance in transitioning prior to discharge?</td><td>50</td><td>75</td><td>80</td><td>80</td><td>75</td><td>80</td><td>22</td><td>74</td></tr>
</table>
N = All discharges in the month
n = number audited
* Mean from prior review period reflects 2 months of audits.
Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: As previously noted, the Hospital provided additional training to treatment teams around discharge and treatment planning, with a focused module on developing discharge criteria, discharge plans and identifying discharge barriers. Among the topics covered were ensuring staff were identified to address criteria and to work to remove barriers. See V.A.3 and Tab #1 for information about the training. The Hospital also continues to implement the revised TLC programming and curricula have far more robust offerings to address transition issues, and many of the groups include community visits to learn how to manage shopping, public transportation, etc. See VII.A.4 for specific listing of TLC groups and activities.

Audits show significant improvement in transitioning individuals to the community, improving from a mean of 22% during</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		the last review period to 74% during this period. This is further supported by the Hospital's low 30 day rehospitalization rate which was below 6% consistently since October 2010, and well below the national public rate of 7.84%. The Hospital will continue with monthly audits.
VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Recommendations:** 1. Implement and monitor the Corrective Action Plan. SEH Response: The Hospital is implementing and monitoring the CAP. ***See CAP, March 2011*** 2. Consider adding a note in the clinical record that consumer was provided a copy of discharge plan. SEH Response: The Hospital considered this recommendation, has elected not to implement it but has developed an alternative. The Discharge Plan of Care is a form for which Avatar allows for electronic signatures. The feature is activated, and one is located in the treatment rooms on each unit (and in the social workers' office for the civil admissions unit). The signature pads were relocated to the treatment rooms to facilitate access. There are occasions where individuals in care refuse to sign the electronic signature pad; in those cases the individuals will be asked to sign the printed copy that is given to them. If the individual still refuses to sign, social workers now will indicate on the printed version form if an individual refuses to sign. Copies of any form for which an electronic signature is not obtained are being sent to the Director of Treatment Services and beginning April 2011, will be scanned into the record through the FILE NET system once it is fully implemented. **Facility findings:**

DISCHARGE MONITORING AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	17	17	20	22	15	22	**21**	**19**
n	4	4	5	5	4	5	**5**	**5**
%S	24	24	25	23	27	23	**24**	**24**
%C. # 6 Is there documented evidence of active collaboration with a CSA?	100	75	80	80	100	80	**43**	**85**
%C. # 7 Was the outpatient psychiatrist identified?	100	100	60	80	100	100	**78**	**89**
%C. #8 Was the outpatient/community support worker identified?	100	100	80	100	100	100	**87**	**96**
%C. # 9 Was the next outpatient (medication or therapy) appointment date indicated?	100	75	40	60	100	100	**71**	**76**
%C. # 10 Was the outpatient medical appointment date indicated?	0	0	50	0	100	0	**40**	**25**
%C. # 11 Was the specific role of medication completed?	50	100	100	80	75	75	**58**	**81**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. # 12 Was the exact type of day services or employment indicated?	100	100	100	80	100	80	**71**	**92**
%C. # 13 Were the type and location of substance abuse/addiction services indicated?	n/a	50	0	100	50	0	**50**	**44**
%C. # 14 If the individual has an active Axis III diagnosis, were ongoing medical needs identified?	100	100	75	100	100	100	**59**	**94**
%C. # 15 Was housing secured?	75	75	75	80	75	100	**71**	**80**
%C. # 16 Was the individual's benefit information completed?	75	25	50	60	75	80	**83**	**62**
%C. # 17 Were any other specialized services identified?	100	50	100	100	100	100	**68**	**88**
%C. # 18 Was the discharge plan of care signed by the individual or his/her legal representative?	**	**	**	**	25	80	**n/a**	**56**
%C. # 19 Was a copy of the discharge plan of care given to the individual or the individual's family or legal representative?	**	**	**	**	25	80	**n/a**	**56**

N = All discharges in the month
n = number audited
* * Not available to verify signatures in Avatar-predated provision of signature pads.
Tab # 68 DISCHARGE AUDIT RESULTS

Analysis/Action Plans: See VII.A. Audits show improvement on nine indicators, and a decline in performance on three indicators. Discharge audits will continue. Social work supervisors, as well as the other discipline directors, will review data monthly to identify systemic issues or trend among individual practitioners.

VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	**Recommendations:** Continue to monitor progress. SEH Response: Audits by the MHA around provision of aftercare services and discharge process continue. ***Tab # 73, DMH, Division of Integrated Care Post Discharge Care Audit Results.***
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	**Recommendations:** 1. Continue to monitor progress. SEH Response: Audits by the MHA around provision of aftercare services and discharge process continue. ***Tab # 73, DMH, Division of Integrated Care Post Discharge Care Audit Results.*** The trend suggests improving stability in housing and some improvement in individual's maintaining their day activities.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Recommendations:** Continue to monitor progress. SEH Response: Sufficient staff remain on board to implement the provisions relating to discharge planning.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.	**SPECIFIC TREATMENT SERVICES**	
VIII.A	Psychiatric Care	
	By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	
VIII.A.1	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	
VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Recommendations:** 1. Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. SEH Response: See VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. 2. Implement SEH CAP of October 7, 2010 relative to this section. SEH Response: The October 7, 2010 CAP was implemented and subsequently updated effective March 4, 2011. A copy of the updated CAP can be found in the Attachments as a separate document. While the Medication audits by Pharmacy were discontinued during this period as recommended by DOJ consultant, the Hospital modified the Psychiatric Update form and audit tool in an effort to improve the clinical flow and to strengthen the sections addressing response to treatment (both pharmacological and non-pharmacological), key events in the period since the last update and whether the IRP supports the individual's goals and objectives given the individual's current condition, among other things. ***See Tab # 17 Psychiatric Update Form and Tab # 18 Psychiatric Update Audit form, (effective January, 2011).*** In addition, medical staff were trained on the need to address the rationale for high risk medication practices in their assessments, and this is included in the audits. Monthly audits of the CIPA and Psychiatric Update continue, and the Medical Director and/or Director of Psychiatric Services work with individual psychiatrists as performance issues surface during the audits.
VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;	**Recommendations:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7. SEH Response: See VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7. **Facility findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

PSYCHIATRIC REASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 7 (old tool) Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and how the benefits of these interventions outweighed their risks, triggers, frequency, etc?	67	100	50	*	*	*	**68**	**77**
%C # 5 (new tool) Explanation for the STAT medication' benefits that outweigh the risks?	*	*	*	n/a	100	100	*	**100**
%C # 6 (new tool) Benefits and risks of restraint or seclusion explained	*	*	*	n/a	n/a	n/a	*	**n/a**
%C # 8 (old tool) If medication is being administered involuntarily is there adequate explanation why?	75	100	75	*	*	*	**88**	**80**
%C #7 Are the appropriate adverse reactions noted in the appropriate subsection with respect to FGA or SGA antipsychotics	81	94	100	86	88	100	**88**	**91**
%C #8 Specification and rationale for two or more antipsychotics	67	100	100	100	100	92	**89**	**94**
%C # 9 Were the risk assessment subsections of the psychiatric update fully and accurately completed?	100	100	100	100	100	100	**95**	**100**
%C # 10 Does the psychiatric update accurately reflect the individual's response to treatment/progress	100	100	100	100	100	100	**99**	**100**
%C # 11 Diagnosis reflect current clinical data	100	100	100	96	100	100	**98**	**99**
%C # 13 Justification for R/O or NOS diagnosis	75	78	100	100	100	75	**82**	**86**
%C # 15 Justification for using anti-cholinergics	100	100	88	n/a	100	100	**84**	**97**
%C # 16 Psychiatric Update reflects lab levels obtained at appropriate interval	88	100	100	100	100	100	**92**	**99**
% # 17 If abnormal labs are indicated, is there evidence of appropriate follow up and response?	97	100	100	100	96	100	**95**	**99**
%C # 18 Does the pharmacological plan of care reflect the diagnosis, mental status assessment and individual's response to treatment?	97	100	100	96	100	100	**99**	**99**
%C #19 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	100	100	100	100	100	100	**90**	**100**
%C # 23 If completed by a resident, is there documented evidence that the psychiatric update was reviewed by attending psychiatrist and issues noted?	100	100	100	75	100	100	**83**	**98**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>N = End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* Data for this indicator not collected for this month
N/a = no cases applicable
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Hospital modified its Psychiatric Update to include recommendations made by DOJ consultants and to improve the clinical flow of the form, and also changed a number of the prompts that are expected to improve the documentation around the individual's progress and any significant developments. See Tab # 17, Psychiatric Update Form Highlights of the new psychiatric update form, (which was effective end of October 2010 and thereafter refined in April 2011), that address significant developments in clinical status and psychiatric follow up, include the following elements of the Interim History (most are mandatory fields): 1) the individual's response to medication, 2) overall assessment of the individual's psychiatric condition (Improving, unchanged, worsening), 3) a narrative section where the psychiatrist is expected to describe the overall assessment in the individual's condition since the last assessment, 4) whether the individual is progressing toward treatment goals with a narrative description 5) whether the IRP supports the goals/objectives given the individual's current condition, 6) whether labs were taken and 7) description of any abnormal and normal labs, and 8) whether consultations were obtained/results. The Psychiatric Update's section relating to pharmacological treatment includes information about presence of side effects, a description of changes to medication and why, blood level monitoring, as well as addressing non-pharmacological interventions. Finally, the plan section of the Update requires the psychiatrist to state the rationale for continuing or changing medication regimen and other treatments, addresses medical problems, or need for consults or strategies to address abnormal labs.

As noted, the audit tool for Psychiatric Updates was modified in January 2011, so some indicators only have data from three months of the review period, and other indicators were dropped at that time. Performance improved on all indicators and only falls below the 90% mark on one currently audited indicator. Audits monitoring performance of this requirement will continue. The Director of Medical Affairs will monitor for changes in trends or issues around a particular practitioner's performance and will address them with the individual practitioner as appropriate.</td></tr>
<tr><td>VIII.A.1.c</td><td>timely and justifiable updates of diagnosis and treatment, as clinically appropriate;</td><td>Recommendations:

Same as in VI.A.1, VI.A.3, VI.A.4 and VI.A.7.

SEH Response: See VI.A.1, VI.A.3, VI.A.4 and VI.A.7.

Facility's findings:

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
</table></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #10 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	100	100	100	100	100	100	**99**	**100**
%C # 11 Does the diagnosis reflect current clinical data or was it changed or updated based upon change in current clinical data?	100	100	100	96	100	100	**98**	**99**
%C #18 Does the pharmacological plan of care reflect the diagnoses, mental status assessment and individual's response to treatment?	97	100	100	96	100	100	**99**	**99**
%C #21 Does the psychiatric update include an appropriate plan that includes integration of behavioral and psychiatric interventions?	100	100	100	96	100	100	**97**	**99**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: Performance remains excellent, and the Hospital's Medical Director and Director of Psychiatric Services continue to monitor individuals who carry an NOS or R/O diagnoses. Audits monitoring this requirement will continue. The Director of Medical Affairs will monitor for changes in trends or issues around a particular practitioner's performance.

VIII.A.1.d

documentation of analyses of risks and benefits of chosen treatment interventions;

Recommendations:

Same as in VI.A.1 and VI.A.7.

SEH Response: See VI.A.1 and VI.A.7.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # 19 Are the risks associated with the medication regimen addressed?	86	100	100	100	100	100	**86**	**97**

N= Number of admissions
n= 20% sample per audit plan
Tab # 16 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 7 (old tool)Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and how the benefits of these interventions outweighed their risks, triggers, frequency, etc?	67	100	50	*	*	*	**68**	**77**
%C # 5 (new tool) Explanation for the STAT medication benefits that outweigh the risks?	*	*	*	n/a	100	100	*****	**100**
%C # 6 (new tool) Benefits and risks of restraint or seclusion explained	*	*	*	n/a	n/a	n/a	*****	**n/a**
%C #7 Are the appropriate adverse reactions noted in the appropriate subsection with respect to FGA or SGA antipsychotics	81	94	100	86	88	100	**88**	**91**
%C #8 Specification and rationale for two or more antipsychotics	67	100	100	100	100	92	**89**	**94**
%C # 15 If the medication regimen includes use of anti-cholinergics in an individual with diagnosis of cognitive disorder, is there an adequate justification?	100	100	88	n/a	100	100	**84**	**97**
%C # 17 If abnormal labs are indicated, is there evidence of appropriate follow up and response?	97	100	100	100	96	100	**95**	**99**
%C #19 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	100	100	100	100	100	100	**90**	**100**
%C # 20 Does the psychopharmacological plan of care adequately address the use of benzodiazepines in high risk populations	100	100	100	100	100	100	**88**	**100**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* No data was collected for this indicator for the month indicated
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: This is another requirement that was addressed in revisions to the Psychiatric Update. ***See Tab # 17, Psychiatric Update.*** Beginning in late October 2010, the current treatment section of the Update now includes questions around whether the individual is experiencing side effects, whether there has been any change in medication and if so, what and why, whether the benefits of medication prescribed and risks and/or side effects have been discussed with the individual and requires a summary of that conversation. The Psychiatric Update also requires the psychiatrist to address the use of restraint or seclusion or STAT medications in the context of whether medication changes may be in order.

The audits will continue to monitor whether psychiatrists are documenting the rationale underlying medication choices

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		and the risks/ benefits; this is especially true around use of STAT medications and use of benzodiazepines. The Medical Director based upon the audits will identify practitioner issues. In addition, the medication guidelines were modified. The Medical Director will review the documentation expectations during his monthly meetings with psychiatrists.
VIII.A.1.e	assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Recommendations:** 1. Same as in V.B.5, VI.A.2.and VI.A.7. SEH Response: See V.B.5, VI.A.2.and VI.A.7. **Facility's findings:**

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C #13 Were the following components of a risk assessment completed?*	100	100	100	*	*	*	**100**	**100**
%C #13a Risk of self injury	100	100	100	100	100	100	**98**	**100**
%C # 13b Risk of completed suicide	100	100	100	100	100	83	**98**	**98**
%C # 13c Risk of physical aggression	100	100	100	100	100	83	**100**	**98**
%C # 13d Risk of sexual aggression	100	100	100	100	100	83	**100**	**98**
%C # 13e Risk of elopement	100	100	100	100	100	83	**100**	**98**
%C # 14 For each type of risk that was identified as mild or above, were appropriate precautions identified?	100	100	100	100	100	100	**95**	**100**

N= Number of admissions
n= number audited. Target is 20%
* Subsections a through e added in March 2010. Data from prior review for subsections not available
Tab # 16 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 7 (old tool) Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and how the benefits of these interventions outweighed their risks, triggers, frequency, etc?	67	100	50	*	*	*	**68**	**77**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 5 (new tool) Explanation for the STAT medication' benefits that outweigh the risks?	*	*	*	n/a	100	100	*	**100**
%C # 6 (new tool) Benefits and risks of restraint or seclusion explained	*	*	*	n/a	n/a	n/a	*	**n/a**
%C #9 Were the risk assessment subsections of the psychiatric update fully and accurately completed?	100	100	100	100	100	100	**95**	**100**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
* No data was collected for this indicator for the month indicated
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The audit results suggest high performance around completion of risk assessments, and addressing use of STAT medications and restraint or seclusion. The Medical Director will share audit results with the psychiatrists; he will continue to work with psychiatrists around the quality of documentation.

In addition, the Hospital is tracking high risk behaviors or medical conditions through the High Risk Indicator Event System and High Risk Indicator Tracking and Review Policy. There are two pertinent aspects to the system that address this DOJ requirement. First, the Hospital continues to monitor those individuals involved in 3 or more major UIs in a 30 day period, although the process was slightly modified during the review period. As modified, the Risk Manager notifies the treatment team and the Director of Psychiatric Services when an individual has a third major incident within a 30 day period. Now however, the Director of Psychiatric Services gives a few days to the treatment team to address the issue, and then, within a week, reviews the record and makes additional recommendations to the team if needed, or if no additional recommendations are needed, so indicates in the medical record. ***See Tab # 56, Risk Indicator Tracking Reports.*** This will continue. In addition, the Hospital, effective March 2011, finalized and began implementing the High Risk Indicator Tracking and Review Policy. ***See Tab # 151 High Risk Indicator Tracking and Review Policy.*** Under the policy, eight categories of behavioral high risks and eight categories of medical high risks were identified and individuals in care who meet the criteria are now identified and tracked until removed from the lists. The policy provides for three levels of interventions, including the first level by the IRP teams, a second level of review by the Director of Psychiatric Services (or designee) of any individual who meets a high risk threshold and a third level clinical consultation team (CCT) which reviews any individual who meets the high risk threshold more than once in a six month period, remains on the list more than six months, or requires placement on a list for the second time in a six month period. Individuals in care who meet the criteria were identified in March 2011, and tracking has begun.

VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Recommendations:** 1. Same as in VI.A.1 and VI.A.7. SEH Response: See VI.A.1 and VI.A.7, VIII.A.1.e. **Facility's findings:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # 19 Are the risks associated with the medication regimen addressed?	86	100	100	100	100	100	**86**	**97**

N= Number of admissions
n=number audited. Target is 20% sample per audit plan
Tab # 16 CIPA AUDIT RESULTS

PSYCHIATRIC REASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 7 Are the appropriate adverse reactions noted in the appropriate subsection with respect to treatment with FGA or SGA anti-psychotics?	81	94	100	86	88	100	**88**	**91**
%C # 14 Medication side effects, benefits and risks are explained	*	*	*	100	100	100	*	**100**
%C # 16 Does the Psychiatric Update reflect that lab levels were obtained?	88	100	100	100	100	100	**92**	**99**
%C # 17 If abnormal results are indicated, is there evidence of appropriate follow up and response?	97	100	100	100	96	100	**95**	**99**
%C # 19 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	100	100	100	100	100	100	**90**	**100**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* No data was collected for this indicator for the month indicated
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plans: The Psychiatric Update form was modified to capture additional information about response to medication and presence of side effects. The Interim History section now requires the psychiatrist to categorize the individual's response to medication as full, partial or no response and address, inter alia, whether the individual is progressing toward treatment goals. In the pharmacological section of the current treatment section, the psychiatrist is prompted to report any side effects and describe them, address whether medications were changed, what the changes were and the rationale for the changes and whether the benefits of medication and potential side effects were discussed with the individual. ***See Tab # 17 Psychiatric Update Form.*** The Psychiatric Update audit form was also modified. ***See Tab # 18 Psychiatric Update Audit Form and instructions.***

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>The audits suggest high levels of performance. The Hospital will continue monitoring through the audits.</td></tr>
<tr><td>VIII.A.1.g</td><td>documentation of reasons for complex pharmacological treatment;</td><td>
Recommendations:
1. Same as in VI.A.1 and VI.A.7.

SEH Response: See VI.A.1 and VI.A.7.

2. Continue to monitor this requirement regarding the use of polypharmacy based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">PSYCHIATRIC REASSESSMENT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C #8 Specification and rationale for two or more antipsychotics</td><td>67</td><td>100</td><td>100</td><td>100</td><td>100</td><td>92</td><td>89</td><td>94</td></tr>
<tr><td>%C # 15 If the medication regimen includes use of anti-cholinergics in high risk category, is there an adequate justification?</td><td>100</td><td>100</td><td>88</td><td>n/a</td><td>100</td><td>100</td><td>84</td><td>97</td></tr>
<tr><td>%C # 19 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>90</td><td>100</td></tr>
<tr><td>%C # 20 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse diagnosis?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>88</td><td>100</td></tr>
</table>
N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Analysis/Action Plan: This requirement is being audited through the Psychiatric Update audit. In the prior review period this was also monitored through the Medication Monitoring audits completed by Pharmacy audits but those audits were discontinued per the recommendation of the DOJ consultant. The data of audited cases shows improvement and good performance in the relevant indicators. In addition, the Director of Psychiatry periodically pulls reports involving cases of complex pharmacology and monitors its usage; he follows up as necessary with individual doctors.

Further the Hospital is continuing to track other key data. Below is a chart which summarizes these categories. (The Hospital was unable to calculate averages as requested for this rating period, but expects to be able to do so for the next rating period.)

Indicator	Number of individuals as of August 31, 2010	Number of individuals as of February 28, 2011	Previous period (3/1/10-8/31/10) Average based upon last day of each month	Current period (9/1/10-2/28/11) Average based upon last day of each month
Daily Census	313	275	**319**	**302**
#1 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days)	44	37	Not available	Not available
# 2 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days) and diagnosed with substance abuse disorder	10	11	Not available	Not available
# 3 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days) and diagnosed with a cognitive disorder	18	14	Not available	Not available
#4 Total # of individuals receiving anticholinergics for > or equal 60 days (at least 60 out of the last 70 days)	71	54	Not available	Not available
# 5 Total # of individuals receiving anticholinergics for > or equal 60 days (at least 60 out of the last 70 days) and diagnosed with Tardive Dyskinesia	14	12	Not available	Not available
# 6 Total # of individuals receiving anticholinergics for > or equal to 60 days (at least 60 out of the last 70 days) and diagnosed with cognitive disorder	13	14	Not available	Not available

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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td># 7 Total # of individuals receiving anticholinergics for greater than or equal to 60 days and 65 or older</td><td>10</td><td>11</td><td>Not available</td><td>Not available</td></tr>
<tr><td># 8 Total #of individuals receiving two or more anti-psychotic medications</td><td>285</td><td>258</td><td>Not available</td><td>Not available</td></tr>
<tr><td># 9 Total # of individuals receiving four or more psychotropic medications</td><td>44</td><td>35</td><td>Not available</td><td>Not available</td></tr>
<tr><td># 10 Total # of individuals receiving NGA</td><td>238</td><td>221</td><td>Not available</td><td>Not available</td></tr>
<tr><td># 11 Total # of individuals receiving NGA medications with a diagnosis of DM</td><td>15</td><td>17</td><td>Not available</td><td>Not available</td></tr>
<tr><td># 12 Total # of individuals receiving NGA medications and new onset of DM during rating period</td><td>4</td><td>3</td><td>Not available</td><td>Not available</td></tr>
</table>
See Tab # 157 Data Summary Reports on Diagnoses and Medications
The Hospital will continue with audits.
</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>
Recommendations:
1. Same as in VI.A.1 and VI.A.7.
SEH Response: See VI.A.1 and A.7.
2. Provide monitoring data (Psychiatric Update/Medication Monitoring Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
SEH Response: See data below. Please note that per the recommendation in Section V.B.9, the Hospital discontinued the medication monitoring audits.
3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
SEH Response: See data below.
Facility’s findings:
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

PSYCHIATRIC REASSESSMENT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C # 7 (old tool) Is there an adequate explanation for the use of STAT medications, seclusion/restraint-specifically if and how the benefits of these interventions outweighed their risks, any triggers, frequency, etc.?*	67	100	50	*	*	*	**68**	**77**
% C # 5 (new tool) Explanation for the STAT medication's benefits that outweigh risks	*	*	*	n/a	100	100	*	**100**
%C # 6 (new tool)Benefits and risks of restraint and seclusion explained	*	*	*	n/a	n/a	n/a	*	**n/a**
%C #18 Does the pharmacological plan of care reflect adequately address the diagnoses, mental status assessment and individual's response to treatment?	97	100	100	96	100	100	**99**	**99**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* No data was collected for this indicator for the month indicated
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis/Action Plan: The Hospital will continue its monthly audits. The Medical Director is reminding staff about the importance of including rationales in the Psychiatric Updates.

VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	
VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	
VIII.A.2.a.i	Clinically justified	**Recommendations:** 1. Implement corrective actions to correct the deficiencies outlined by this consultant regarding the monitoring of individuals receiving new generation antipsychotic medications. SEH Response: The Hospital has taken several steps to address this recommendation. First, the medication guidelines were amended to add a standard to ensure adequate monitoring of vital signs, including temperature, for individuals receiving

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

clozapine. (Addresses issues identified as # 1 and 2 on page 122 of DOJ's report). Second, the Hospital modified its Psychiatric Update form which now includes prompts relating to presence of "relevant labs/serum levels", requesting description of abnormal labs and a description for normal labs, whether there were any recent consults/studies and requesting a description of any recent consults. Third, physicians were given a paper copy of the lab monitoring guidelines to make it always available to them. Finally, the Director of Psychiatric Services reviews the laboratory orders/results for all individuals presented to the Forensic Review Board to ensure they are up-to-date.

2. Continue to monitor this requirement regarding high risk medication uses (Psychiatric Update and Medication Monitoring Audits), based on an adequate sample during the review period. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below. Please note that the Hospital modified the Psychiatric Update audit to monitor high risk medication uses and discontinued the medication monitoring audit per the recommendation in the November 2010 report at cell V.B.9

3. Continue to provide information regarding the number of individuals receiving high risk medication uses during the review period compared to the last review period. Provide average number of individuals during the review period and address the following types of medication uses:
   a) Intra-class polypharmacy (two or more antipsychotics);
   b) Inter-class polypharmacy(four or more);
   c) Anticholinergics > 90 days for individuals age 65 or above;
   d) Anticholinergics > 90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias);
   e) Benzodiazepines >90 days for individuals diagnosed with any substance use disorder; and
   f) Benzodiazepines >90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias).

SEH Response: Although the DOJ consultant requested that the Hospital provided averages data it is unable to do so with this report, but expects to be able to do so for the next review.

Indicator	Number of individuals as of August 31, 2010	Number of individuals as of February 28, 2011
Daily Census	**313**	**275**
#1 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days)	44	37
# 2 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days) and diagnosed with substance abuse disorder	10	11

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

# 3 Total # individuals receiving benzodiazepines for more than 90 days (at least 90 of last 100 days) and diagnosed with cognitive disorder (Borderline Intellectual functioning, Cognitive Disorder NOS, any Dementias, Mental Retardation)	18	14
#4 Total # of individuals receiving anticholinergics for > or equal 60 days (at least 60 of the last 70 days)	71	54
# 5 Total # of individuals receiving anticholinergics for > or equal 60 days (at least 60 of the last 70 days) and diagnosed with Tardive Dyskinesia	14	12
# 6 Total # of individuals receiving anticholinergics for > or equal to 60 days (at least 60 of the last 70 days) and diagnosed with cognitive disorder	13	14
# 7 Total # of individuals receiving anticholinergics for greater than or equal to 60 days (at least 60 of the last 70 days) and 65 or older	10	11
# 8 Total #of individuals receiving two or more anti-psychotic medications	285	258
# 9 Total # of individuals receiving four or more psychotropic medications	44	35
# 10 Total # of individuals receiving NGA	238	221
# 11 Total # of individuals receiving NGA medications with a diagnosis of DM	15	17
# 12 Total # of individuals receiving NGA medications and new onset of DM	4	3

Tab # 157 Data Summary Reports on Diagnoses and Medications

Facility's findings:

PSYCHIATRIC REASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	246	**280**	**267**
n	32	33	25	28	42	23	**24**	**31**
%S	11	12	9	11	16	9	**9**	**11**
%C #8 Specification and rationale for two or more antipsychotics	67	100	100	100	100	92	**89**	**94**
%C # 15 If the medication regimen includes use of anti-cholinergics in high risk category, is there an adequate justification?	100	100	88	n/a	100	100	**84**	**97**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C # 19 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects? 100 100 100 100 100 100 **90** **100** %C # 20 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse diagnosis? 100 100 100 100 100 100 **88** **100** N= End of month census less monthly admissions n = Number audited. (Target is two per unit psychiatrist per audit sample plan ***Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS*** **Analysis and Action:** As previously noted, the Hospital stopped the medication monitoring audits per the recommendation of a DOJ consultant. The Psychiatric Update audits are continuing. The data from the Psychiatric Update audits suggest overall improving performance with respect to each of the indicators, and all indicators are now above 90%. This is confirmed by the data around medication practices in high risk populations, although the lower numbers may also be affected by the lower census.
VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.v	evaluated for side effects; and	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.vi	documented.	**Recommendations:** 1. Same as above.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Same as above.
VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	**Recommendations:** 1. Same as above. SEH Response: Same as above.
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;	**Recommendations:** 1. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. SEH Response: Completed. The guidelines were updated during this review period to include a standard for monitoring vital signs of individuals receiving clozaril. 2. Provide a summary of updates in these guidelines. SEH Response: The guidelines were updated during this review period to include a standard for monitoring vital signs of individuals receiving clozaril. In addition, after a DUE on gabapentin was completed, a cautionary statement was added which notes that statistically, gabapentin is not an effective mood-stabilizing treatment for bipolar disorder and has no therapeutic advantage in having fewer side effects over better established medications such as lithium and valproic acid. Other changes were formatting or spelling corrections. ***See Tab # 87 Medication Guidelines (revised)*** **Analysis and Action Plan:** Continue periodic review of medication guidelines and update as needed.
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;	**Recommendations:** 1. Same as in VIII.A.1.h. SEH Response: The Hospital protocol clearly provides that advance PRN orders may not be written for psychotropic medications in anticipation of behavioral emergencies or psychiatric symptoms. It is monitored through a report available daily in Avatar, and is reviewed by Pharmacy when verifying medication orders. It is also audited through the Psychiatric Update audits which also review use of STAT medications. The Hospital identified three instances of orders written as PRN for psychotropic meds during the review period, but in all cases the order was limited to circumstances of when the individual refused PO medications and their guardians had consented to IM administration which therefore did not violate the policy. **Facility's findings:** **PSYCHIATRIC REASSESSMENT AUDIT RESULTS** Sep | Oct | Nov | Dec | Jan | Feb | **Mean-P** | **Mean-C**

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<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>N</td><td>280</td><td>273</td><td>271</td><td>266</td><td>266</td><td>246</td><td>280</td><td>267</td></tr>
<tr><td>n</td><td>32</td><td>33</td><td>25</td><td>28</td><td>42</td><td>23</td><td>24</td><td>31</td></tr>
<tr><td>%S</td><td>11</td><td>12</td><td>9</td><td>11</td><td>16</td><td>9</td><td>9</td><td>11</td></tr>
<tr><td>%C # 7 (old tool) Is there an adequate explanation for the use of STAT medications, seclusion/restraint-specifically if and how the benefits of these interventions outweighed their risks, any triggers, frequency, etc.?*</td><td>67</td><td>100</td><td>50</td><td>*</td><td>*</td><td>*</td><td>68</td><td>77</td></tr>
<tr><td>%C #5 (new tool) Is there an adequate explanation for STAT medications (benefits outweigh risks)</td><td>**</td><td>**</td><td>**</td><td>n/a</td><td>100</td><td>100</td><td>*</td><td>100</td></tr>
</table>
N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
* This indicator was modified for audits beginning in January, 2011
** This indicator was introduced in January 2011
Tab # 11 PSYCHIATRIC REASSESSMENT AUDIT RESULTS

Analysis and Action Plan: Continue monitoring per current methodology.
</td></tr>
<tr><td>VIII.A.2.b.iii</td><td>establish a system for the pharmacist to communicate drug alerts to the medical staff; and</td><td>
Recommendations:

1. Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the prescribing practitioners.

SEH Response: See below.

2. Present documentation of review by the P&T Committee of drug alerts.

SEH Response: Drug alerts are present to the P and T Committee. See ***Tab #90 Pharmacy and Therapeutics Committee Minutes, (Sep 2010-February 2011)*** There were 5 drug alerts issued by Pharmacy for the medications risperdal, actos, lupron, albuterol sulfate, and antipsychotic drugs labeling concerning treatment during pregnancy, during the review period (September 2010 through February 2011)
</td></tr>
<tr><td>VIII.A.2.b.iv</td><td>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.</td><td>
Recommendations:

1. Implement corrective actions to address under-reporting of ADRs.

SEH Response: The Hospital continues to monitor ADR reporting through it Pharmacy and Therapeutics Committee and continues to work with physicians around the importance of reporting ADRs, but admittedly strategies to date have not proven to be wholly effective. During this review period, the Medical Director and Chief Pharmacist monitored the 24 hour nursing report and identified cases in which an ADR may have occurred and a report warranted. This was effective in reminding staff of the duty to report, and contributed to the increased reporting, although this method does not catch all
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SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

cases in which an ADR should be reported. The Hospital will continue this monitoring.

In addition, the Hospital will be undertaking a six sigma analysis with the goal of enhancing adverse drug reaction and medical variance reporting, much like it did with the recording medication administration six sigma analysis. The parameters of the study are still being designed, but a description will be available during the May 2011 visit.

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

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

Total Number of Reported ADRs by Month								
Previous Review Period	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Mean**
Current Review Period	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**		
Previous	10	0	11	8	3	10	**42**	**7.0**
Current	5	7	6	7	10	5	**40**	**6.7**

Tab # 93 Pharmacy and Therapeutics Committee Data

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

Probability of ADRs								
Probability	**Previous Period**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Mean**
	Current Period	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**		
Doubtful	**Previous**	2	0	0	0	0	0	**2**	**0.3**
	Current	0	0	0	0	0	0	**0**	**0.0**
Possible	**Previous**	6	0	3	3	2	7	**21**	**3.5**
	Current	4	4	6	5	7	3	**29**	**4.8**
Probable	**Previous**	2	0	6	5	1	3	**17**	**2.8**
	Current	1	3	0	2	3	2	**11**	**1.8**
Definite	**Previous**	0	0	2	0	0	0	**2**	**0.3**
	Current	0	0	0	0	0	0	**0**	**0.0**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Severity of ADRs

Severity Level	Previous Period / Current Period	Mar-10 / Sep-10	Apr-10 / Oct-10	May-10 / Nov-10	Jun-10 / Dec-10	Jul-10 / Jan-11	Aug-10 / Feb-11	Total	Mean
Mild (0)	Previous	2	0	0	1	0	1	**4**	**0.7**
	Current	0	2	0	2	4	2	**10**	**1.7**
Moderate (1~2)	Previous	8	0	11	7	3	9	**38**	**6.3**
	Current	5	5	6	5	6	3	**30**	**5.0**
Severe (3~5)	Previous	0	0	0	0	0	0	**0**	**0.0**
	Current	0	0	0	0	0	0	**0**	**0.0**

Outcome of Reaction

Result	Sep	Oct	Nov	Dec	Jan	Feb	Total	Mean
Recovered/resolved Completely	2	2	2	5	7	4	**22**	**3.7**
Recovered/resolved with sequelae	0	0	2	0	0	0	**2**	**0.3**
Recovering/resolving	0	0	0	0	0	0	**0**	**0.0**
Not recovered/not resolved	0	1	2	2	3	1	**9**	**1.5**
Fatal	0	0	0	0	0	**0**	**0**	**0.0**
Unknown	3	4	0	0	0	**0**	**7**	**1.2**

Reporter Discipline

Result	Sep	Oct	Nov	Dec	Jan	Feb	Total	Mean
Nurse	0	0	0	0	1	0	**1**	**0.2**
Pharmacist	1	0	0	0	0	1	**2**	**0.3**
Medical	2	1	4	3	3	2	**15**	**2.5**
Psychiatrist	2	6	2	4	6	2	**22**	**3.7**

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

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

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

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ADR#	ID #	Incident Date	Description
ADR #34	#920847	3/18/2010	Weight gain; glucose intolerance
ADR #42	#123447	5/15/2010	Weight gain
ADR #66	#924695	8/13/2010	Piano-like tardive movements of both upper extremities
ADR #82	#122138	10/25/2010	Moderate dyskinetic movements
ADR #118	#923716	3/17/2011	Increased pigmentation, high prolactin level

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

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

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

SEH Response: See response to a) above.

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

a) Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.
b) Date of each DUE;
c) Description of each DUE including methods used;
d) Outline of each DUE's recommendations; and
e) Outline of actions taken in response to the recommendations.
f) Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns.

SEH Response: The Hospital undertook three DUEs during this review period. ***Report Tab # 86 Drug Use Evaluations.*** One, dated February 7, 2011, was a study of individuals prescribed gabapentin for psychiatric disorders. The study identified 7individuals in care that met the criteria, and most had been prescribed the medication initially by someone other than the current psychiatrist. Gabapentin was discontinued for 5 of the 7 individuals by the end of the evaluation. Medication guidelines were amended to include a cautionary statement about the use of gabapentin for psychiatric reasons. A second DUE dated March 14, 2011, was a study of hypnotics and insomnia; 36 individuals in care were

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

prescribed medication for insomnia. Of these individuals, 20 were randomly selected for a review of nursing documentation related to sleeping habits during a week long period; monitoring including bedtime, number of awakenings, duration of awakenings, daytime napping habits. Based upon the results, the reviewers recommended that a program of sleep hygiene be introduced. The third study related to B-12 vitamin deficiency and medical follow up. The study looked at clinician's response to possible Vitamin B12 deficiency by looking at follow up care provided after a low or borderline test result. The study assessed whether clinicians appropriately followed up by either ordering further work ups or treated individuals with B12 supplements. The study reviewed test results from a 2 year period. Nine cases showed abnormal results, 8 of which were treated. Two hundred twenty three cases had borderline results. Of these, 153 were treated with B12, 5 had further testing ordered, and 70 had no follow up or treatment.

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

SEH Response: The Hospital will be undertaking a six sigma analysis with the goal of enhancing medication variance reporting, much like it did with the recording medication administration six sigma analysis. The parameters of the study are still being designed, but a description will be available during the May 2011 visit.

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

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

Total Number of Reported Medication Variances by Month								
Previous Review Period	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Mean**
Current Review Period	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-10**	**Feb-10**		
Previous	14	12	7	14	12	11	70	**11.7**
Current	18	6	8	21	2	20	75	**12.5**

See Tab # 93 MVR SUMMARY REPORTS

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

Number of Medication Variances by Type									
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Total**	**Mean-P**	**Mean-C**
Administering	9	2	3	5	0	4	**23**	**3.3**	**3.8**
Dispensing	0	2	0	4	1	2	**9**	**2.2**	**1.5**
Monitoring	0	0	0	0	0	0	**0**	**0.0**	**0.0**
Prescribing	2	2	2	10	0	15	**31**	**4.5**	**5.2**
Procurement	0	0	2	2	0	0	**4**	**0.5**	**0.7**

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Transcribing/Documenting	3	0	1	0	0	0	**4**	**1.0**	**0.7**
Other/NA	4	0	0	0	1	0	**5**	**1.5**	**0.8**

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

See Tab # 93 MVR SUMMARY REPORTS

Classification by Actual/Potential Variances								
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mean-P**	**Mean-C**
Potential - A	3	0	0	1	0	0	**2.5**	**0.7**
Potential - B	4	3	3	4	2	13	**4.3**	**4.8**
Potential Subtotal	*7*	*3*	*3*	*5*	*2*	*13*	***6.8***	***5.5***
Actual - C	10	3	5	16	0	5	**4.2**	**6.5**
Actual - D	1	0	0	0	0	2	**0.7**	**0.5**
Actual - E	0	0	0	0	0	0	**0.0**	**0.0**
Actual - F	0	0	0	0	0	0	**0.0**	**0.0**
Actual - G	0	0	0	0	0	0	**0.0**	**0.0**
Actual - H	0	0	0	0	0	0	**0.0**	**0.0**
Actual - I	0	0	0	0	0	0	**0.0**	**0.0**
Actual Subtotal	11	3	5	16	0	7	**4.8**	**7.0**
# of ICA Complete*	*0*	*0*	*0*	*0*	*0*	*0*	***0.0***	***0.0***

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

See Tab # 93 MVR SUMMARY REPORTS

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

Number of Medication Variances by Critical Breakdown Point									
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Total**	**Mean-P**	**Mean-C**
Administering	9	2	3	5	0	3	22	**3.2**	**3.7**
Dispensing	0	2	0	4	1	2	9	**1.7**	**1.5**
Monitoring	0	0	0	0	0	0	0	**0.0**	**0.0**
Prescribing	2	2	2	10	0	15	31	**4.5**	**5.2**
Procurement	0	0	2	2	0	0	4	**0.3**	**0.7**
Transcribing/Documenting	3	0	1	0	0	0	4	**0.5**	**0.7**
Other/NA	4	0	0	0	1	0	5	**1.5**	**0.8**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		See Tab # 93 MVR SUMMARY REPORTS d) Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved; SEH Response: No critical case analyses were required this period. e) Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; Also provide summary outline of each analysis including the following: i) Date of the variance; ii) Brief Description of the variance; iii) Outline of ICA findings and recommendations; and iv) Outline of actions taken in response to the recommendations SEH Response: No critical case analyses were required this period. f) Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances; SEH Response: ***See Tab # 90 Pharmacy and Therapeutics Committee Minutes.*** The Committee reviews each month the Medication Variance Reporting data, as well as a synopsis of each reported medication variance. The information is summarized in the minutes, and a more full description of each medication variance case is handed out and reviewed at each meeting. g) Evidence of corrective actions to address patterns and trends identified in medication variances. SEH Response: The Hospital continues to focus on medication variances involving missing medication administration documentation. Each month, a report is prepared by the Office of Statistics and Reporting concerning aspects of ADR and MVR data which is submitted to the Pharmacy and Therapeutics Committee. ***See Tab # 93 Pharmacy and Therapeutics Committee Monthly Report.*** The Hospital is also continuing to monitor medication administration documentation. During this review period, the percentage of missing documentation has fallen from 0.57% in September 2010, to 0.44 % in February, 2011. The percentage of nurses with no missing documentation was 50% in February 2011. Information is tracked by unit and by nurse. ***See Tab # 102 Medication Administration Documentation Data Report.*** It should be noted that the trend in January and February suggests that missing medication administration documentation increased, so this will be monitored closely by nursing. The Hospital is also undertaking a second six sigma study which is designed to enhance medication variance reporting. 6. Provide data regarding Mortality reviews of all unexpected deaths during the review period and ensure completion of an external review of all unexpected mortalities and integration of results of the independent external medical mortality review and post-mortem examinations in the final level interdisciplinary review in a timely manner. SEH Response: The DMH Mental Health Authority continues to act as the independent external review of mortalities. Its recommendations are presented to the Performance Improvement Committee and are tracked by the Performance

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Improvement Department. During this review period, there were three deaths of inpatients. ***See Tab # 152 Mortality reports.*** All Hospital mortality reports were recently finalized and submitted to DMH for review.
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	**Recommendation:** Continue to provide information to confirm continued compliance with this requirement in all acute care and long-term care units in the facility. SEH Response: Compliance maintained.
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:	**Recommendations:** Same as in V.A.2.e and VI.A.7. SEH Response: See V.A.2.e and VI.A.7.
VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	**Recommendations:** Same as above. SEH Response: Same as above.
VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	**Recommendations:** Same as above. SEH Response: Same as above.
VIII.A.4.c	integrate psychiatric and behavioral treatments.	**Recommendations:** 1. Same as above. SEH Response: 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.	**Recommendations:** 1. Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. SEH Response: See VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.
VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Recommendations:** 1. Implement corrective actions to improve alignment between the individual's Stage of Change and IRP Objectives/Interventions and the formulation of proper discharge criteria regarding substance use disorders. SEH response: The Hospital has undertaken several initiatives to address this recommendation. It continued to monitor the alignment of stage of change to IRP objectives, interventions and development of the discharge criteria through the co-

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

occurring disorders self-audit. Based upon audit results during the first three months of the review period, a decision was made to suspend the audits and provide technical assistance to treatment teams to improve the alignment of diagnosis, stage of change and IRP interventions. The Hospital's internal substance abuse expert met with each treatment team and, with them, reviewed the record of each individual with a diagnosis of substance abuse to assist in determining the appropriate stage of change and whether it was aligned with IRP objectives, interventions, and development of discharge criteria. This occurred during December 2010 and January 2011 in lieu of audits, which restarted in February 2011. That month's audit showed significant improvement in several key aspects of substance abuse treatment.

In addition, the TLCs developed an updated strategy around substance abuse treatment. The Hospital developed a "readiness" ruler to assess all individuals with substance abuse diagnosis. ***See Tab # 80 Readiness Ruler Assessment*** Training was provided to co-occurring group leaders on completing the "readiness ruler" assessment in determining stage of change. Under the Hospital's plan, co-occurring disorder staff will complete a readiness assessment and get a baseline assessment of individuals with substance abuse diagnoses by the end of March 2011, which will be repeated at 3-4 month intervals. The individuals will then be reassigned to groups that reflect the individual's stage of change, and number and type of groups themselves will be modified to reflect the results of each "readiness ruler" assessment.

2. Continue to monitor this requirement (CIPA and Co-occurring Disorders Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

4. Same as in V.D.1 and VI.A.5.

SEH Response: See V.D.1 and VI.A.5.

Facility's findings:

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	7	6	7	7	6	**7**	**7**
%S	23	21	19	20	21	21	**19**	**21**
%C # 9 Was a substance abuse assessment completed, and if not, was the reason clearly provided?	100	86	100	100	100	100	**98**	**98**

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N = Monthly Admissions
n = number audited- target is 20% sample per month
Tab # 16 CIPA AUDIT RESULTS

Co-occurring disorder self audits were not conducted in Dec through January in order to work with teams to improve stage of change alignment and IRP objectives and interventions. See response to recommendation # 1 above

CO-OCCURRING DISORDERS SELF AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	153	141	137			153	**146**	**146**
n	10	10	10			10	**14**	**10**
%S	7	7	7			7	**9**	**7**
%C #1 IRP addresses both the identified mental illness and substance use disorder.	70	60	50			80	**80**	**65**
%C #2 IRP reflects the individual's stage of change with respect to SUD	80	40	30			60	**70**	**53**
%C #3 If #2 is yes, TLC interventions appropriately link with documented stage of change	38	50	33			100	**59**	**57**
%C #4 IRP has discharge criteria on SUD	25	22	22			60	**23**	**33**
%C #5 If #4 is yes, criteria are individualized and written properly.	67	100	100			83	**100**	**85**

N = Individuals with substance use diagnoses
n = number audited- target is 10% sample per month
n/a = not available
Tab # 57 SUBSTANCE ABUSE IRP AUDIT RESULTS

Analysis and Action Plan: The data from the most recent six month review period around substance abuse screening show excellent performance in the substance abuse assessment completed as part of the Comprehensive Initial Psychiatric Assessment (CIPA).

In contrast, the substance abuse IRP audits conducted during the September through November 2010 period showed improvement was needed across most indicators, especially around stage of change and IRP objectives and interventions. Because of the audit results, a decision was made to suspend the audits and instead review with treatment teams each IRP and stage of change for all individuals in care with a substance abuse diagnosis. In addition, co-occurring disorder staff received training in completing "readiness ruler" assessments, which will be done every 3-4 months to assess an individual's progress; the results will also be used to realign TLC groups around individuals' needs. Co-occurring disorder audits for the month of February show improvement around IRP planning for those with substance abuse, which should continue as TLCs implement the readiness ruler concept and all IRPs are updated.

Substance abuse-related offerings in the TLCs include Stage of Change, Smart Recovery, Relapse Prevention, Learning

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>about Healthy Living, Quit Smoking, “Double Trouble in Recovery”, AA and NA, Anger Management for Individuals with Co-occurring Disorders, Substance Abuse Education, Sexual Safety and Sobriety, Principles of Recovery, Relapse Prevention, Recovery Process, and Relaxation and Stress Reduction</td></tr>
<tr><td>VIII.A.7</td><td>By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.</td><td>
Recommendations:

1. Continue to monitor this requirement (CIPA and TD Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SEH Response: See data below.

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

SEH Response: See data below.

Facility’s findings:

<table>
<tr><th colspan="3">TARDIVE DYSKINESIA AUDIT RESULTS</th></tr>
<tr><td></td><td>8/31/2010</td><td>3/16/2011</td></tr>
<tr><td>P Target Population (# TD Patients)</td><td>38</td><td>35</td></tr>
<tr><td>S Population reviewed</td><td>37</td><td>35</td></tr>
<tr><td>%S</td><td>97</td><td>100</td></tr>
<tr><td>%C # 1 Is there evidence of at least a semi-annual AIMS</td><td>62</td><td>91</td></tr>
<tr><td>%C # 2 Is there evidence of a neurology consult?</td><td>35</td><td>69</td></tr>
<tr><td>%C #3 Is there evidence of consideration in medication choices?</td><td>95</td><td>100</td></tr>
<tr><td>%C #4 Are there interventions (i.e. patient education, medication) targeting TD on the IRP</td><td>76</td><td>66</td></tr>
<tr><td>%C #4a Is there an update to TD status in the most recent psychiatric update?</td><td>n/a</td><td>91</td></tr>
<tr><td>%C #5 Are first generation anti-psychotic medications prescribed?</td><td>41</td><td>34</td></tr>
<tr><td>%C #6 If first generation anti-psychotic medications are prescribed, is there justification in the monthly notes?</td><td>93</td><td>100</td></tr>
<tr><td>%C #9 Discuss results of audit with psychiatrist</td><td>95</td><td>100</td></tr>
</table>
Tab # 64 TD AUDIT RESULTS

<table>
<tr><th colspan="9">COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>31</td><td>34</td><td>32</td><td>35</td><td>33</td><td>29</td><td>38</td><td>32</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>n</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td><td>6</td><td>7</td><td>7</td></tr>
<tr><td>%S</td><td>23</td><td>21</td><td>19</td><td>20</td><td>21</td><td>21</td><td>19</td><td>21</td></tr>
<tr><td>%C # 20 AIMS test administered</td><td>43</td><td>100</td><td>83</td><td>71</td><td>100</td><td>100</td><td>77</td><td>83</td></tr>
</table>
N = Monthly Admissions
n = number audited- target is 20% sample per month
Tab # 16 CIPA AUDIT RESULTS

Analysis/Action Plan: Data from the CIPA audits shows steady improvement in the completion of AIMS tests upon admission, with three months at 100% during the review period; the weighted mean improved from 77% during the last review period to 83% for the current review period. Similarly, significant improvement was noted in the tardive dyskinesia audits, particularly around completion of the semi-annual AIMS test, the obtaining of neurology consultations, the documentation of consideration of medication choices, documenting justification for use of first generation anti-psychotics (from 93% to 100%). One area declined however, relating to addressing TD in the IRP interventions. Each case was discussed with the individual psychiatrist for follow up.
</td></tr>
<tr><td>B</td><td>Psychological Care</td><td></td></tr>
<tr><td></td><td>By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological support and services to individuals who require such services.</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></td></tr>
<tr><td>VIII.B.1.a</td><td>ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected. to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;[2]</td><td>Recommendations:
1. Complete the formation of the PBS team.

SEH Response: The PBS team is complete, as it includes a PBS team leader (clinical psychologist), three PBS specialists and a data analyst. The PBS team does not believe a registered nurse is needed for the team at this time.

2. Ensure that Risk Management data on individuals in care with frequent aggressive episodes is routinely made available to the Psychology Department for follow up.</td></tr>
</table>

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Completed. This information is sent to the PBS team weekly.

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

SEH Response: See data below.

Facility's findings:

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	7	6	2	6	6	2	**5**	**5**
%S	23	18	6	17	18	7	**12**	**15**
%C #B- 2 (Part B) Behavioral intervention screening	100	100	100	100	100	100	**96**	**100**
%C # B- 3 (Part B) Behavioral observations	100	100	100	83	83	100	**93**	**93**
%C # B- 5b (Part B) Behavioral plan appropriateness	86	100	50	83	100	100	**100**	**90**

N = Monthly admissions
n = number audited-target is 20% sample (Audit sample plan)
Tab # 21 IPA AUDIT RESULTS

Analysis and Action Plan: Data show high rates of compliance in completing the behavioral screens in the IPA Part B, so no specific actions will be taken, although training of psychologists around PBS will continue as needed; this includes training relating to specific individuals and the range of PBS services, including IBI guidelines and plans. Over the next six months, psychology will work to increase the audit sample size for IPAs. In addition, audits of the IBIs, PBS guidelines and PBS plans have begun.

The Hospital also now includes the PBS team leader in notifications of the High Risk Indicator Events, so he is able to provide consultation earlier on those cases where behavior issues warrant.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	and the system for earning reinforcement;	**Facility's findings:**

BEHAVIORAL INTERVENTIONS AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Total-P* (May-Aug)	Total-C (Sep-Feb)
N	3	2	4	9	1	4	**21**	**23**
n	2	1	2	2	1	2	**8**	**10**
%S	67	50	50	22	100	50	**38**	**43**
%C #1 The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms.	100	100	100	100	100	100	**88**	**100**
%C #4 A functional assessment is completed	100	100	100	100	100	100	**n/a**	**100**
%C #10 Appropriate interventions are developed if the target maladaptive behavior is to be made inefficient.	50	100	50	100	100	100	**88**	**78**

N = Referred for behavioral interventions
n = number audited- (Audit sample plan calls for 100% sampling)
* Total from the prior review period reflects only four (4) months of audits between May and August 2010.
Tab # 101 BEHAVIORAL INTERVENTIONS AUDIT RESULTS.

Analysis/Action Plan: The Hospital continues to improve the quality of IBIs, meeting 100% in two of three indicators and, while the mean for indicator # 10 decreased during the period, the trend in the last three months shows significant improvement, at 100% in three consecutive months. Because of this trend, no actions beyond continuation of audits will be taken.

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;	**Recommendation:** Maintain current level of practice. SEH Response: Practice level maintained. **Facility's findings:**

BEHAVIORAL INTERVENTIONS AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Total P	Total-C
N	3	2	4	9	1	4	**21**	**23**
n	2	1	2	2	1	2	**8**	**10**
%S	67	50	50	22	100	50	**38**	**43**
%C # 12 Behavioral interventions do not use aversive contingencies.	100	100	50	100	100	100	**100**	**90**

N = Referred for behavioral interventions

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>n = number audited- (Audit sample plan calls for 100% sampling)
Tab # 101 BEHAVIORAL INTERVENTIONS AUDIT RESULTS

Analysis/action plan: The Hospital continues to improve the quality of IBIs, as audits show the IBIs are not including aversive contingencies in 100% of cases audited in the last three months. Because of this trend, no actions beyond continuation of audits will be taken.</td></tr>
<tr><td>VIII.B.1.d</td><td>ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;</td><td>Recommendations:
1. This cell repeats cell VIII.B.1.a

SEH Response: See VIII.B.1.a</td></tr>
<tr><td>VIII.B.1.e</td><td>ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and</td><td>Recommendations:

Implement fidelity checks.

SEH Response: The PBS team has begun fidelity checks by monitoring treatment teams for those individuals with behavioral plans or guidelines. Some data are available. See Boggio Advanced Document Request Tab # 25

Facility’s Findings:

<table>
<tr><th colspan="9">BEHAVIORAL INTERVENTIONS AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Total-P</td><td>Total-C</td></tr>
<tr><td>N</td><td>3</td><td>2</td><td>4</td><td>9</td><td>1</td><td>4</td><td>21</td><td>23</td></tr>
<tr><td>n</td><td>2</td><td>1</td><td>2</td><td>2</td><td>1</td><td>2</td><td>8</td><td>10</td></tr>
<tr><td>%S</td><td>67</td><td>50</td><td>50</td><td>22</td><td>100</td><td>50</td><td>38</td><td>43</td></tr>
<tr><td>%C. #1. The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>88</td><td>100</td></tr>
<tr><td>#2. Appropriate data collection methods are used</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>50</td><td>100</td></tr>
<tr><td>#3. A structural assessment is completed</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>N/A</td><td>100</td></tr>
<tr><td>#4. A functional assessment is completed</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>N/A</td><td>100</td></tr>
<tr><td>#5. The target maladaptive behavior is described in terms of its predisposing, precipitating, and perpetuating factors</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>88</td><td>100</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		#6. A baseline estimate of the behavior is presented in terms of objective measures (e.g., rate, frequency, duration, severity, intensity).	50	0	100	50	100	100	**38**	**70**
		#7. At least one hypothesis is generated from the assessment data	100	100	100	100	0	100	**100**	**90**
		#8. Behavioral interventions are directly related to the hypothesis	100	100	100	100	100	100	**100**	**100**
		#9. Appropriate interventions are developed if the target maladaptive behavior is to be made irrelevant	50	100	100	100	100	100	**100**	**90**
		#10. Appropriate interventions are developed if the target maladaptive behavior is to be made inefficient	50	100	50	100	100	100	**88**	**78**
		#11. Appropriate interventions are developed if the target maladaptive behavior is to be made ineffective	100	100	100	100	100	100	**100**	**100**
		#12. Behavioral interventions do not use aversive contingencies	100	100	50	100	100	100	**100**	**90**
		#13. The behavioral intervention plan is revised as clinically indicated by outcome data	100	100	n/a	100	100	100	**N/A**	**100**
		#14. Should the individual engage in the target maladaptive behavior, the staff know how to respond to it in an effective manner	50	100	50	100	0	100	**88**	**70**

N = Individuals referred for behavioral interventions
n = number audited
Tab # 101 BEHAVIORAL INTERVENTIONS AUDIT RESULTS.

Analysis/Action Plans: The data above reflect audits of IBIs, behavioral guidelines and plans in place. The data show that behavioral plans, IBIs and guidelines generally are of excellent quality and that trends over the last three months show sustained improvement for most indicators. In fact the audits showed 100% compliance in all indicators in February 2011. It should be noted that January 2011 data may have been affected as only one new plan/IBI was developed and thus only one was reviewed. Based upon the data, no additional actions will be taken, but audits will continue and corrective actions will be taken as indicated.

VIII.B.1.f	ensure that there are adequate number of psychologists for each unit, where needed- with experience in behavior management, to provide adequate assessments and behavioral treatment programs.	**Recommendation:** Fill current psychology department vacancies and proceed with plans for three new positions. SEH Response: Due to budget pressures none of the three positions have been filled, and none are on the list of positions approved to be filled. ***Tab # 42 List of Vacancies approved to be filled.*** However, with the closure of the Annex, the psychologists previously assigned there are available to support units who need assistance in completing various assessments.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td>VIII.B.2</td><td>By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.</td><td>
Recommendation:

1. Take steps to insure that all initial assessments (RSA, IPA, SWIA and Nursing Assessment) specifically indicate recommended groups from the online course catalogue, and that the auditing of these assessments includes monitoring for this item.

SEH Response: Psychology, rehabilitation services and social work modified their instructions to specify that clinicians should include such recommendations. Social work, rehabilitation services and psychology are now auditing this as part of their initial assessment audits. Nursing is working with the Avatar team to modify the CINA (by creating a Part A and Part B) and to change nursing security so that they will be able to add nursing interventions directly to IIRP.

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

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="5">GROUP FACILITATOR MONITORING AUDIT RESULTS</th></tr>
<tr><th></th><th>Rev Per #1 (Nov 10 ~Feb 11)</th><th>Rev Per #2 (Mar 11~June 11)</th><th>Rev Per #3 (July 11~Oct 11)</th><th>Mean-C</th></tr>
<tr><td>N
Chaplain
Consumer Affairs
Nursing
Nutrition Services
Psychiatry
Psychology
Rehabilitation Services
Social Work
Treatment Programs</td><td>82
1
3
16
2
15
10
17
12
6</td><td></td><td></td><td></td></tr>
<tr><td>n</td><td>104</td><td></td><td></td><td></td></tr>
<tr><td>%C. #1. The current session starts and ends on time</td><td>95</td><td></td><td></td><td></td></tr>
<tr><td>#2. The group facilitator greets participants to begin the session.</td><td>98</td><td></td><td></td><td></td></tr>
<tr><td>#3. GF briefly reviews the work from the prior session.</td><td>94</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT				
		#4. GF introduces sessions topics and goals.	96			
		#5. GF shows familiarity with the lesson plan and materials	97			
		#6. GF attempts to engage each participant in the session.	97			
		#7. GF keeps participants on task during the session.	95			
		#8. GF presentation style keeps the majority of participants attentive and interested.	87			
		#9. GF tests and evaluates the participants understanding through questions, role play or other means.	94			
		#10. GF presents information in a manner appropriate to the functioning level of the participants.	99			
		#11. At the conclusion of the session, the GF summarizes the work done in the session	91			
		#12. The GF and/or co-GF used at least one effective teaching technique.	96			
		#13. GF ensures the lesson plan for the current session is available and follows it.	87			
		#14. GF uses the individual's strengths, preferences, and interests.	98			

N= number of Unique Group facilitators Observed
n= Total number of groups observed

See Tab # 124 GROUP FACILITATOR MONITORING AUDIT RESULTS

CLINICAL CHART AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	196	191	194	219	183	184	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C #20 There is adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.	58	100	89	94	71	86	**n/a**	**83**

See Tab # 3 CLINICAL CHART AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action plan: The Hospital began monitoring group facilitators using a monitoring form and instructions to assess the performance of group leaders. ***See Tab # 124 Group Facilitator Monitoring Form and Instructions and Results.*** Audits of all group leaders will be completed three times per year. The Hospital will use the audit results to identify those individuals who would benefit from additional training, and those staff will attend the "refresher" training. In September 2010, the Hospital restarted its group leaders training program. Sixty one staff completed training. ***See Tab # 153 for Group Leader Training Information.*** (Psychiatrists and psychologists are not expected to take this course, but can if they choose to do so.) The training is a six week course, 12 hours total. A new session began March 24, 2011. The Hospital continues to refine the TLCs to better meet the needs of individuals in care. As previously noted, beginning September 20, 2010, the 4th Generation of the TLCs was introduced. The key improvements that were made include more comprehensive cognitive programming that includes online cognitive skill building for mildly impaired, cognitive skill building (paper/pencil) for the moderately impaired and sensory enhancement/reminiscence/remotivation techniques for individuals with mental retardation or dementia. Second, far more groups now are "dosed", and meet several times per week to allow for more depth in presenting the curricula and greater opportunity for skill acquisition. In addition there will be new basic social skills groups that will include role playing and videotaping. ***Tab # 69 TLC and Unit Based Group Schedules*** More recently, TLC leadership focused on modifying programming for those who are not engaged in treatment at the TLC. They identified approximately 25-30 individuals who are most likely not to participate in programming and referred those individuals to psychology for assessment. Psychology evaluated the individuals to determine if they would benefit from such interventions as PBS, motivational therapies or if psychosis may be affecting their ability to participate. TLC staff also met with the unit psychologist for each individual and modifications were made to group schedules as appropriate. Medication regimens were reviewed by the psychiatrist for those individuals for whom degree of psychosis was identified as problematic. In addition, PBS is now meeting with TLC nursing staff once per week to discuss individuals with any type of behavioral intervention to help reinforce PBS training and implementation of the various PBS interventions. Finally, Rehabilitation Services just introduced a positive "reinforcer" for individuals based upon their attendance and participation. In this initiative, every one to two weeks, individuals who are attending a group, randomly selected at variable intervals, will have a fun activity, rather than group. The individuals will not know which group or which day the "reinforcer" will occur, but only individuals in the groups at the selected time will be able to participate.
VIII.B.3	By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.	**Recommendations:** 1. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

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

2. Continue to develop mechanisms to increase patient engagement on the intensive treatment mall.

SEH Response: TLC leadership focused on modifying programming for those who are not engaged in treatment at the TLC. They identified approximately 25-30 individuals who are most likely not to participate in programming and referred those individuals to psychology for assessment. Psychology evaluated individuals to determine if they would benefit from such interventions as PBS, motivational therapies or if psychosis may be affecting their ability to participate. TLC staff also met with the unit psychologist for each individual and modifications were made to group schedules as appropriate. Medication regimens were reviewed by the psychiatrist for those individuals for whom degree of psychosis was identified as problematic. In addition, PBS is now meeting with TLC nursing staff once per week to discuss individuals with any type of behavioral intervention to help reinforce PBS training and implementation of the various PBS interventions. Other changes included locking the entrance to TLC support so that individuals could not slip in to avoid treatment and finally, Rehabilitation Services just introduced a “reinforcer” for individuals based upon their attendance and participation. Under this strategy, every one to two weeks, individuals who are attending a group, randomly selected at variable intervals, will have a fun activity, rather than group. The individuals will not know which group or which day the “reinforcer” will occur, but only individuals in the groups at the selected time will be able to participate.

Facility’s findings: See VIII.B.2

Analysis/Action Plans: Continue with audits as well as the group leader training.</td></tr>
<tr><td>VIII.B.4</td><td>By 18 months from the Effective Date hereof, SEH shall ensure that:</td><td></td></tr>
<tr><td>VIII.B.4.a</td><td>behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;</td><td>Recommendations:
Maintain current level of practice.

SEH Response: Level of practice maintained.

Facility’s findings:

<table>
<tr><th colspan="9">BEHAVIORAL INTERVENTIONS AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Total-P</td><td>Total-C</td></tr>
<tr><td>N</td><td>3</td><td>2</td><td>4</td><td>9</td><td>1</td><td>4</td><td>21</td><td>23</td></tr>
<tr><td>n</td><td>2</td><td>1</td><td>2</td><td>2</td><td>1</td><td>2</td><td>8</td><td>10</td></tr>
<tr><td>%S</td><td>67</td><td>50</td><td>50</td><td>22</td><td>100</td><td>50</td><td>38</td><td>43</td></tr>
<tr><td>#12. Behavioral interventions do not use of aversive contingencies</td><td>100</td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>100</td><td>90</td></tr>
</table>
N = All new or revised behavioral interventions in the review month
n = number audited</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 101 BEHAVIORAL INTERVENTIONS AUDIT RESULTS **Analysis/Action Plans:** Data show high levels of compliance with this requirement. Continue with audits.
VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Recommendation:** Maintain current level of practice. SEH Response: Level of practice maintained. Substance abuse related offerings in the mall were enhanced and include offerings of Stages of Change, Smart Recovery, Relapse Prevention, Learning about Healthy Living, Quit Smoking, "Double Trouble in Recovery", AA and NA, Anger Management for Individuals with Co-occurring Disorders, Substance Abuse Education, Sexual Safety and Sobriety, Principles of Recovery, Relapse Prevention, Recovery Process, and Relaxation and Stress Reduction. The Hospital has undertaken several initiatives to address those with co-occurring disorders. It continued to monitor the alignment of stage of change to IRP objectives, interventions and development of the discharge criteria through the co-occurring disorders self-audit. Based upon audit results during the first three months of the audit period, a decision was made to suspend the audits and provide technical assistance to treatment teams to improve the alignment of diagnosis, stage of change and IRP interventions. The Hospital's internal substance abuse expert met with each treatment team and they jointly reviewed the record of each individual with a diagnosis of substance abuse to assist the team in determining the appropriate stage of change and whether it was aligned with IRP objectives, interventions, and development of discharge criteria. This occurred during December 2010 and January 2011 in lieu of audits, which restarted in February 2011. That month's audit showed significant improvement in key aspects of substance abuse treatment. In addition, the TLCs developed an updated strategy around substance abuse treatment. The Hospital developed a "readiness" ruler to assess all individuals with a substance abuse diagnosis. ***See Tab # 80 Readiness Ruler Assessment*** Training was provided to co-occurring group leaders on completing the "readiness ruler" assessment in determining stage of change. Under the Hospital's plan, co-occurring disorder staff will complete a readiness assessment and get a baseline assessment of individual's with substance abuse diagnoses by the end of March 2011, which will be repeated at 3-4 month intervals. The individual will then be reassigned to groups that reflect the individual's stage of change, and number and type of groups themselves will be modified to reflect the results of the "readiness ruler" assessment results.
VIII.B.4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Recommendations:** 1. Provide staff training to ensure that Discharge Plan of Care accurately reflects all of the patient's diagnoses and that specific recommendations are in place for the treatment and/or support needed for individuals with cognitive disorders. SEH Response: Completed. Treatment teams were provided training by outside consultants around identifying discharge criteria, developing discharge plan and addressing discharge barriers. ***See IRP Training Data, Tab # 1.*** 2. Audit the Discharge Plan of Care as part of the Clinical Chart Review or Chart Review process.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>SEH Response: The Discharge Plan of Care document is reviewed as part of the discharge audits. The questions on the audit tool assess if all the individual's diagnoses are present and if the role of medication, the type of day activity, the type/location of any substance abuse services, housing or other specialized services were identified. See Tab # 67 Discharge Plan of Care Audit Tool. In addition, the clinical chart audits include assessment of discharge criteria, discharge barriers and discharge plan. See Tab # 10 Clinical Chart Audit Tool/Instructions.

Analysis/Action Plans: The Hospital continues to work closely with the Department of Developmental Disabilities and since September 1, 2010, seven DDS individuals have been discharged from the hospital. The Hospital also continues to have bi-weekly telephone conference calls with DDS.</td></tr>
<tr><td>VIII.B.4.d</td><td>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;</td><td>Recommendation:
Maintain current level of practice.

SEH Response: Level of practice maintained.</td></tr>
<tr><td>VIII.B.4.e</td><td>psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;</td><td>Recommendations:

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

SEH Response: See data below.

Facility's findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P*</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>184</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #4 Treatment and medication regimens are modified, as appropriate, considering such factors as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs. **</td><td></td><td></td><td></td><td></td><td></td><td></td><td>64</td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C #15 The team revised the focus of hospitalization, objectives, as appropriate, to reflect the individual's changing needs.</td><td>15</td><td>81</td><td>41</td><td>60</td><td>35</td><td>52</td><td>59</td><td>48</td></tr>
</table>
N = All IRP reviews scheduled, IRP database 9/23/10
n = number audited
* Mean from the prior review period reflects only two months of audits.
** Data was collected for this indicator but because auditors had different interpretations, it was deemed not reliable. The instructions have been modified and data will be available for the upcoming review.
Tab #3 CLINICAL CHART AUDIT RESULTS.

Analysis/Action Plan: Data was collected for indicator # 4 but because auditors had different interpretations, it was deemed not reliable. The instructions have been modified and data will be available for the upcoming review. See Tab # 10, Clinical chart audit tool and instructions for modified form. Data collected for other indicators, however suggest that teams are not yet revising objectives as expected. To address this, the Hospital provided additional training to teams around developing and writing focus statements, objectives and interventions, discharge related criteria, plans and barriers and completing the present status section of the clinical formulations. In addition, consultants have reviewed and provided coaching to teams on the written clinical formulations and IRPs See V.A.3 for more information about training.
See Tab # 1 for IRP Training Materials and Data.
</td></tr>
<tr><td>VIII.B.4.f</td><td>clinically relevant information remains readily accessible; and</td><td>Recommendation:
Maintain current level of practice.

SEH Response: Level of practice maintained.</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>Recommendations:

1. Institute fidelity checks.

SEH Response: Fidelity checks by PBS team have begun. See Boggio Advanced Document Request Tab # 25 Data generally show improvement in staff fidelity to the PBS plans.

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

SEH Response: See data below.
<table>
<tr><th>Discipline</th><th># Required</th><th># Attended</th><th># Competent</th><th>% Attended</th><th>% Competent</th></tr>
<tr><td>Chaplain</td><td>6</td><td>6</td><td>6</td><td>100</td><td>100</td></tr>
<tr><td>Clinical Administrator</td><td>13</td><td>13</td><td>13</td><td>100</td><td>100</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		Dentistry 13 13 13 **100** **100** Dietary 4 4 4 **100** **100** Medical 11 11 11 **100** **100** Nursing - Nurse Manager 18 18 18 **100** **100** Nursing - RN 93 92 92 **99** **99** Nursing - LPN 32 32 32 **100** **100** Nursing - RA 202 201 197 **100** **98** Psychiatry 67 67 67 **100** **100** Psychology 29 28 28 **97** **97** Rehabilitation 21 21 21 **100** **100** Social Work 16 16 16 **100** **100** Treatment Mall 4 4 4 **100** **100** Clinical (Other) 7 7 7 **100** **100** **Total** **536** **533** **529** **99** **99** ***See Tab # 40 PBS Training Data*** **Analysis/action plan:** Now that the PBS team is in place, the team has started the monitoring of staff in performing behavioral treatment consistent with the guidelines or plan and the IBIs. The team is using a monitoring form, and data show general improvement.
C.	Pharmacy Services	
	By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:	
VIII.C.1	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	**Recommendations:** 1. Implement corrective actions to address the significant drop in the pharmacy interventions/recommendations since the last review. SEH Response: The reduction last time was largely due to pharmacy staff conducting the medication monitoring audits and addressing issues as part of those audits. Those audits are no longer being conducted and the numbers have increased.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2. Continue to provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department, with comparison to the prior review period.

SEH Response: See data below.

Table 1. Total Number of Drug Interventions Documented							Sep-09 ~ Feb-10		Mar-10 ~ Aug-10	
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Total	Mean	Total	Mean
Grand Total	**23**	**6**	**1**	**8**	**5**	**5**	**121**	**20**	**48**	**8**

See Tab # 103 PHARMACIST PHYSICIAN COMMUNICATION DATA

Significance of Issue							Mar-10~Aug-10		Sep-10 ~ Feb-10	
	Sep-10	Oct-10	Nov-10	Dec-10	Jan-10	Feb-10	Total	Percent	Total	Percent
Major			2	13	4	6	**14**	**29%**	**25**	**28**
Moderate	3	4	6	17	6	10	**17**	**35%**	**46**	**52**
Minor		1		10	1	1	**12**	**25%**	**13**	**15**
Unknown/NA	2				1	2	**5**	**10%**	**5**	**6**
Grand Total	**5**	**5**	**8**	**40**	**12**	**19**	**48**	**100%**	**89**	**100**

See Tab # 103 PHARMACIST PHYSICIAN COMMUNICATION DATA

Drug Interventions by Intervention Category							Mar-10~Aug-10		Sep-10~Feb-11	
	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Total	Percent	Total	Percent
ALLERGY				1	1	7	**5**	**10%**	**9**	**10**
DOSAGE ISSUES				1			**0**	**0%**	**1**	**1**
DRUG INFORMATION	2				1		**1**	**2%**	**3**	**3**
DUPLICATE/UNNEC THERAPY		2	4		5		**0**	**0%**	**11**	**12**
INDICATION							**1**	**2%**	**0**	**0**
INTERACTION		1		3			**2**	**4%**	**4**	**4**
ON-CALL MED PROCUREMENT							**5**	**10%**	**0**	**0**
ORDER CLARIFICATION			1	11	1		**10**	**21%**	**13**	**15**
ORDER ENTRY	3	1			1	5	**12**	**25%**	**10**	**11**
PATIENT MONITORING			1	7	1		**2**	**4%**	**9**	**10**
POLYPHARMACY							**3**	**6%**	**0**	**0**
PROVIDER CLINICAL CONSULT		1	1	15	1	5	**0**	**0%**	**23**	**26**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SIDE EFFECTS							1	2%	0	0
OTHER					1	2	0	0%	3	3
Grand Total	**5**	**5**	**8**	**40**	**12**	**19**	**48**	**100%**	**89**	**100**

See Tab # 103 PHARMACIST PHYSICIAN COMMUNICATION DATA

Expected Outcome							Mar-10 ~ Aug-10		Sep-10~Feb-11	
	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Total	Percent	Total	Percent
ALLERGY INFO PROVIDED				1		6	1	2%	7	8
AWAITING CALL/UNRESOLVED							1	2%	0	0
CLINICAL CONSULT PROVIDED	2		1	6	1	4	16	33%	14	16
COST SAVINGS							0	0%	0	0
DOSAGE CHANGED	1	2		1	1		1	2%	5	6
DOSAGE CLARIFIED						1	0	0%	1	1
DOSAGE FORM CHANGED				3	2		3	6%	5	6
DOSAGE REDUCED							2	4%	0	0
DRUG INF PROVIDED							1	2%	0	0
FREQUENCY CHANGED			2	1			1	2%	3	3
LABS ORDERED				5	1		0	0%	6	7
MEDICATION CHANGED	1	1		1	1		11	23%	4	4
MEDICATION DISCONTINUED	1	1	4	5	4	7	5	10%	22	25
ORDER RENEWED				4			2	4%	4	4
ORDER UNCHANGED				13	2		4	8%	15	17
Not Identified		1	1			1	0	0%	3	3
Grand Total	**5**	**5**	**8**	**40**	**12**	**19**	**48**	**100%**	**89**	**100**

See Tab # 103 PHARMACIST PHYSICIAN COMMUNICATION DATA

Reason for Action							Mar-10 ~ Aug-10		Sep-10~Feb-11	
	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Total	Percent	Total	Percent
ALLERGY/ADE ID OR PREVENTED				2	1	1	4	8%	4	4

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT									
		ALTERNATIVE MEDICATION RECOMMENDED				3			**4**	**8%**	**3**	**3**
		DOSING ADJUSTMENT							**5**	**10%**	**0**	**0**
		DRUG INFORMATION REQUEST			1			1	**3**	**6%**	**2**	**2**
		DRUG-DRUG INTERACTION		1		4			**2**	**4%**	**5**	**6**
		DUPLICATE ORDER		1	4	1		5	**7**	**15%**	**11**	**12**
		DURATION					1		**0**	**0**	**1**	**1**
		EXCESSIVE DOSAGE	2						**2**	**4%**	**2**	**2**
		INCORRECT FREQUENCY SELECTED			1	2			**2**	**4%**	**3**	**3**
		LABS MISSING							**0**	**0%**	**0**	**0**
		LABS NOT CURRENT				7	1		**0**	**0%**	**8**	**9**
		LABS OUTSIDE OF REFERENCE RANGE							**0**	**0%**	**0**	**0**
		MEDICATION NOT AVAILABLE				4	2	3	**6**	**13%**	**9**	**10**
		NON FORMULARY MEDICATION FORM REQUIRED				1			**2**	**4%**	**1**	**1**
		ORDER EXPIRED OR OMITTED				3			**3**	**6%**	**3**	**3**
		PROVIDE DRUG INFORMATION		1	1				**0**	**0%**	**2**	**2**
		REQUEST TO CHANGE TO FORMULARY MEDICATION							**0**	**0%**	**0**	**0**
		ROUTE/DOSAGE FORM CHANGE		1			1		**2**	**4%**	**2**	**2**
		SUBOPTIMAL DOSAGE							**0**	**0%**	**0**	**0**
		TECHNICAL ASSISTANCE	1			6			**5**	**10%**	**7**	**8**
		THERAPEUTIC DUPLICATION	1	1		1	5		**0**	**0%**	**8**	**9**
		Not Identified	1	0	1	6	1	2	**1**	**2%**	**11**	**12**
		Grand Total	**5**	**5**	**8**	**40**	**12**	**19**	**48**	**100%**	**89**	**100**

See Tab # 103 PHARMACIST PHYSICIAN COMMUNICATION DATA

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		3. Provide clear operational definitions for all categories of the recommendations. SEH Response: Completed. See ***Tab# 103, Pharmacist/Physician communication data/definitions.***
VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Recommendations:** 1. Same as above. SEH Response: Same as above.
D	Nursing and Unit-based Services	
	SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and 'therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	
VIII.D.1	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;	**Recommendations:** 1. The October 7, 2010 SEH Corrective Action Plan (CAP) goals relative to nursing training appear to have been met. Compliance should be maintained. SEH Response: Nursing continues with implementation of training competency program. ***See Tab # 119 Nursing Training course outlines; # 120 Nursing Training Data; Tab # 116 Nursing Competency Plan.*** Focus for training has been on completing the physical observation training and retraining on medication administration which is expected to be completed by the end of April 2011. The current Nursing Competency Plan is undergoing review and modification as needed to ensure it reflects nursing procedures that have been or are about to be updated. It is expected to be completed by May 16, 2011. 2. The CAP contains adequate steps to address continued hospital wide training program development as well as improved employee attendance at competency based annual updates. SEH Response: CAP was implemented and updated effective March 4, 2011. ***See Corrective Action Plan.*** A nurse manager was detailed to nursing education to provide additional expertise and work with staff on units, and a position for a quality education nurse to provide on unit coaching and observation is being created; the Hospital believes that it will have authority to recruit and hire for that position. The goal will be to have five such quality education nurses, but reaching that goal will depend on approval to hire that the Hospital currently does not have. 3. The CNE should consider and implement approaches to ensure that contract nursing personnel demonstrate competency consistent with the functions they are authorized to perform.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: Nursing has focused on improving the week-long training program that contract nurses must complete. Changes to the in service program for contract nurses include completion of all mandatory hospital trainings, complete nursing orientation and pass all competency posttests and checklist with an 80% or higher, having a preceptor assigned to them for unit based training which is currently 2-3 days, and meeting all basic requirements including PPD, background checks, physical etc.

Facility findings: Training data show:

Mental Health Diagnosis, Stages of Change & Therapeutic Communication

June 16th –Current

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	% Post-test Received	Total % Not Competent
LPN	30	30	0	100	10%	100%	0
RN	71	71	0	100	17%	100%	0
RA	196	196	0	100	8%	100%	0
Sup. RN	8	8	0	100	6%	100%	0
Nurse Mgr.	10	10	0	100	0%	100%	0
Grand Total	**315**	**315**	**0**	**100**	**10%**	**100%**	**0**

Mental Health Diagnosis, Stages of Change & Therapeutic Communication New Hires Training Data

9/15/2010 - Current

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
RN	15	15	0	100%	0.00%	100%	0%
Grand Total	**15**	**15**	**0**	**100%**	**0%**	**100%**	**0%**

SEH Nursing Staff - Total Compliance for Medication Administration Training Data
Annual Training To Date Data
(Expected completion date for all RN/LPN staff is April 18, 2011)

1/20/2011 - Ongoing

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
LPN	30	20	10	67%	0%	67%	33%
RN	71	54	17	76%	0%	76%	24%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Sup. RN	8	2	6	25%	0%	25%	75%
Nurse Mgrs	10	10	0	100%	0%	100%	0%
Grand Total	**119**	**86**	**33**	**72%**	**0%**	**72%**	**28%**

SEH Nursing Staff - Total Compliance for Medication Administration
New Hires Training

1/20/11- Current

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
New Hires	**15**	**15**	**0**	**100%**	**0%**	**100%**	**0%**

* 1 Supervisory Nurse and 3 RNs are currently in orientation as of 9/20/10

SEH Nursing Staff – Vital Signs Annual Training

9/10/2010~10/29/2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate (Current)	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
LPNs	30	30	0	100%	0%	100%	0%
RAs	196	196	0	100%	1%	100%	0%
New HIres	0	n/a	0	0%	0	0%	0%
Total	**226**	**226**	**0**	**100%**	**1%**	**100%**	**0%**

* Training started September 10th and is currently in process.

Focused Physical Assessment (Management of Symptoms)
Annual Training Data
(Expected to be completed by April 18, 2011)

1/20/2011 to ongoing

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate (Current)	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
Nurse Mgr	10	10	0	100%	0%	100%	0%
Nurse Sup	8	2	6	25%	0%	25%	75%
Unit RNs	71	54	17	76%	0%	76%	24%
Grand Total	**89**	**66**	**23**	**74%**	**0%**	**74%**	**26%**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Diabetes Annual Training

12/06/10–Ongoing

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	% Post-test Received	Total % Not Competent
LPN	30	26	4	87%	0%	87%	13%
RN	71	68	3	96%	0%	965	4%
RA	196	157	39	80%	0%	80%	20%
Sup. RN	8	7	1	88%	0%	88%	12%
Nurse Mgr.	10	10	0	100%	0%	100%	0%
Grand Total	**315**	**268**	**47**	**85%**	**0%**	**85%**	**15%**

Tab # 119 and # 120 NURSING TRAINING DATA AND OUTLINES

Analysis/Action plan: The Hospital integrated related concepts of the required training areas and either has completed or is progressing toward completion of the required training areas. As of March 15, 2011, one hundred percent (100%) of experienced nursing staff have completed and are current in competency based training around mental health diagnosis and related symptoms, which includes identification and monitoring of symptoms and target variables. One hundred percent of new employees completed training around mental health diagnoses and related symptoms. In addition, two unit based in-services are underway, including Mood Disorder In-service and Suicide Awareness In-service. ***Tab # 119 and # 120 Nursing training outlines and data.***

Seventy two percent of staff have been retrained to date around psychotropic medications, and identification of their side effects was completed as part of the medication administration training, and all newly hired registered nurses have all been trained on these modules. Each of these trainings also included training on related documentation requirements. Training of the remaining staff is targeted for completion by mid April 2011. Training on taking of vital signs was completed and 100% of staff met this competency. Training is also underway on physical assessment of individuals in care and is also targeted to be completed by mid April 2011; to date 74% of staff have successfully completed this training. Finally, 85% of nursing staff have successfully completed diabetes annual training.

A new nursing documentation procedure was developed and is being rolled out to staff. ***Tab # 106 Nursing procedure re documentation.*** This procedure supplements specific documentation requirements that are embedded in subject matter specific procedures and are included in the specific related training. For the new documentation procedure, the plan is to provide a copy to each nursing staff member and have nurse managers act as coaches in implementing it. This will be monitored to determine if more formal training will be required.

The Hospital continues to implement its nursing training program. Currently it is led by a Director of Nursing Education, and includes four trainers (a RA is now part of the training office). In addition, depending on availability of funds, it hopes to recruit for one or more quality education and compliance nurses who will spend the majority of the day on houses or in the TLCs to observe practice and provide coaching to improve practice and assess training needs. Feedback from

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		observations will also be transmitted to the Director of Nursing Education so that curricula adjustments can be made if needed. In addition, beginning in February 2011 nurse managers or charge nurses observed at least one insulin administration each month for each RN or LPN using a structured audit tool. ***See Tab # 121 Medication Administration Observation audit tool.*** The tool, which is based upon the nursing procedure is designed to address competency and included checks on general awareness of insulin management and diabetes, ability to monitor blood glucose, ability to verify insulin, ability to administer insulin, and adherence to documentation requirements. One hundred percent of RNs (71) and LPNS (30) were observed completing an insulin administration. Data from the observations show that among RNs, criteria related to ability to monitor blood glucose (86%) and adhere to documentation requirements (88%) were rated the lowest and that ability to administer insulin was rated as 96%, while ability to verify insulin was rated at 99%. Only 38% of RNs on one unit and 29% on a second unit successfully rechecked blood glucose levels when results were abnormal, which was the only area in the blood glucose section with which RNs were having difficulty. Only 38% of RNs on a unit and 43% on a second unit properly documented insulin administration. These RNs will be required to go to remedial training in the skills lab. Among LPNs, the performance was higher, with all indicators at or above 90%. One LPN has been assigned to remedial training in the skills lab. In April 2011 nurse managers will expand their observations to include medication administrations, so that each RN or LPN will be observed at least once each quarter completing either an insulin administration or a medication administration.
VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Recommendations:** 1. The SEH CAP (V Treatment Planning; VIII, Treatment Services; and V.VIII, X regarding integrating skill acquisition and house based interventions) contains some actions that will support nursing to meet this provision. Others are needed that address unit operations. SEH Response: Nurse managers were trained, with clinical administrators, in the development of focus statements, objectives and interventions targeting those with medical needs or issues. Training was done by consultants who included a nurse. In addition, clinical chart audits and IRP observation audits are occurring each month, and auditors provide coaching and feedback. With respect to nursing operations, the two assistant director of nursing (ADONs) are working closely with nurse managers to address unit operations issues. Each review nursing shift assignments, observe shift reports and provide coaching to nurse managers based upon what they observed. For each individual that is transferred to a medical facility, the ADONs review the change of status/transfer forms and discuss the transfer forms with the nurse manager the next day. Suggestions are made to improve the quality of information as needed. They also review notes for up to three days after the individual returns to assess quality of documentation and assessments. In addition, nursing continues its work on nursing procedures. The Hospital recently adopted a clinical procedure which incorporates the Lippencott manuals now available on the units. ***See Tab # 105 Nursing Clinical Procedure*** The next step will be to cancel existing nursing procedures that are replaced by the new clinical procedure which is expected to be

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		completed by May 2011. Nursing procedures that have been revised as of the writing of this report and are attached to the report include: Nursing Clinical Procedures, Patient Transfer To and Return From Outside Facility for Evaluation, Assessing Change in Patient Condition, Nursing Assessment, Nursing Documentation, Fall Prevention/Injury Reduction and Risk Assessment, and Intake & Output Procedure. The following additional nursing procedures are undergoing review and revision and should be available by the time of the visit: Dysphagia Assessment and Management, Levels of Observation, Decubitus Prevention and Management, all nursing procedures relating to restraint, seclusion or protective measures, all nursing procedures relating to medication administration, Nursing Performance Improvement, Nursing Competency Plan, Assignment of Nursing Care, Plan for Provision of Care, Change of Shift report. ***See Tab # #s 104 – 116, # 123.*** See also Analysis and action steps below for status update. 2. Develop a mechanism for the RN to enter relevant nursing interventions into the IIRP. Train the designated RN to prioritize and individualize interventions. SEH Response: RNs have been given access to the IIRP and as of mid April 2011 are expected to directly enter nursing interventions into the IIRP. The CINA is being revised, to include two sections, Part A to be completed within 8 hours of admission, and Part B within 24 hours of admission. The form includes a section of nursing interventions. Nurse managers were trained on writing focus statements, objectives and interventions, with a focus on medical needs. Nurse managers are training their staff, and the individual who does many of the CINAs has been trained on how to complete interventions. 3. Develop a structure and process for nursing leadership to analyze audit findings, document actions to address findings, and evaluate the effectiveness of those actions. SEH Response: A process is currently in place. Nurse managers or ADONs complete monthly audits of nursing assessments. The raw data is analyzed by the Office of Reporting and Statistics and provided to nursing leadership. Audit results are then presented at weekly nurse manager meetings and trends are discussed and action steps developed. In addition, each nurse manager reviews RN and RA notes from one record each day to assess quality, and will follow up with staff on strengths and areas in need of improvement. The results of this documentation review are reported to the CNE each week, and are shared with nurse managers at their weekly meetings. If needed, action plans are developed. 4. Revise the existing assignment sheet to be aligned with a recovery oriented environment and to ensure enhanced engagement with individuals including EARN implementation. SEH Response: The Hospital is working with a consultant to review the assignment procedure and sheet. It should be completed by the May 2011 visit. 5. Train all charge RNs and Nurse Managers on using a new assignment sheet to organize work flow and enhance accountability. SEH Response: Staff will be trained once the sheet has been revised.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

6. Train RNs on how to write a progress note.

SEH Response: A new nursing documentation procedure was developed and is being rolled out to staff. ***Tab # 106 Nursing procedure re documentation.*** This procedure supplements specific documentation requirements that are embedded in subject matter specific procedures and are included in the specific related training. For the new documentation procedure, the plan is to provide a copy to each nursing staff member and have nurse managers act as coaches in implementing it. This will be monitored to determine if more formal training will be required.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P***	**Mean-C**
N	122	140	158	208	186	188	**212**	**167**
n	19	15	12	16	22	23	**22**	**18**
%S	16	11	8	8	12	12	**10**	**11**
%C # Data fields Presence of RN in IRP meetings	84	79	81	94	91	91	**88**	**87**

N=All IRPs scheduled
n=number audited in the month
* The mean from the indicated period is based upon three months of audits
Tab # 9 IRP OBSERVATION AUDIT RESULTS

INITIAL NURSING ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	31	34	32	35	33	29	**38**	**32**
n	6	8	3	8	8	4	**7**	**6**
%S	19	24	9	23	24	14	**17**	**19**
Completed within 8 hours	67	88	100	88	89	67	**72**	**85**
%C #9 If assessment identified risk in any risk screens, was nature of risk described sufficiently to develop adequate nursing interventions to address risk	100	83	100	63	88	75	**53**	**81**
%C #13 If prior medical history was noted was there appropriate description of the event so that interventions could be identified if needed?	75	67	100	75	100	100	**65**	**85**
%C # 16 Did the assessment include a physical assessment of all systems	100	100	100	88	100	100	**68**	**97**
%C #17 If a positive physical assessment is noted, is there a description of the symptoms or event sufficient to develop interventions and minimize risk to patient?	75	67	n/a	75	83	100	**60**	**81**
%C #25 Did the record overall support the findings in the mental status examination sections?	100	88	100	100	100	100	**69**	**97**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 26 Were the MSE section findings consistent with the risk assessment findings?	100	100	100	100	100	100	**71**	**100**
%C #28 Was the recovery assessment section completed?	100	88	100	63	100	75	**66**	**87**
%C #30 Do the assessments in each domain of the functional rehabilitation screens accurately reflect the record?	0	88	100	86	67	33	**74**	**68**
%C #33 Were nursing interventions developed?	83	75	0	75	100	75	**64**	**76**
%C #34 Was a nursing intervention developed for each area of risk identified in the assessment?	67	75	n/a	50	78	75	**47**	**69**
%C #35 Were the nursing interventions specific and individualized and tailored to the individual's needs?	50	71	N/A	25	67	100	**35**	**58**
%C #36 Were the interventions appropriate to the functional level of the individual?	100	100	N/A	75	89	67	**46**	**88**

N= Monthly Admissions
n= Population monitored (target is 20% sample)
Tab #4 CINA AUDIT RESULTS

NURSING UPDATE ASSESSMENT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	280	273	271	266	266	263	**272**	**270**
n	18	12	10	16	12	13	**12**	**14**
%S	6	4	4	6	5	5	**4**	**5**
%C #2 Has the advance instruction/comfort plan form been reviewed and updated			70	94	92	100	**n/a**	**90**
%C # 5 Are strengths clearly described	88	83	100	94	92	100	**88**	**92**
%C # 6 Is the current mental status carefully described			100	100	92	92	**n/a**	**96**
%C # 7 Is improvement re current mental status summarized per instructions			100	100	92	92	**n/a**	**96**
%C # 8 Is current safety risk indicated			90	92	92	100	**n/a**	**94**
%C # 9 Is change in safety risk since last update noted			89	75	80	75	**n/a**	**79**
%C # 10 Summary of current health and wellness challenges which require monitoring or treatment adequately noted			89	100	100	92	**n/a**	**96**
%C # 11 Pertinent risk assessment tool ratings (falls, skin integrity, dysphagia) included			67	78	100	91	**n/a**	**86**
%C # 12 Includes cognitive and perceptual/neurological symptoms if indicated			63	100	90	100	**n/a**	**90**
%C # 13 Includes summary of vital signs and weight			56	69	75	92	**n/a**	**74**
%C # 14 Includes pertinent changes in lab values			50	92	67	100	**n/a**	**79**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 15b Describes if individual can care for ADLs independently			67	100	75	92	**n/a**	**86**
% C # 16 Includes progress/lack of progress and conclusion			57	94	75	100	**n/a**	**85**
%C # 26 Summarizes the progress toward recovery goals			60	75	50	50	**n/a**	**60**
%C # 29 Describes relationships in the milieu			56	69	50	82	**n/a**	**65**
%C # 30 Describes circumstances if individual has been involved in conflicts or arguments			63	67	75	83	**n/a**	**71**
%C # 32 Describes hobbies or leisure skills			56	69	42	70	**n/a**	**59**
%C # 34 Notes discharge issues			67	73	82	80	**n/a**	**76**
%C # 35 Notes progress or lack of progress and conclusions			75	77	67	91	**n/a**	**77**
%C # 36 Describes if individual knows what nursing is doing for him and why			90	81	91	70	**n/a**	**83**
%C # 37 RN summarizes progress and makes recommendations to IRP			56	83	100	70	**n/a**	**79**
%C # 38 RN identifies issues not covered in focus areas or data that reflect currently inactive problems but may become issues later			25	71	100	67	**n/a**	**71**

Note new tool used in Nov, 2010
N= End of month Census less new monthly admissions
n= number of updates audited
See Tab# 4 NURSING UPDATE AUDIT RESULTS

Analysis/Action Plan: Data show generally that the attendance of the registered nurse at the IRP is about the same as the last reporting period. ***See Tab# 4 CINA and Nursing Update audit results*** Data from the CINA shows performance around the quality of the initial nursing assessment is improved over last review period, but is still not meeting the expected level for many indicators. The Hospital is modifying the CINA by dividing it into two parts. As of the writing of this report, the revised CINA was in AVATAR testing by staff. In addition, a modified version of the CINA will be used as an annual nursing assessment.

The nursing update audit tool was substantially modified to reflect the nursing update form utilized during the review period and includes assessment of the quality of documentation and assessment. ***Tab # 28 Nursing Update form; Tab # 29 and # 4 Nursing Update Audit Tool/instructions/audit results.*** The data show performance in most indicators in the 70-80 percent range so improvement is needed. Clinical chart audits continue around IRP and nursing interventions, see VIII.D.9.

Nursing is modifying relevant forms and procedures to improve practice in IRP participation, reporting on an individual's progress and documenting responses to medication and behavioral interventions. ***See Updated CAP for specific steps.*** First, major changes are being made to the CINA and Nursing Update forms, and a new annual nursing assessment version of the CINA is being created. The CINA is being divided into two Parts, with Part A due in 8 hours and Part B due in 24

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		hours, to reflect that in many cases, nursing was unable to obtain information needed to complete the CINA within the 8 hours, and thus key information was not available to treatment teams. Under the new form, which is in development by Avatar and should be live by the May 2011 visit, Part A will include risk assessments (including violence, trauma, suicide, falls, dysphagia screen etc), summary of recent psychiatric or substance abuse treatment, a substance abuse screening, a summary of medical and surgical history, identification of allergies, a physical assessment, a brief mental status examination, summary of ADLs and nursing interventions for each focus area of the IRP, among other areas. Part B of the CINA will include a recovery assessment, patient safety information and a summary that includes descriptions of the presenting problems and immediate concerns and immediate nursing interventions implemented. ***See Tab 26 CINA Forms and related documents*** The Nursing Progress Update serves as the weekly or monthly note (depending on individual's length of stay), and includes prompts for updating the comfort plan, review of legal status, and key clinical data (i.e. vital signs, weight and strengths). In addition, the Nursing Progress Update requires a summary analysis of each active IRP focus area with a focus on progress or lack thereof in each area and recommendations for revisions to the IRP interventions. This form went LIVE in Avatar on March 24, 2011. Finally, nursing is developing an annual nursing assessment that will be done each year during the individual's anniversary month. It includes a full review of subjective and objective data, update risk screenings, current mental status assessment, assessment of progress and changes to psychiatric and physical conditions, and reports on each focus area in the IRP. The form will be a version of the CINA. "Light bulbs" for each field in each form will be available to the nurse on the forms themselves as to what is to be included so staff will not need to refer to a separate document for information. Nurse managers received training on development of IRP focus statements, objectives and interventions relating to medical issues and will train unit staff. This responsibility will be shifted over time to the Quality Educators, assuming funding is identified to hire them; one is expected to be hired in April 2011, and up to four others are planned. In addition, nurse managers and some RNs attended IRP training around development of discharge criteria and discharge plans. Training was done by the consultants and teams participated using real cases. Another initiative to improve clinical care is the Recovery Assistant Peer Specialist pilot (RAPS) initiative which was implemented late March 2011. This program was created as part of the Violence Reduction Initiative and is linked to EARN. Each shift has a RAP, who assists the charge nurse to support the unit. The duties include ensuring that any staff acting as a 1:1 is aware of the reasons for the intervention as well as the individual's comfort plan, communicating information to the treatment team during IRPs from off day shift 1:1s and providing coaching to other RAs on individual/staff interactions. With respect to behavioral interventions, the PBS team will be providing weekly coaching to TLC nursing staff relating to those individuals whose participation in the TLC programming is marginal at best, reinforcing PBS training nursing staff have had. In addition, PBS team has provided training to nursing staff on three units on positive collaboration, ***See Tab # 82 Collaborative Problem Solving Training*** This initiative involved training all treatment staff on four units (the units with the highest incidents of psychiatric emergencies – 1D, 1E and 1F and is underway on 2C) on a different way to approach individuals and resolve staff – individual conflicts. Eventually all staff on all units will be provided this training. Finally, the Hospital is seeking a more prevention focused crisis intervention training for staff. The scope of work is completed and a contract it is possible that it will be awarded by the May 2011 visit.
VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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;	1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: See VIII.D.2 for update on forms to address this. In addition, nursing developed a form that will be completed by RNs upon transfer of an individual in care to (and received from) outside hospital for medical evaluation or treatment as well as a new Seizure Observation Form. ***See Tab # 104 Nursing Procedure, Transfer to and From Emergency Department/Hospital and Tab # 62 Seizure Management Policy.*** The Transfer Form includes information as to why the individual in care was transferred, diagnoses, vital signs, baseline mental status, assessment upon return and any new medications or treatments ordered. It also tracks whether the individual has been educated about the new medications or treatment. Currently, the CNE or ADONs are reviewing the 24 hour nursing report to identify transfer cases, and are working with nurse managers to ensure all nursing transfer documentation is complete and thorough, that return related documentation is completed, and that documentation in the few days following return addresses key medical issues. The seizure observation form tracks key information about seizure, including date and time, activity of individual at time of seizure, details about the seizure (duration, description of seizure etc), post-seizure behavior, individual's response to the seizure, injuries and date, time, name and dose of last medication. See also V.D.1 recommendation # 1 response. Nursing is updating its competency standards to reflect the revisions to the nursing procedures described above, which should be completed by the time of the May 2011 visit. As noted in the revised CAP dated March 4, 2011, the Hospital is focusing on training staff concerning physical assessment training and completed vital signs training. Data show all nursing staff have completed vital signs training, and that 74% of RNs and supervisors have completed physical assessment training (this latter training is set to be completed by mid April, 2011 for all RN staff. In addition, nursing reviewed and updated its procedure relating to Assessment in Change of condition and related forms to provide improved guidance. ***Tab # 123 Nursing Procedure, Assessment of Change of Condition*** Nursing education is reviewing the procedure to determine if any changes to its curriculum are needed but this is not expected to affect the substantive content of the physical assessment training. It is currently refining the dysphagia policy. Finally, the Hospital in March 2011 implemented its High Risk Indicator Review and Tracking Policy. The policy includes 8 categories of medical high risks (choking/aspiration); bowel obstruction, falls, seizures, TB (active); MRSA; cognitive impairment with high risk medications and refusal of medications for physical conditions. The policy sets standards for when someone should be added to the high risk list, as well as criteria for removal from the lists. 2. Align the nursing policy for assessing change in individual condition with the hospital policy addressing medical services. SEH Response: Completed. ***See Tab # 71 General Medical Services Policy; Tab # 123, Nursing Procedure, Assessment of Change of Condition.*** 3. Consider revising the template to document nursing assessments for physical status change so that it provides

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		prompts to support nurses to conduct and document assessments necessary for the particular physical status change. SEH Response: Completed. 4. Immediately provide training to all RNs on how to assess individuals whose physical status changes. SEH Response: Training on physical assessment (4 hour course) is underway and is expected to be completed by mid April 2011. The course was developed by nursing education with input from nursing leadership; content reflects the results of the nurse manager review of documentation around medical transfers. In addition, staff are being retrained on medication administration which is another 4 hour module. 5. Develop/revise the monitoring instrument and include qualitative criteria; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. SEH Response: See responses to recommendations 1-4 and related attachments to the report. An audit tool is being developed to reflect the new forms and procedures, and auditing is targeted to begin in May 2011. The tool should be available by the May 2011 visit. 6. Identify and take actions to resolve barriers to consistent documentation of interventions for physical care. SEH Response: Forms have been developed for transfers to and from medical hospitals and for seizure observations. The CNE, ADONs and nurse managers are reviewing the documentation related to transfers and are providing coaching to staff. In addition, documentation is included in the physical assessment training that began in January, 2011 and should be concluded by mid April, 2011. Revised nursing procedures relating to assessment of change in condition and intake/output were recently completed, ***see Tab # 123 Assessment of Change of Condition, , and # 110 Intake/Output Monitoring,*** and a procedures relating to decubitus preventions and management and dysphagia are expected to be completed by May 2011. These procedures will include standards around documentation. Joint training with Nurse Managers and Clinical Administrators was held around development of focus areas, objectives and interventions for individuals with physical conditions; nurse managers are working with RN staff on the units to address nursing IRP interventions. ***See Tab # 1, IRP Training.*** In addition, clinical chart audits are monitoring documentation around nursing interventions. ***See Tab # 10 Clinical chart audit form and # 3 Clinical Chart Audit results.*** **Analysis and action steps:** See Responses to recommendations in this subcell. See also Revised CAP dated March 4, 2011 that is attached to this report.
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Addressed in revised CAP dated March 4, 2011. Training curricula is implemented; staff are completing training around insulin and medication administration. Nurse managers or ADONs are observing at least one insulin or medication administration each quarter using a structured tool. ***See Tab # 121 Insulin Administration Audit Tool.*** The first round of observations were completed in February 2011 and involved observations of insulin administrations. The tool, which is based upon the nursing procedure is designed to address competency and included checks on general awareness of insulin management and diabetes, ability to monitor blood glucose, ability to verify insulin, ability to administer insulin, and adherence to documentation requirements. One hundred percent of RNs (71) and LPNS (30) were observed completing an insulin administration. Data from the observations show that among RNs, criteria relating to the ability to monitor blood glucose (86%) and adhere to documentation requirements (88%) were rated the lowest and that ability to administer insulin was rated as 96%, while ability to verify insulin was rated at 99%. However, only 38% of RNs on one unit and 29% on a second unit successfully rechecked blood glucose levels when results were abnormal, which was the only area in the blood glucose section with which RNs were having difficulty. Only 38% of RNs on a unit and 43% on a second unit properly documented insulin administration. These RNs will be required to go to remedial training in the skills lab. Among LPNs, the performance was higher, with all indicators at or above 90%. One LPN has been assigned to remedial training in the skills lab. ***See Tab # 121 Insulin Administration Audit Results*** 2. Identify and resolve barriers to consistent documentation of medication administration. SEH Response: The Hospital continues to track missing administration documentation, ***Tab # 102, Medication Administration Documentation.*** Data show performance continues to meet the Hospital's target of no more than 0.5% missing documentation, but in both January and February 2011, there was a slight increase from December's low of 0.29% 3. Develop audit criteria and establish a process to regularly audit medication administration. SEH Response: Nurse managers or charge nurses observed one insulin administration for each RN or LPN using a structured tool. ***See Tab #121 Medication Administration Audit Tool*** This will continue on a quarterly basis, although either medication administration or insulin administration will be observed. In addition, once hired, this will transition to the quality educators who will complete observations and coaching around medication administration. 4. As an interim measure, the CNE should consider reviewing the proper medication administration practices with all Nurse Managers so that they can increase their own monitoring of medication administration. They may need to be relieved of other duties/routine reports to do this. SEH Response: See response to Recommendations 2 and 3. **Analysis/Action plan:** See responses to recommendations. The Hospital continues to monitor the rate of missed documentation for routinely scheduled medications. ***Tab # 102 Medication Administration documentation report.*** Data show that in August 2010, 48% of nurses had no missing documentation, that 37% had >1 but <= 10 missing; 13% had >10 but <=50; and only 3% had more than 50 missing. This trend continues to improve; in comparison, in February, 2011, 50% of nurses had no missing documentation, 42% had >1 but < 10, 8% had >10 but < 50, and 0% had more than 50 missing documentations. Information is also tracked by unit. This will continue. The Hospital policy on medication administration

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>was updated to include specific language around first dose medication monitoring and the nursing procedure is also being updated. See Tab # 125 Medication Ordering and Administration Policy. See also information provided in VIII.D.2 relating to medication administration retraining.</td></tr>
<tr><td>VIII.D.5</td><td>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;</td><td>Recommendations:

1. The CAP goals relative to competency based medication administration training have been met. Additional goals and strategies may be necessary relative to the actual practice on the unit. See VIII.D.4

SEH Response: See VIII.D.2 and VIII.D.4 Tab # 120 Nursing Training Data

Analysis/Action plan: As noted, nursing staff were provided a second 4 hour medication administration course as an adjunct to physical observation training. See Tab # 119 (Training course outlines) and # 120 (Nursing training data). Staff will be observed routinely at least once per quarter while doing medication or insulin administration and data will be collected using an audit tool. This began in February, and data are reported above. Once the quality educators are hired, they will also do observations and coaching on medication administration techniques.</td></tr>
<tr><td>VIII.D.6</td><td>Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors</td><td>Recommendations:
Maintain compliance.

SEH Response: Compliance maintained. Forty two medication errors of all types were reported by nursing during the reporting period. Missing medication administration documentation continues to be monitored. Data show improvement between August 2010 and February 2011.

<table>
<tr><th colspan="9">MEDICATION VARIANCES BY REPORTER</th></tr>
<tr><th></th><th>Sep~10</th><th>Oct~10</th><th>Nov~10</th><th>Dec~10</th><th>Jan~11</th><th>Feb~11</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>Physician</td><td>3</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>3.7</td><td>0.7</td></tr>
<tr><td>Nursing</td><td>14</td><td>3</td><td>6</td><td>11</td><td>2</td><td>6</td><td>5.2</td><td>7.0</td></tr>
<tr><td>Pharmacy</td><td>1</td><td>2</td><td>1</td><td>10</td><td>0</td><td>14</td><td>2.7</td><td>4.7</td></tr>
<tr><td>Not identified</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0.2</td><td>0.2</td></tr>
</table>
See Tab # 93 MVR data

See VIII.D.4 for additional information and data.</td></tr>
<tr><td>VIII.D.7</td><td>Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;</td><td>Recommendation:
See VIII.D.4

SEH Response: See VIII.D.4</td></tr>
<tr><td>VIII.D.8</td><td>Ensure that staff monitor, document, and report the status of symptoms and target</td><td>Recommendations:
1. See VIII.D.2, VIII.D.3, and VIII.D.9.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;	SEH Response: See VIII.D.2, VIII.D.3, and VIII.D.9. **Facility's findings:** See information and data in VIII.D.2.
9	Ensure that each individual's treatment plan identifies:	
VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Recommendation:** 1. The CAP contains adequate steps to meet the IRP requirements of this provision. SEH Response: CAP is being implemented. It was revised on March 4, 2011 and is attached to the report. See VIII.D.2 for summary of status of implementation and ***Tab # 1 IRP training materials and data.*** 2. Provide competency based training to staff regarding the new policy/procedure that addresses dysphagia and/or choking. SEH Response: The nursing procedure governing dysphagia was reviewed and is being modified somewhat to ensure consistency with other nursing procedures and Hospital policies. It should be available by the May 2011 visit**.** The nursing competency plan is being updated to reflect changes in the various nursing procedures, and it too should be available by May 16, 2011. 3. Monitor policy implementation, identify trends, take action to address trends, monitor effectiveness of actions taken. SEH Response: Not yet begun, See response to Recommendation # 2. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N	196	191	194	219	183	184	**176**	**195**
n	23	23	23	18	22	25	**22**	**22**
%S	12	12	12	8	12	14	**13**	**12**
%C. #17. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement	87	91	87	94	86	100	**91**	**91**

N = All IRPs due in the review month
n = number audited
Sample size is two per unit (as of the writing of this report, there are 11 units)
Tab # 3 CLINICAL CHART AUDIT RESULTS

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>See also VIII.D.2 for additional information.

Analysis/Action Plans: Data show generally high performance on this indicator, with a mean over 90%. Clinical administrators and nurse managers were provided additional training (held jointly) in February 2011 on developing focus statements, objectives and interventions, using the physical health focus area in this training. In addition, nurse managers and some unit RNs attended a second session on discharge related issues and IRPs. A copy of the training materials and IRP Training data can be found at Tab # 1, IRP Training materials and data. The nurse managers are training their staff on what they have learned. The Hospital will continue the monthly IRP observation and clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.</td></tr>
<tr><td>VIII.D.9.b</td><td>the related symptoms and target variables to be monitored by nursing and other unit staff; and</td><td>Recommendations:
See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a

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

Facility’s Findings:
<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>184</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #18. The IRP identifies the related symptoms and target variables to be monitored by nursing and other staff</td><td>43</td><td>95</td><td>83</td><td>78</td><td>86</td><td>83</td><td>80</td><td>78</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: Data show a marginal decline in performance on this indicator. Clinical administrators and nurse managers were provided additional training (held jointly) in February 2011 on developing focus statements, objectives and interventions, using physical health focus area in this training. A copy of the training materials and IRP Training data can be found at Tab # 1, IRP Training materials and data. The nurse managers are training their staff on what they have learned. The Hospital will continue the monthly IRP observation and clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.</td></tr>
<tr><td>VIII.D.9.c</td><td>the frequency by which staff need to monitor such symptoms:</td><td>Recommendation:
See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a.</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
SEH Response: See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a.

Facility's Findings:

<table>
<tr><th colspan="9">CLINICAL CHART AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>196</td><td>191</td><td>194</td><td>219</td><td>183</td><td>184</td><td>176</td><td>195</td></tr>
<tr><td>n</td><td>23</td><td>23</td><td>23</td><td>18</td><td>22</td><td>25</td><td>22</td><td>22</td></tr>
<tr><td>%S</td><td>12</td><td>12</td><td>12</td><td>8</td><td>12</td><td>14</td><td>13</td><td>12</td></tr>
<tr><td>%C. #19. The IRP identifies the frequency by which staff need to monitor such symptoms</td><td>39</td><td>91</td><td>78</td><td>94</td><td>86</td><td>92</td><td>77</td><td>80</td></tr>
</table>
N = All IRPs due in the review month
n = number audited
Tab # 3 CLINICAL CHART AUDIT RESULTS

Analysis/Action Plans: See VIII.D.9.b. Data show improved performance on this indicator. Audits tracking this indicator will continue.
</td></tr>
<tr><td>VIII.D.10</td><td>Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:</td><td></td></tr>
<tr><td>VIII.D.10.a</td><td>actively collect data with regard to infections and communicable diseases;</td><td>
Recommendations:

SEH CAP includes adequate actions to address PPD tracking. Since the proposed system relies on the Nurse Manager (NM), SEH will need to closely monitor the effectiveness of the plan. SEH may need to consider alternative approaches that are not reliant upon NM data entry.

SEH Response: The Hospital developed a method to obtain PPD information from Avatar system beginning in February, 2011. See Delacy Advanced Documents Tab # 018, 019

Facility's Findings:

<table>
<tr><th colspan="9">Employee Health Indicators</th><th colspan="2">Progress</th></tr>
<tr><td colspan="3">Indicator</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N1~4</td><td>Total SEH employees*</td><td>#</td><td>771</td><td>762</td><td>756</td><td>748</td><td>759</td><td>759</td><td>783</td><td></td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

1	Employees who had work restriction due to a communicable disease	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**	**0.0%**
2	Employees who had a blood pathogen exposure	%	0.1%	0.0%	0.0%	0.1%	0.0%	0.1%	**0.0%**	**0.1 %**
3	Employees who received influenza vaccine	%	0.0%	28.0%	0.0%	0.0%	0.0%	0.0%	**5.1%**	**4.7%**
4	Employees who had a PPD conversion	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**	**0.0%**

***** *Total number of SEH active employees at the end of month*

Patient Care Indicators									**Progress**	
	Indicator		***Sep***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mean-P***	***Mean-C***
N1/2	***Total Patient Days***	***#***	***9063***	***9213***	***8799***	***8983***	***9031***	***7925***	***9401***	***8836***
N3	***Total Admissions***	***#***	***31***	***34***	***32***	***35***	***33***	***29***	***39***	***32***
1	Healthcare Associated Infections	Rate*	1.43	1.52	0.91	1.00	2.10	3.28	**0.87**	**1.68**
2	Multi-drug Resistant Organisms	Rate*	0.11	0.00	0.00	0.22	0.00	0.00	**0.11**	**0.06**
3	Patients who are cultured for MRSA on admission	%	3.2	0.0	0.0	31.4	18.2	6.9	**11.9**	**10.3**

***** *Rate: Number of events per 1,000 patient days*

Hospital Hygiene Indicators									**Progress**	
	Indicator		***Sep***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mean-P***	***Mean-C***
N	***Total number observed***	***#***	***30***	***30***	***30***	***30***	***30***	***30***	***30***	***30***
1	Hand Hygiene Compliance	%	70	60	50	67	77	70	**59**	**66**

See Tab # 131, Infection Control Data and Trends for additional information.

Analysis/Action Plan: The Hospital will continue to monitor infection related trends. The Hospital created a database to track implementation of recommendations from various sources such as investigations, and special studies; infection control related recommendations will be tracked through this system. The Hospital is also addressing the issue of low rates of obtaining nasal swabs from individuals in care upon admission. This will be monitored by the Director of Medical Services to ensure individuals are properly assessed for MRSA upon admission.

VIII.D.10.b	assess these data for trends;	**Recommendations:** SEH is encouraged to follow through with planned actions to ensure that the IC requirements in VIII.D.10.c- e are documented and are accurately represented in the minutes. SEH may also determine an alternative approach to ensure the consistent documentation of these required functions.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Completed. The Hospital has modified its manner of reporting minutes from the Infection Control Committee. The minutes better reflect the discussion of data and trends had by the Committee, and the discussions are more clearly presented. ***See Tab # 131, Infection Control Data and Trends. See also Tab # 130 for Infection Control Committee Minutes.*** In addition, recommendations made from Infection Control Committee to Performance Improvement Committee will be tracked through the Hospital's new database. ***See Tab # 139 Screen shots recommendations tracking database.*** 2. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: Completed. The Hospital has modified its manner of reporting minutes from the Infection Control Committee. The minutes now reflect the discussion of trends that had been occurring at the Committee, but now the discussions are more clearly presented. ***See revised CAP*** dated March 4, 2011.
VIII.D.10.c	initiate inquiries regarding problematic trends;	**Recommendations:** 1. See VIII.D.10.b. SEH Response: See VIII.D.10.b. 2. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: Completed. ***See revised CAP*** dated March 4, 2011. To the extent available, national data and past data will be utilized to compare progress and determine nature of any trends.
VIII.D.10.d	identify necessary corrective action;	**Recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: ***See revised CAP*** dated March 4, 2011. To the extent available, national data and past data will be utilized to compare progress and determine nature of any trends. Information comparing the Hospital's performance against national standards will be included in information presented to the ICC. The Infection Control Officer will work with the Infection Control Committee and the Director of Medical Affairs to develop necessary corrective actions. These will be reported to PID for tracking through the newly created database. 2. See VIII.D.10.b SEH Response: See VIII.D.10.a, b, e.
VIII.D.10.e	monitor to ensure that appropriate remedies are achieved;	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: ***See revised CAP*** dated March 4, 2011. The Infection Control Officer will work with the Infection Control Committee and the Director of Medical Affairs to develop necessary corrective actions. These will be reported to PID for tracking through the newly created Hospital Recommendations Database maintained by PID. PID will track implementation, effectiveness and whether the implementation is sustained. 2. See VIII.D.10.b SEH Response: See VIII.D.10.b.
VIII.D.10.f	integrate this information into SEH's quality assurance review; and	**Recommendation:** 1. Specify the linkages between the ICC and hospital-wide Quality Assurance/Performance Improvement in Section 10 (Performance Improvement) of the Infection Control policy. SEH Response: Completed. ***See Tab # 128 Infection Control Policy relating to QA/Performance Improvement***
VIII.D.10.g	ensure that nursing staff implement the infection control program.	**Recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: See revised CAP dated March 4, 2011. In addition, the Infection Control Officer is available to attend IRP meetings for individuals with infection control needs. 2. Identify and resolve barriers to consistent documentation of infection control program implementation. SEH Response: The Hospital revised its CAP to address this recommendation. The Infection Control Officer developed nursing documentation standards for various types of infections (Flu, Ear infections, VRE, Scabies, MRSA, C.Diff, Isolation Precautions, Cold, UTI) and has reviewed them with nurse managers. ***See Tab # 132 Infection Control, Nursing Documentation standards*** 3. Continue to develop a menu of IRP objectives and interventions to support staff to include IC matters in the IRP as relevant. SEH Response: This was completed for the last visit. The Infection Control Officer has decided that he would not create additional menu items, but would also make himself available to attend IRP meetings so that objectives and interventions do not become formulaic. He developed standards for documentation of specific infectious diseases.
VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		1. The CAP contains adequate steps to address this provision. Conducting and documenting regular staffing evaluations during the nursing leadership meetings would strengthen management integration. SEH Response: Unfortunately, the District's budget pressures have adversely impacted implementation of the CAP around staffing. In February 2011, a job fair for nurses was held at the Hospital. The goal was to hire 30 RNs. One hundred and sixty five individuals attended and 85 were interviewed. Of those, 46 passed the screening interviews and were given intent to make offer letters contingent upon references, license checks etc. Unfortunately, due to budget pressures, DMH and the Office of the Chief Financial Officer only authorized the Hospital to hire four nurses. ***See Tab # 42 List of Vacancies Approved to be filled.*** Further, the Hospital has not been permitted to fill any vacancy that occurred prior to January 1, 2011. Consequently, even with the closure of the two units at the Annex, there remain critical shortages of nursing staff and overreliance on overtime.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.	**RESTRAINTS, SECLUSION, AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS**	
	By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	
X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	
X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: This is included in the revised CAP. The Hospital is purchasing an alternative nonviolent crisis intervention training module; the scope of work is on the street, and it anticipates that a vendor could be selected within 30 days. The Hospital is seeking training that is more prevention focused than the current curricula used. The training will be tailored to meet the Hospital's needs. Approximately ten individuals will be trained as trainers who will then train Hospital staff. The Hospital anticipates training of the trainers will occur in Spring, 2011. 2. Methodically review all policies (hospital and nursing) addressing restraint/seclusion, protective devices, and emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards. SEH Response: As of the time of the writing of this report, this is ongoing, with the assistance of an outside consultant. The Hospital policies are still being reviewed and revised as appropriate, and review of nursing procedures continues. The current policy is attached to the Report, but a revised policy is expected by the May 2011 visit. ***Tab # 51 Restraint or Seclusion for Behavioral Reasons Policy, Tab # 154 Medical and Protective Devices Policy.*** 3. Ensure that the content on all forms is consistent with policies/procedures and supports staff to complete required documentation. SEH Response: Ongoing. Changes were made in Avatar for both the Doctor's Order form for Seclusion and Restraint as well as the Level of Observation Flow Sheet. Targeted symptoms was removed from the Doctor's order and a new code to track information on informing the individual of the criteria for release was added to the Level of Observation form. ***Tab # 156, Avatar Enhancements and Implementation List***

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Analysis/Action Plans: The Hospital policy prohibits use of prone restraint, prone containment or prone transportation. There were no incidents of prone restraint, or prone transportation. However, during this review period, there were two incidents which, after investigation, the Risk Manager concluded that the individuals were placed in the prone position during efforts to control the individual. In both instances, the Risk Manager concluded that the individual in care was not turned to the supine position as soon as practicable as required by Hospital policy, although both were turned over and sustained no injury. The Hospital is continuing restraint and seclusion training. In addition, as of the writing of this report, it issued a scope of work for new non-violent crisis intervention training that will include training on proper ways to hold an individual in care as part of efforts to ensure his/her safety and that of others.

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

The CAP contains adequate steps to address the need for improved employee attendance at competency based annual updates.

SEH Response: The Hospital is purchasing a new non-violent crisis intervention module, and will implement it through a train-the-trainer approach. Hospital trainers will be trained in the Spring 2011 and will roll out training to all direct care employees thereafter. See X.B.1 for more details and the collaborative problem solving training completed to date. The Hospital continues to train employees in use of restraint or seclusion and NVCI. See Tab # 127 Training data, Seclusion and restraint, NVCI training and Collaborative Problem-solving.

As data show, overall compliance with seclusion and restraint training improved from 72% during last review period to 92% during this review period.

<table>
<tr><td colspan="5">Restraint or Seclusion for Behavioral Reasons: Existing Employees</td><td>3/15/2011</td></tr>
<tr><th>Discipline</th><th># Required</th><th># Attended</th><th># Competent</th><th>% Attended</th><th>% Competent*/ % of Attendees Competent**</th></tr>
<tr><td>Chaplain</td><td>6</td><td>6</td><td>6</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Clinical Administrator</td><td>12</td><td>12</td><td>12</td><td>100%</td><td>100%/100%</td></tr>
<tr><td>Dentistry</td><td>13</td><td>8</td><td>8</td><td>62%</td><td>62%/100%</td></tr>
<tr><td>Dietary</td><td>4</td><td>2</td><td>2</td><td>50%</td><td>50%/100%</td></tr>
<tr><td>Medical</td><td>9</td><td>5</td><td>5</td><td>56%</td><td>56%/100%</td></tr>
<tr><td>Nursing - Nurse Manager</td><td>17</td><td>15</td><td>15</td><td>88%</td><td>88%/100%</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nursing - RN	72	70	70	97%	97%/100%
Nursing - LPN	30	30	30	100%	100%/100%
Nursing - RA	195	183	183	94%	94%/100%
Psychiatry	67	65	65	97%	97%/100%
Psychology	28	22	22	79%	79%/100%
Rehabilitation	19	13	13	68%	68%/100%
Social Work	16	15	15	94%	94%/100%
Treatment Mall	4	3	3	75%	75%/100%
Clinical (Other)	12	10	10	83%	83%/100%
Security (including Contractors)	37	37	37	100%	100%/100%
Total	**541**	**496**	**496**	**92%**	**92%/100%**

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

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

Restraint or Seclusion for Behavioral Reasons: New Employees					09/01/10 ~ 03/15/11
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	1	1	50%	50%/100%
Total	**19**	**18**	**18**	**95%**	**100%/100%**

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

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

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

NVCI: Existing Employees	3/15/2011

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	6	6	100%	100%/100%
Clinical Administrator	12	7	7	58%	58%/100%
Dentistry	13	12	12	92%	92%/100%
Dietary	4	4	4	100%	100%/100%
Medical	9	6	6	67%	67%/100%
Nursing - Nurse Manager	17	8	8	47%	47%/100%
Nursing - RN	72	43	43	60%	60%/100%
Nursing - LPN	30	19	19	63%	63%/100%
Nursing - RA	195	119	119	61%	61%/100%
Psychiatry	67	57	57	85%	85%/100%
Psychology	28	24	24	86%	86%/100%
Rehabilitation	19	16	16	84%	84%/100%
Social Work	16	13	13	81%	81%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	12	8	8	67%	67%/100%
Security (including Contractors)	37	35	35	95%	95%/100%
Total	**541**	**381**	**381**	**70%**	**70%/100%**

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

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

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

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	1	1	50%	50%/100%
Total	**19**	**18**	**18**	**95%**	**100%/100%**

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

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

See Tab # 127 Restraint and Seclusion and NVCI Training Data and Curricula Outlines

Analysis/Action Steps: Data show that compliance with restraint and seclusion training substantially improved for all disciplines during this rating period. For Seclusion and restraint training (selected disciplines only):

Discipline	% Compliant Prior review period Seclusion and restraint training	% Compliant Current review period Seclusion and restraint training
Nurse manager	72%	88%
RN	67%	97%
LPN	74%	100%
RA	66%	94%
Psychiatrist	91%	97%
Security	0%	100%

For NVCI training there was improvement in each discipline, but not as significant as with restraint and seclusion training:

Discipline	% Compliant Prior review period NCVI training	% Compliant Current review period NCVI training
Nurse manager	44%	47%
RN	48%	60%
LPN	68%	63%
RA	59%	61%
Psychiatrist	76%	85%
Security	N/A	95%

See Tab # 127 Seclusion and restraint, NVCI training and Collaborative Problem-solving training data.

In an effort to improve compliance with these trainings, several steps were taken. First, a senior RA was transferred to Office of Training and Organizational Development to provide additional capacity for training around NVCI. Next, Executive Staff members are being provided with data from Office of Training that reflect the status of employee completion of training. This allows Executive staff to monitor those whose training is not current or about to expire. Third, the restraint and seclusion training and the non-violent crisis Intervention trainings are held at least twice monthly as part of new

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>employee orientation; these sessions are now open to existing employees and will be announced on the intranet so employees have additional opportunities for training. Further, training is being done also during evening and night shifts and these efforts will continue.

Staff on three houses have been trained (and a fourth unit is currently in training) in Collaborative Problem Solving by PBS staff, and the plan is to have all staff trained in it as well. Collaborative Problem solving training involves training staff on alternative ways to resolve conflicts, with a focus on staff/individual in care conflicts. See Tab # 82 Collaborative Problem Solving Training outline.</td></tr>
<tr><td>X.A.3</td><td>the use of side rails on beds, including a plan:</td><td>Recommendation:

Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken.

SEH Response: Use of side rails is monitored through the 24 hour nursing report and was tracked by the Compliance Office beginning in November 2010. During the period of November 2010 through February 28, 2011, eight individuals were placed on side rails for one or more nights. None of the side rails were used as restraint, but were used instead for safety. The chart below summarizes side rail use.

<table>
<tr><th>Individual in Care #</th><th>Number of Days Side Rails Ordered Between November 12, 2010 and February 28, 2011</th><th>Reason for use</th></tr>
<tr><td>#90327</td><td>43</td><td>To prevent falls and injury while in bed</td></tr>
<tr><td>#96950</td><td>29</td><td>To prevent falls and injury</td></tr>
<tr><td>#111397</td><td>84</td><td>To prevent falls and injury</td></tr>
<tr><td>#117930</td><td>10</td><td>To prevent falls and injury</td></tr>
<tr><td>#128382</td><td>18</td><td>To prevent falls and injury</td></tr>
<tr><td>#91847</td><td>13</td><td>One side rail to be up for safety</td></tr>
<tr><td>#112144</td><td>110</td><td>For safety and fall precautions</td></tr>
<tr><td>#925129</td><td>56</td><td>To prevent falls and injury</td></tr>
</table>

Use is consistent with the Hospital policy on Use of Protective measures (for safety), Tab # 154 Use of Protective Devices policy. Further, clinical formulations and IRPs reflect use of side rails.</td></tr>
<tr><td>X.A.3.a</td><td>to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and</td><td>Recommendation:
1. See X.A.3.

SEH Response: See X.A.3.</td></tr>
<tr><td>X.A.3.b</td><td>to provide that individualized treatment</td><td>Recommendation:</td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>plans address the use of side rails for those who need them, including identification .of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.</td><td>1. See X.A.3.

SEH Response: See X.A.3.</td></tr>
<tr><td>X.B</td><td>By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:</td><td></td></tr>
<tr><td>X.B.1</td><td>are used after a hierarchy of less restrictive measures has been considered and documented;</td><td>Recommendations:
Implement Corrective Action Plan around annual training.

SEH Response: See Section X.A.1 and X.A.2.

Facility's Findings:

<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N</td><td>5</td><td>5</td><td>6</td><td>13</td><td>4</td><td>3</td><td>6</td><td>6</td></tr>
<tr><td>n</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
<tr><td>%C # 2 Documentation reflects that individual posed an imminent danger to self or others if not restrained or secluded</td><td>100</td><td>100</td><td>67</td><td>100</td><td>100</td><td>100</td><td>94</td><td>94</td></tr>
<tr><td>%C # 3 Documentation reflects r/s used to ensure safety of individuals or others, after less restrictive interventions have been considered and documented</td><td>100</td><td>100</td><td>100</td><td>67</td><td>100</td><td>100</td><td>100</td><td>94</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
* Question was not in the tool used during March and April
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Restraint and seclusion usage continues to fall well below the national public rates of percent of individuals restrained or secluded of 3.6% for restraint and 2.6% for seclusion.
<table>
<tr><th colspan="7">PERCENT OF INDIVIDUALS RESTRAINED OR SECLUDED</th></tr>
<tr><td></td><td>Sep-10</td><td>Oct-10</td><td>Nov-10</td><td>Dec-10</td><td>Jan-10</td><td>Feb-10</td></tr>
<tr><td>Restraint</td><td>0.0%</td><td>0.9%</td><td>0.9%</td><td>0.6%</td><td>0.3%</td><td>0.0%</td></tr>
<tr><td>Seclusion</td><td>0.9%</td><td>0.6%</td><td>0.6%</td><td>1.2%</td><td>0.6%</td><td>0.6%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
NPR Rate percent of individuals restrained=3.6%
NPR Rate percent of individuals secluded=2.6%
See PRISM Report, Tab # 53

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

<table>
<tr><th colspan="7">RATE OF INDIVIDUALS RESTRAINED OR SECLUDED HOURS</th></tr>
<tr><td></td><td>Sep-10</td><td>Oct-10</td><td>Nov-10</td><td>Dec-10</td><td>Jan-10</td><td>Feb-10</td></tr>
<tr><td>Restraint</td><td>0.00</td><td>0.02</td><td>0.01</td><td>0.03</td><td>0.00</td><td>0.00</td></tr>
<tr><td>Seclusion</td><td>0.01</td><td>0.01</td><td>0.02</td><td>0.03</td><td>0.01</td><td>0.01</td></tr>
</table>
NPR Hours Rate of restraint=0.55
NPR Hours Rate of seclusion=0.42
See PRISM Report, Tab # 53

See Tab # 53 PRISM report.

Analysis/Action Plans: The Hospital is performing above the 90% mark for this requirement.

It also has taken steps to address has several strategies to further reduce restraint or seclusion use. First, at a clinical leadership meeting in early Fall, 2010 the results of the Psychiatric Emergency study described in the previous report were presented to treatment teams, who broke into small groups to address the issue of house rules and how they may be contributing to psychiatric emergencies. Each team reviewed its house rules and all units made some adjustments, mostly around visitation and food, two identified triggers. See Tab # 140 House Rule Modification Summary List. Second, the Hospital is purchasing new curriculum for nonviolent crisis intervention that is more prevention focused. It is expected that internal trainers will be trained in Spring, 2011 and it will be rolled out to staff thereafter. Third, the Hospital began training treatment teams on Collaborative Problem Solving. Staff on 1D, 1F and 1E (all shifts) were trained as of the writing of this report and 2C is currently being trained. The training, which was developed and completed by the Hospital's PBS team, provides team members with new skills to address both the individual in care's concerns as well as the staff's concerns. All units will receive this training. See Tab # 82 Collaborative Problem Solving training materials and rosters. Finally, the Hospital is implementing a Recovery Assistant Peer Specialist (RAPS) plan where experienced skilled recovery assistants will provide support and mentoring for others on the units. See Tab # 138 Violence Reduction Initiative materials, Peer Specialist Pilot The pilot was introduced in mid March, 2011, and will include an evaluation component after a 4-6 month implementation period.
</td></tr>
<tr><td>X.B.2</td><td>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</td><td>
Recommendations:

1. SEH should consider developing a plan to address this provision in the next CAP.

SEH Response: While it is not formally part of the CAP, the Hospital has taken a number of steps to address this, including
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Collaborative Problem-Solving training (completed on three of the units with the highest number of codes and all units will be trained), and purchasing a new non-violent crisis intervention training curricula. See cell X.A.1 for more information. Further, unit based groups are occurring on the admissions units for individuals before they go to the TLC. The forensic admission units also have some groups. See discussion below. ***See Tab # 69 TLC and Unit based schedules***

2. Evaluate EARN implementation.

SEH Response: Nursing continues to implement the EARN initiative. ***See Tab # 116 EARN Implementation.*** Each unit is completing its bulletin board that is to be updated each shift. Nursing is developing an EARN competency, and EARN instruction is included in new employee orientation; the formal competency will be rolled out to current nursing staff this Spring. A new patient contact EARN sheet was developed and piloted in the TLCs, and once the form is finalized, it will be included in Avatar development. A database is also planned to track EARN contact information from the EARN contact sheets utilized on the units. The EARN steering committee meets quarterly, and the new RAPS (Recovery Assistant Peer Specialists) participate. The new EARN House committees started reviewing the implementation barriers and the need in each House for 1) review or education, 2) mitigating the process / approach differences (of any) between the more forensically inclined areas and the less so, 3) devising a plan to re-survey for baseline in the new hospital configuration using the past devised short consumer and staff surveys, and 5) identifying how nursing can obtain data from AVATAR on medication administration.

In addition, nursing presented to the PIC in March 2011 a plan to evaluate EARN beginning in June 2011, just after the one year implementation date. The assessment will include reviewing data around use of IM, NOW and STAT medications over time (data review), increased patient and staff satisfaction from last year to this year (surveys), use of restraint, seclusion, number of falls and ER visits, and number of psychiatric emergencies (data). In addition, the EARN Steering Committee is sponsoring EARN peer review case conferences to assist staff with their engagement techniques. Nursing will be assisted by Office of Statistics and Reporting and PID in conducting this evaluation.

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

SEH Response: Data show some improvement in the TLC attendance and ward based group attendance, but additional analysis is underway to review data by various cohorts. ***Tab # 46 Treatment Hours Report, Tab # 85 Weekend and Evening Activities.***

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	5	5	6	13	4	3	**6**	**6**
n	3	3	3	3	3	3	**3**	**3**
%S	60	60	50	23	75	100	**50**	**50**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>%C # 4 There is no evidence that restraint/seclusion was used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.</td><td>67</td><td>50</td><td>100</td><td>100</td><td>100</td><td>100</td><td>n/a</td><td>88</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data from the restraint and seclusion audits show that in general, restraint or seclusion is utilized only to ensure the individual's safety or that of another. While the compliance mean is at 88%, the trend in the last four months was improving, with each month at 100% See also data at X.B.1. The Hospital provides a number of treatment interventions from the time of admission, including TLC groups and ward based groups. The admissions units all offer group therapies, in addition to completing assessments. See Tab # 069 TLC and Unit Based group schedules. For example, the civil admissions unit (1E) has recreational therapy, substance abuse treatment, music therapy, self-esteem group, spirituality group, expression group, relaxation group, living well, medical groups, fitness groups, trauma informed care group, understanding your illness, discharge planning, reality orientation; groups are scheduled five days a week, for four hours each day. See Tab # 69 TLC and Unit based schedules. Groups on the forensic admissions units also include competency and recreational groups. See also V.D.5.
</td></tr>
<tr><td>X.B.3</td><td>are not used as part of a behavioral intervention; and</td><td>Recommendation:
1. See VIII.B.1.c.

SEH Response: See VIII.B.1.c</td></tr>
<tr><td>X.B.4</td><td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>Recommendation:

Maintain compliance.

SEH Response:

Facility's Findings:
<table>
<tr><th colspan="9">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><th></th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>N</td><td>5</td><td>5</td><td>6</td><td>13</td><td>4</td><td>3</td><td>6</td><td>6</td></tr>
<tr><td>n</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C #5 Documentation reflects that r/s episode was terminated as soon as the individual in care met the behavioral criteria for release (no longer posed an imminent danger to self or others) or physician's order expired without a renewal	67	100	100	100	100	100	**100**	**94**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data suggest good performance on this measure. No further action is required.

X.C By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:

X.C.1 the specific behaviors requiring the procedure;

Recommendation:
Maintain compliance.

SEH Response: Compliance maintained.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	5	5	6	13	4	3	**6**	**6**
n	3	3	3	3	3	3	**3**	**3**
%S	60	60	50	23	75	100	**50**	**50**
%C # 6 The physicians order for restraint or seclusion includes the specific behaviors requiring the procedure.	100	50	100	100	100	67	**n/a**	**88**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data from the audits show generally a high level of compliance with this requirement, with a mean of 88 % on the relevant indicator; two of the 18 cases reviewed did not meet the requirement. The Medical Director is working with physicians around completion of orders for restraint or seclusion.

There was a major incident in November 2010, where it was discovered that night (and some evening) nursing staff had secluded an individual in care for part or all of the night over the course of at least 10 nights without a doctor's order. Investigations of abuse or neglect were conducted and substantiated. Four RNs were terminated, 6 RAs were terminated

<table>
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<tr><td></td><td></td><td>and 6 RAs were suspended.</td></tr>
<tr><td>X.C.2</td><td>the maximum duration of the order;</td><td>Recommendation:
Maintain compliance.

SEH Response: Compliance maintained.

Facility's Findings:

<table>
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<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
<tr><td>%C # 7 Physician's order for restraint/seclusion includes the maximum duration of the order.</td><td>67</td><td>0</td><td>67</td><td>100</td><td>100</td><td>100</td><td>100</td><td>76</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Compliance fell in the early months of the review period, but improved and was consistent at the 100% rate for the last three months of the review period. It appears that the low compliance in the early months may be a result of physicians using paper orders rather than using AVATAR. The Hospital will continue to monitor this through the restraint and seclusion audits.</td></tr>
<tr><td>X.C.3</td><td>behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;</td><td>Recommendations:

Maintain compliance.

Facility's Findings:

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<tr><td>n</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
</table></td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 8 Physician's order includes behavioral criteria for release which, if met require the individual's release even if the maximum duration of the initiating order has not expired.	67	0	67	100	100	100	**88**	**76**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Compliance fell in the early months of the review period, but improved and was consistent at the 100% rate for the last three months of the review period. Seclusion and restraint audits will continue to monitor this requirement. See response to recommendation # 1 for additional information.

X.C.4 ensure that the individual's physician be promptly consulted regarding the restrictive intervention;

Recommendation:

Maintain compliance.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Total-P**	**Total-C**
N	5	5	6	13	4	3	**6**	**6**
n	3	3	3	3	3	3	**3**	**3**
%S	60	60	50	23	75	100	**50**	**50**
%C # 9 The attending physician was promptly consulted regarding the use of the restraint or seclusion	50	100	100	100	100	100	**n/a**	**93**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The Hospital is meeting this requirement. No further action is required.

X.C.5 ensure that at least every 30 minutes, individuals in seclusion or restraint must be reinformed of the behavioral criteria for their release from the restrictive intervention;

Recommendations:

Proceed with plan to adjust audit tool to align with the provision and maintain compliance.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS								
	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>N</td><td>5</td><td>5</td><td>6</td><td>13</td><td>4</td><td>3</td><td>6</td><td>6</td></tr>
<tr><td>n</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
<tr><td>%C # 11 Individual was informed of the behavioral criteria for their release at least every 30 minutes</td><td>0</td><td>n/a</td><td>0</td><td>100</td><td>100</td><td>33</td><td>n/a</td><td>56</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The audit tool was redesigned to align with the Agreement's requirement. The results of the audits suggest that nursing staff are not completing the levels of observation form in its entirety, as at times nursing will note the individual in care's actions but not interventions by nursing staff. The Levels of Observation form was modified in Avatar to include a special code to track when staff inform the individual in care of behavioral criteria for release, but it appears staff may need additional training on completing the form.
</td></tr>
<tr><td>X.C.6</td><td>ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;</td><td>
Recommendation:
The CAP adequately addresses this issue. Continue monitoring to evaluate the degree to which the current improvement plan is effective.

SEH Response: CAP actions implemented.

Facility's Findings:
<table>
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<tr><td>n</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>60</td><td>60</td><td>50</td><td>23</td><td>75</td><td>100</td><td>50</td><td>50</td></tr>
<tr><td>%C # 12Treatment team debriefing held within 24 hours or next business day of termination of r/s event</td><td>67</td><td>100</td><td>100</td><td>67</td><td>67</td><td>100</td><td>18</td><td>88</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: Data show substantial improvement in meeting this requirement. Actions taken pursuant to corrective action plan will continue.
</td></tr>
<tr><td>X.C.7</td><td>comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and</td><td>
Recommendations:

Continue monitoring.

SEH Response: Monitoring continues.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	5	5	6	13	4	3	**6**	**6**
n	3	3	3	3	3	3	**3**	**3**
%S	60	60	50	23	75	100	**50**	**50**
%C # 14 Physician conducted face-to- face assessment within one hour of initiation of r/s event	67	100	67	67	100	100	**88**	**82**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 RESTRAINT AND SECLUSION AUDIT RESULTS

Analysis/Action Plans: The data show improvement is needed on this requirement although the trend over the last two months of the rating period was much improved. The Hospital believes that in most cases, the physician is conducting a face-to- face assessment, but the notes in all cases are not making that clear. The Medical Director and the Director of Psychiatry training have reminded physicians to ensure the progress note makes it clear if a face-to-face assessment was completed.

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.	**Recommendation:** 1. See X.A.2 SEH Response: See X.A.2.

SECLUSION AND RESTRAINT AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	**Mean-P**	**Mean-C**
N	5	5	6	13	4	3	**6**	**6**
n	3	3	3	3	3	3	**3**	**3**
%S	60	60	50	23	75	100	**50**	**50**
%C # 15 individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	67	50	67	67	67	67	**n/a**	**65**

Analysis/Action Plans: See X.A.2

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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.	**Recommendation:** Ensure that the variables currently available in STAT medication reports are included in the new emergency involuntary medication monitoring system. SEH Response: The Hospital, is able to identify those individuals who are given STAT medications, and since October 2010, those whose STAT medications are given on an involuntary basis. This information is shared each month with Pharmacy and Therapeutics Committee. The daily average of emergency involuntary medication administration has ranged from 0.4 (partial month) in October to a high of 1.7 in November 2010. ***See Tab # 93, Pharmacy and Therapeutics Monthly Report.***
X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Recommendation:** See X.A.1 and X.B.1 SEH Response: See X.A.1 and X.B.1. ***See Tab # 56 Tracking Reports for High Risk indicators, and Tab # 151 High Risk Indicator Tracking and Review Policy.*** The High Risk Tracking and Review policy specifically requires that the teams review treatment plans of any individual placed in seclusion or restraints more than 3 times in a four week period. This is also monitored by the Director of Psychiatric Services, who is notified of all incidents of three or more major UIs in a 30 day period.
X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Recommendations:** Monitor the use of emergency involuntary psychotropic medication administration. SEH Response: The Hospital is able to identify those individuals who are given STAT medications, and since October 2010, those whose STAT medications are given on an emergency involuntary basis. This information is shared each month with Pharmacy and Therapeutics Committee. The daily average of emergency involuntary medication administration has ranged from 0.4 (partial month) in October to a high of 1.7 in November, 2010. ***See Tab # 93, Pharmacy and Therapeutics Monthly Report.*** **Facility's Findings:**

<table>
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<tr><td></td><td></td><td>
<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>N # of EIM events during the month
# of Unique Patients Given EIM
Total EIM ordered/administered</td><td></td><td>9
7
10</td><td>10
5
18</td><td>8
7
12</td><td>4
2
13</td><td>12
9
24</td><td>*</td><td>9
6
15</td></tr>
<tr><td>n</td><td></td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>*</td><td>2</td></tr>
<tr><td>%S</td><td></td><td>22</td><td>20</td><td>25</td><td>50</td><td>17</td><td>*</td><td>23</td></tr>
<tr><td>%C #1 EIMs are used on a time-limited, short term basis and not as a substitute for adequate treatment of the underlying cause of the individual’s distress.</td><td></td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>*</td><td>90</td></tr>
</table>
N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 162 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

Analysis/Action Plans: The audits show high levels of compliance. The Hospital will continue monitoring this through audits.
</td></tr>
<tr><td>X.F.2</td><td>a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and</td><td>
Recommendations:
1. See F.X.1

SEH Response: See X.F.1.

Facility’s Findings:

<table>
<tr><th colspan="9">EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
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7
12</td><td>4
2
13</td><td>12
9
24</td><td>*</td><td>9
6
15</td></tr>
<tr><td>n</td><td></td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td><td>*</td><td>2</td></tr>
<tr><td>%S</td><td></td><td>22</td><td>20</td><td>25</td><td>50</td><td>17</td><td>*</td><td>23</td></tr>
<tr><td>%C #2. A physician conducted a face-to-face assessment of the individual within one hour of the administration of the EIM</td><td></td><td>100</td><td>50</td><td>100</td><td>100</td><td>100</td><td>*</td><td>90</td></tr>
</table>
N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 162 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

Analysis/Action Plans: The audits show high levels of compliance. The Hospital will continue monitoring this through audits.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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.	**Recommendation:** 1. SEH should consider developing a plan to address this provision in the next CAP. SEH Response: This information is being audited through the emergency involuntary medication audits and the High Risk Indicator Tracking and Review Policy. ***Tab # 151 High Risk Indicator Tracking and Review Policy.*** 2. Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes. SEH Response: This is tracked through the emergency involuntary medication audits and the High Risk Indicator Tracking and Review Policy. ***Tab # 151 High Risk Indicator Tracking and Review Policy.*** Further, PID is planning an analysis of STAT medication. This study will delineate whether a STAT medication was given voluntarily or involuntarily, as well as the frequency of STAT medication use. **Facility's Findings:**

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

	Sep	Oct	Nov	Dec	Jan	Feb	Mean-P	Mean-C
N # of EIM events during the month		9	10	8	4	12	*	**9**
# of Unique Patients Given EIM		7	5	7	2	9		**6**
# Total EIM ordered/administered		10	18	12	13	24		**15**
n		2	2	2	2	2	*	**2**
%S		22	20	25	50	17	*	**23**
%C #3. The individual's core treatment team conducts a review (within three business days) whenever three administrations of Emergency psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate		100	100	n/a	100	100	*	**100**

N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 162 EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
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.	**Recommendations:** 1. See X.A.2. SEH Response: See X.A.2. The training curriculum for restraints and seclusion was modified in August 2010 to include a segment on emergency involuntary medication.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XI.	**PROTECTION FROM HARM**	
	By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect.· SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals' living at the facility.	The Hospital continues to operate in the new state of the art facility. The Annex at RMB closed on February 28, 2011; all individuals in care are now housed in the main hospital building. Training on reporting abuse and neglect continues to be included in the new employee orientation, and the annual renewal is offered multiple times during the year. Employees have until March 31 of each year to complete the annual training. The percentage compliant improved from the last reporting period 93% for current period to 87% for prior period). See data below. ***Tab # 135 Reporting Abuse and Neglect Training data and curriculum outline.*** The Hospital created an online course which should provide increased flexibility for staff to complete it.

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

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	6	6	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	13	13	13	100%	92%/100%
Dietary	4	4	4	100%	100%/100%
Medical	9	8	8	89%	100%/100%
Nursing - Nurse Manager	17	15	15	88%	88%/100%
Nursing - RN	72	60	60	83%	83%/100%
Nursing - LPN	30	25	25	83%	83%/100%
Nursing - RA	195	168	168	86%	86%/100%
Psychiatry	67	66	66	99%	99%/100%
Psychology	28	28	28	100%	100%/100%
Rehabilitation	19	19	19	100%	100%/100%
Social Work	15	15	15	100%	100%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	12	12	12	100%	100%/100%
Non-Clinical/Administrative	211	208	208	99%	99%/100%
Total	**714**	**663**	**663**	**93%**	**93%/100%**

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Reporting Suspected Individual Abuse, Neglect & Exploitation New Employees — **09/01/10 ~ 03/15/11**

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%
Non-Clinical	5	5	5	100%	100%/100%
Total	**24**	**24**	**24**	**100%**	**100%/100%**

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

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

Additional information: During this review period, the Hospital finalized a High Risk Indicator Tracking and Review policy. ***See Tab # 151 High Risk Tracking and Review Policy.*** The policy identifies 8 categories of behavioral high risks and 8 categories of medical high risks, and specifies criteria for placement on a list and criteria for removal from a list. In early March 2011, the Hospital identified individuals who met the criteria and began tracking them. As of mid March 2010, there were 123 individuals in care (45.2% of the population) on one or more high risk lists. The highest categories include risk of violence, ULs and falls, as well as high risk medication refusals, although this latter category is probably over inclusive. See ***Tab # 149 Summary of High Risk Indicator Lists.*** This is in addition to the list of individuals with three or more major UIs in a 30 day period, which continues to be monitored by the Risk Manager. ***See Tab # 56 Risk Indicator UI Tracking Reports.***

Also during this review period, the Hospital's Risk Manager identified two incidents that effectively constituted a violation of the Hospital's seclusion and restraint policy by prolonging the time frame in which an individual was in a prone position during the course of a restraint incident. In both cases, he substantiated abuse after investigations. A third incident was not substantiated after an investigation.

There was a major incident in November 2010, where it was discovered that night (and some evening) nursing staff had secluded an individual in care for part or all of the night over the course of at least 10 nights without a doctor's order. An investigations of abuse or neglect was conducted and substantiated. Four RNs were terminated, 6 RAs were terminated and 6 RAs were suspended.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.	**INCIDENT MANAGEMENT**	
	By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	
XII.A	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Recommendation:** 1. Monitor the timely implementation of the Incident Management policies. SEH Response: Ongoing. The Hospital continues to monitor the application of the Incident Management policies in several ways. First, the Risk Manager reviews each UI in order, *inter alia*, to identify areas of noncompliance with the incident management policies. He also reviews collateral hospital reports such as the 24 Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents noted in the reports have corresponding UIs. Second, the Risk Manager investigation reports are reviewed by a supervisor to ensure the investigations and reports meet Hospital standards. Finally, all managers review monthly the Unusual Incident Monthly Report **(*See Tab # 142*)**; and the PRISM report . ***See Tab # 53*.** The Hospital reviewed all incident management policies to ensure consistency, and also to ensure the policy language reflects hospital practice, especially concerning actions taken with incidents involving potential criminal action. The Hospital modified the UI investigation policy to allow 45 days to complete an investigation, consistent with the standards set out by the Joint Commission for the Accreditation of Healthcare Organizations. Minor changes also were made to update accurate department and position titles that are referenced in the policy, to clarify the timeframe for initiating an Unusual Incident investigation and other similar revisions. ***See Tab # 134 Unusual Incident Reporting and Documentation Policy; See Tab # 136 Unusual Incident Investigation Policy. See Tab # 133 Reporting Suspected Abuse, Neglect, and Exploitation of Individuals in Care Policy.*** The Hospital also finalized its High Risk Indicator Tracking and Review Policy. ***Tab # 151 High Risk Indicator Tracking and Review Policy.*** Under the finalized policy, standards were created to identify and track individuals who fall within 8 categories of behavioral high risk indicators and 8 categories of medical high risk indicators. The policy specifies the criteria for an individual to be placed on any of the lists and criteria to be removed from a list. Individuals in care who meet the criteria were identified in early March 2011 and the lists are monitored by PID through a newly created database. The lists will be modified as new cases are identified and as others are resolved. A database to track this information is being developed. The Policy also provides for a three tier review and intervention system. The treatment teams provide the first level of intervention by identifying cases where individuals meet a criterion and thus should be placed upon a list; the IRP is also to be updated. The second level intervention is by the Director of Psychiatric Services who must review any case in which an individual meets certain high risk thresholds (3 or more r/s or emergency involuntary medication administrations in a 30

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>day period or 3 or more major UIs of any type in a 30 day period). The third level intervention is by a newly created Clinical Consultation Team (CCT) who must review the care of an individual who meets the high risk threshold more than once in a six month period, or requires placement on the lists for a second time in a three month period. The Clinical Consultation Team must make findings, conclusions, and recommendations to the treatment teams to reduce the risk status of the individual and shall be documented by minutes. As of the writing of this report, the membership of the CCT has been identified, but it has not yet met as no cases currently meet the criteria for third level review. The CCT includes the Director of Medical Affairs, the President of the Medical Staff, the Director of Psychology, the Director of Clinical Operations, the Director of Treatment Services and the Chief Nurse Executive. The Director of PID is the ex officio chair.</td></tr>
<tr><td>XII.A.1</td><td>identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;</td><td>Recommendation:
1. Continue current practice.

SEH Response: Ongoing. The Hospital continues to monitor 24 categories of unusual incidents, including restraint/seclusion incidents and elopements. This information is included in the monthly PRISM report and/or the annual Trend Analysis. See Tab # 53 PRISM report, Tab # 142 UI Monthly Report and Tab # 155 Trend Analysis.

<table>
<tr><th colspan="9">UNAUTHORIZED LEAVE, RESTRAINT AND SECLUSION DATA</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean-P</td><td>Mean-C</td></tr>
<tr><td>Number of elopements</td><td>1</td><td>8</td><td>2</td><td>1</td><td>2</td><td>4</td><td>4</td><td>3</td></tr>
<tr><td>% Unique Individuals Restrained</td><td>0%</td><td>0.9%</td><td>0.9%</td><td>0.6%</td><td>0.3%</td><td>0.0%</td><td></td><td></td></tr>
<tr><td>% Unique Individuals Secluded</td><td>0.9%</td><td>0.6%</td><td>0.6%</td><td>1.2%</td><td>0.6%</td><td>0.6%</td><td></td><td></td></tr>
</table>

See Tab # 53 PRISM report</td></tr>
<tr><td>XII.A.2</td><td>immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;</td><td>Recommendation:
1. Continue current practice of identifying failure to report allegations of A/N/E in the manner prescribed in policy.

SEH Response: Current practice continues. The Hospital also has a senior executive staff member on call 24 hours a day, and the solution center staff contact the covering administrator in the event of an emergency.

Facility's findings:

<table>
<tr><th colspan="14">Report Delay of Abuse and Neglect Incidents</th></tr>
<tr><td rowspan="2">Report Gap (Days)</td><td colspan="6">Previous Review Period (Mar-10 ~ Aug-10)</td><td colspan="6">Current Review Period (Sep-10~Feb-11)</td><td rowspan="2">Previous Total</td><td rowspan="2">Current Total</td></tr>
<tr><td>2010-3</td><td>2010-4</td><td>2010-5</td><td>2010-6</td><td>2010-7</td><td>2010-8</td><td>2010-9</td><td>2010-10</td><td>2010-11</td><td>2010-12</td><td>2011-1</td><td>2011-2</td></tr>
<tr><td><=1 day (on time)</td><td>2</td><td>1</td><td>1</td><td>1</td><td>2</td><td>4</td><td>2</td><td>7</td><td>4</td><td>2</td><td>5</td><td>4</td><td>11</td><td>24</td></tr>
<tr><td>>1 & <=5 days</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>3</td><td>3</td><td>2</td><td>9</td></tr>
<tr><td>>5 & <=10 days</td><td>1</td><td>0</td><td>2</td><td>1</td><td>0</td><td>1</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>5</td><td>1</td></tr>
<tr><td>>10 days</td><td>0</td><td>1</td><td>2</td><td>1</td><td>2</td><td>0</td><td>1</td><td>0</td><td>13</td><td>1</td><td>1</td><td>0</td><td>6</td><td>16</td></tr>
</table>
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Total abuse/neglect UIs	**3**	**3**	**5**	**3**	**5**	**5**	**3**	**8**	**19**	**4**	**9**	**7**	**24**	**50**
Timely reporting (<=1 day)	***2 67%***	***1 33%***	***1 20%***	***1 33%***	***2 40%***	***4 80%***	***2 67%***	***7 88%***	***4 21%***	***2 50%***	***5 56%***	***4 57%***	***46%***	***48%***
Reports Delayed (>1 day)	***1 33%***	***2 67%***	***4 80%***	***2 67%***	***3 60%***	***1 20%***	***1 33%***	***1 13%***	***15 79%***	***2 50%***	***4 44%***	***3 43%***	***13 54%***	***26 52%***

See Tab # 142 UI Monthly Report.

Analysis/Action Steps: Overall the number of abuse/neglect reports submitted timely improved slightly, from 46% in the prior period to 48% during this period. The percentage of delayed abuse/neglect reports (>1 day after incident occurred) slightly dropped (52%) from the previous period (54%). It should be noted that at this time, the Hospital still measures timeliness from the date of the incident, not from the date of discovery, so that the 52% statistic likely overstates the percentage of abuse or neglect incidents involving a delay. The increase in November 2010 in the number of neglect or abuse reports was largely due to senior managers, by monitoring cameras, discovering staff sleeping on night shift.

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

The Risk Manager has taken actions to ensure that staff are compliant with their duty to report UIs of all types. The Risk Manager reviews collateral hospital reports such as the 24 Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents of any type noted in the reports have corresponding UIs if required by the policy.

During this rating period it was discovered that night and some evening staff on one unit had placed an individual in care in seclusion on more than one occasion without a doctor's order. After investigation, 10 staff were terminated or resigned in lieu of termination and 6 nursing staff members were suspended.

See also XII.A.1.

XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Recommendation:** When a staff member named in an allegation of A/N/E is not removed under the exception in Policy 302.4-09, the investigation should include documentation of this circumstance. SEH Response: The Hospital implemented this recommendation with investigations that were completed beginning in February, 2011. The Hospital conducted 39 investigations between September 1, 2010 and February 28, 2011. Of the 39 investigations, all but one are completed; 21 were substantiated and 17 were unsubstantiated. Of the 21 that were substantiated 100% had

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		either formal disciplinary actions taken, staff were retrained, or procedures and forms were modified as a result of the findings. ***See Chura Advanced Document Request, Tab # 9.***
XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Recommendation:** Take the measures outlined in the hospital's CAP to address staff training—both for orientation training for new employees and for recurring training for current employees. These measures adequately address the provision of training provision and monitoring of participation. SEH Response: The Hospital continued efforts to ensure that all staff members receive annual A/N/E training and pass the competency test. Reporting abuse and neglect training is now available on line, and all employees training must be renewed by March 31 of each year. See training data below. The Hospital is implementing the requirement that your annual training be updated by the end of the employee's birthday month. Notices will be posted on the intranet to remind employees of this new policy.

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

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	6	6	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	13	13	13	100%	92%/100%
Dietary	4	4	4	100%	100%/100%
Medical	9	8	8	89%	100%/100%
Nursing - Nurse Manager	17	15	15	88%	88%/100%
Nursing - RN	72	60	60	83%	83%/100%
Nursing - LPN	30	25	25	83%	83%/100%
Nursing - RA	195	168	168	86%	86%/100%
Psychiatry	67	66	66	99%	99%/100%
Psychology	28	28	28	100%	100%/100%
Rehabilitation	19	19	19	100%	100%/100%
Social Work	15	15	15	100%	100%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	12	12	12	100%	100%/100%
Non-Clinical/Administrative	211	208	208	99%	99%/100%
Total	**714**	**663**	**663**	**93%**	**93%/100%**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

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

Reporting Suspected Individual Abuse, Neglect & Exploitation New Employees

09/01/10 ~ 03/31/11

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%
Non-Clinical	5	5	5	100%	100%/100%
Total	**24**	**24**	**24**	**100%**	**100%/100%**

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

Tab # 135 Reporting Suspected A/N/E Training Data

Compared with last review period, there is substantial improvement in the number of staff who competently completed A/N/E training as either the annual refresher training or new employee training. During this review period, 100% of all new hires and 93% of continuing employees have been trained to competency. Training data is regularly monitored by the Training and Professional Development staff to determine employee compliance with A/N/E training. A noncompliance with training notice is sent to staff that have not completed training.

Data for UI completion of annual training is not as good for current employees. Data show:

Reporting Unusual Incidences: Continuing Employees

9/1/2010 - 3/31/2011

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	4	4	67%	67%/100%
Clinical Administrator	12	3	3	25%	25%/100%
Dentistry	13	9	9	69%	69%/100%
Dietary	4	4	4	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Medical	9	1	1	11%	11%/100%
Nursing - Nurse Manager	17	4	4	24%	24%/100%
Nursing - RN	72	23	23	32%	32%/100%
Nursing - LPN	30	10	10	33%	33%/100%
Nursing - RA	195	58	58	30%	30%/100%
Psychiatry	67	47	47	70%	70%/100%
Psychology	28	16	16	57%	57%/100%
Rehabilitation	19	8	8	42%	42%/100%
Social Work	15	6	6	40%	40%/100%
Treatment Mall	4	2	2	50%	50%/100%
Clinical (Other)	12	5	5	42%	42%/100%
Non-Clinical Staff	211	76	76	36%	36%/100%
Total	**714**	**276**	**276**	**39%**	**39%/100%**

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

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

Reporting Unusual Incidences: New Employees				09/01/10 ~ 03/15/11	
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%
Non-Clinical	5	5	5	100%	100%/100%
Total	**24**	**24**	**24**	**100%**	**100%/100%**

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 158 Selected Annual Training Data This is expected to improve as the Hospital transitions to a birthday month system for compliance.
XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	**Recommendation:** 1. Continue current practice. SEH Response: Current practice continues. A/N/E training is part of the mandatory new employee training that each new employee must complete within the first two weeks after their employment start date. The Hospital is meeting this requirement.

Reporting Unusual Incidences: New Employees

09/01/10 ~ 03/15/11

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%
Non-Clinical	5	5	5	100%	100%/100%
Total	**24**	**24**	**24**	**100%**	**100%/100%**

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

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

Understanding the Rights of Individuals Receiving Care: New Employees

09/01/10 ~ 03/15/11

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

		Non-Clinical 5 5 5 100% 100%/100% **Total 24 24 24 100% 100%/100%** ** Percentage of those who passed competency exam out of the total number of employees required for training.* *** Percentage of those who passed competency exam out of the total number of employees who attended training*

Reporting Suspected Individual Abuse, Neglect & Exploitation: New Employees
09/01/10 ~ 03/15/11

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	14	14	14	100%	100%/100%
Nursing - RA	1	1	1	100%	100%/100%
Rehabilitation	2	2	2	100%	100%/100%
Non-Clinical	5	5	5	100%	100%/100%
Total	**24**	**24**	**24**	**100%**	**100%/100%**

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

See Tab # 158 New Employee Training Curricula and Data

XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Recommendation:** 1. Continue current practice. SEH Response: The Hospital continues its current practice of posting on each house a brief statement of how to report incidents.
XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Recommendation:** 1. Continue to address the question of law enforcement referral in each investigation of A/N/E and whenever criminal activity is involved. SEH Response: Ongoing. On March 3, 2011, there was an incident where there was an allegation of a sexual assault by an Individual in care against another Individual in care. MPD was contacted and its Sexual Assault Unit conducted an investigation. The Sexual Assault Unit determined that the allegations were unsubstantiated.
XII.A.8	mechanisms to ensure that any staff person,	**Recommendation:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline "harassment, threats, or licensure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	1. Continue current practice of reinforcing with staff the responsibility to report incidents and the protections available to them for good-faith reporting. SEH Response: The right to be free from retaliation for reporting an allegation of A/N/E continues to be covered in both the new employee and refresher modules of the Reporting Suspected A/N/E training. ***See Tab # 135 Reporting Abuse and Neglect Training data and curricula.*** There have been no reports or evidence that any individual or staff experienced retaliation for reporting allegations of abuse, neglect or exploitation during this review period.
XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Recommendation:** 1. Identify in policy the hospital's expectations regarding timeliness in completing A/N/E investigations. SEH Response: The Hospital amended its UI investigation policy to require that investigations be completed within 45 days. ***Tab # 136 UI Investigations Policy.*** The 45 days is consistent with requirements set forth by Joint Commission on the Accreditation of Healthcare Organizations. 2. Take any measures possible to expedite the complete and timely investigation of incidents. SEH Response: The Hospital still faces challenges in completing timely investigations of incidents as defined in the policy. ***See Tab # 136 Unusual Incident Investigation Policy***. A second investigator was hired, and improvement in timely completion of investigations was made. During the prior rating period of March 2010 through August 2010, the average time to complete an investigation was 108 days. For the current rating period, the average time was 63 days. This marks a 58% decrease in the time to complete an investigation, which is a significant improvement. The Risk Manager and PID Director also identified another staff member who will be trained as an investigator who will be able to serve as a back up in the future, assuming funding can be identified.
XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Recommendation:** 1. Provide close supervision of investigation to ensure their completeness and compliance with Hospital policy. SEH Response: Ongoing. The Director of PID reviews all written investigations prior to finalization.
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;	**Recommendation:** 1. Continue current practice. SEH Response: The Risk Manager and the investigator have completed the required competency based training on investigations.
XII.B.3	include a mechanism which will monitor the performance of staff charged with	**Recommendations:** 1. Ensure that all persons who may have witnessed an incident are interviewed and that a summary of the interview is

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	included in the investigation report. SEH Response: Ongoing. The Risk Manager and investigator use their judgment in deciding who to interview as part of an investigation based upon all the information sources available to them. In all cases, the complainant and any identified staff are interviewed. In many cases, cameras have caught the incident, and film is reviewed. In other instances, staff or individuals in care are interviewed. There are times however, when the investigators determine that a particular individual will not be interviewed. Decisions to interview individuals in care are made after consideration of the individual's clinical condition. Further, at times when information is corroborated by a number of sources, the investigator may elect not to interview more ancillary witnesses.
XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as s result of investigations.	**Recommendations:** 1. Implement the plan reportedly still in place to assign Quality Improvement Coordinators to specific houses and disciplines to ensure recommendations made in incidents reach the responsible staff members and to facilitate implementation. SEH Response: Implementation has begun. ***See Tab 139 for Description of House Support Project.*** The Project continues to evolve. Staff from PID and OSR are paired to support individual houses. They provide support around data, sharing the results of many audits with the treatment teams and providing additional information as requested. In addition, the food study is well underway.
XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Recommendations:** 1. Ensure that responses to recommendations provide an assurance that the issue has been addressed and monitoring will occur to ensure that implementation has been effective. SEH Response: The Hospital is tracking recommendations made by the Risk Manager (made after Sept 1, 2010), Hospital Committees and PID special studies, through a newly created database. ***See Tab # 139 Performance Improvement Project List and database screen shots and Recommendations Tracking Report.*** The database tracks implementation, as well as sustainability. PID will utilize current audits or, if necessary, conduct targeted reviews as appropriate to assess the effectiveness of the recommendations and/or implementation. After creating and using the database, the Hospital elected to revise the Quality Assessment Performance Improvement policy to provide for review by the Executive staff of all non training, non HR-related or non-Avatar related recommendations by all sources. (Prior policy only provided for review of PIC recommendations). ***See Tab # 146 Quality Assurance/Performance Improvement Policy.*** The PID Director will meet with Executive Staff once a month to review new recommendations and track Executive Staff approval, modification, or denial of any new recommendations.
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	**Recommendation:** 1. Add disposition and recommendations to the UI database, as planned.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	SEH Response: Completed and ongoing. ***See Tab # 139 Performance Improvement Department Project List, UI Database Screen shots***
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:	**Recommendations:** 1. Plan and present a timetable listing specific actions to reduce violence, such as increased recreational activities, incentives to houses that reduce violence, formation of a Peacemaker's group among individuals in care. Implement the actions as resources become available. The specific actions are suggestions only; the hospital should adopt activities that fit its needs and resources. SEH Response: The Hospital has taken a number of initiatives to reduce violence. First, it has expanded its evening and weekend schedule of activities. ***See Tab # 85 Weekend and Evening Schedule.*** On most evenings, there are activities for both the transitional and intensive programs. Activities include open gym, AA/NA, lens and pens, studio art, art therapy, community trips on Wednesday evenings, games and music, bridge, and a movie night monthly. Weekend activities include art, open gym, educational activities, music activities and pet therapy, and many other activities supported by community volunteers. Second, the Hospital implemented the High Risk Indicator Tracking and Review Policy in March 2011, which is expected to assist in reducing violence. See description in XIII.A. Third, the Hospital is training staff on Collaborative Problem Solving. To date three units (1D, 1E and 1F which had the highest number of incidents) have completed training and training has started on a fourth unit, 2C. The training provides staff with new less confrontational ways to address issues with individuals. ***See Tab # 82 Collaborative Problem Solving and related Training Data.*** All units will receive this training. Fourth, the Hospital is implementing a Recovery Assistant Peer Specialist (RAPS) pilot where experienced RAs will serve as mentors to other RAs to coach and model positive interactions with individuals in care, serve on the EARN committees and also support charge nurses, among other duties. ***See Tab # 138 VRI related materials, RAPS description*** This initiative was recommended by the VRI committee. RAPs were identified in March 2011 and all staff were informed of the initiative. Finally, the Hospital is purchasing a new training module for non-violent crisis intervention. The Hospital will train a core group of 10 individuals who will serve as trainers for the Hospital. Training for the trainers is expected in April 2011 or early May 2011. 2. Continue current practice of tracking and trending incidents. Include the tracking of corrective measures, as planned. SEH Response: Ongoing. The database to track recommendations is up and operational. A PID staff member has been identified to monitor recommendations. Incidents are tracked and trended through the monthly PRISM reports and the annual Trend Analysis. ***See Tab # 53 PRISM Report and # 155 Trend Analysis.*** Various data of interest are presented at monthly PIC meetings.
XII.E.1.	Track trends by at least the following categories:	
XII.E.1.a	type of incident;	**Recommendations:** 1. Continue current practice collecting and analyzing incident data.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's findings:

Type of Incidents								
UI Type	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-10**	**Feb-10**	**Mean-P**	**Mean-C**
Abuse/Neglect/Exploitation	3	8	19	4	9	7	**4**	**8**
Physical Assault	32	29	46	39	41	62	**35**	**42**
Sexual Assault	1	1	2	2	5	2	**1**	**2**
Contraband***	10	11	13	9	12	9	**9**	**11**
Crime	0	0	0	0	2	**1**	**0.8**	**0.5**
Death*****	1	0	2	2	0	**0**	**0.5**	**0.8**
Emergency Invol. Medication	5	6	1	3	3	1	**4**	**3**
Environment	2	5	4	3	2	1	**2.5**	**2.8**
Fall	18	18	20	22	24	**20**	**20**	**20**
Fire	0	0	0	0	0	**0**	**1.0**	**0.0**
Medical Emergency	23	13	23	21	37	26	**21**	**24**
Medication Refusal	58	81	23	14	31	17	**20**	**37**
Medication Variance	18	6	8	21	2	20	**12**	**13**
Physical Injury	28	23	43	29	30	41	**36**	**32**
Psychiatric Emergency	28	24	49	24	16	32	**22**	**29**
Reportable Disease	0	0	0	0	0	0	**0**	**0**
Restraint	0	4	4	8	1	0	**2**	**3**
Seclusion	5	2	2	5	3	3	**3**	**3**
Security Breach	5	2	9	6	3	4	**3**	**5**
Suicide Attempt/Gesture	0	0	0	0	2	0	**0.8**	**0.3**
Unauthorized Leave	1	8	6	1	4	3	**4**	**4**
Vehicle Accident	0	1	0	0	0	0	**0.8**	**0.2**
Vital Sign/Finger Stick Refusal	1	1	1	2	7	1	**3**	**2**
Other Attempted UL*	2	1	3	2	4	**2**	**5**	**2**
Self Injurious Behavior*	1	0	13	7	5	**6**	**2**	**5**
Other (None of above)	36	27	31	30	34	**30**	**31**	**31**
Total*	***212***	***207***	***236***	***195***	***214***	***217***	***174***	***214***

**Attempted UL and Self Injurious Behavior were reported under the 'Other' category and classified following manual review.*

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		One incident may be categorized in multiple UIs and thus the sum of each column may exceed the total number of UIs.* * During the prior review period, staff at RMB or other non JHP buildings were not screened, so the increase in contraband is likely due to staff now being screened and materials taken from them (ie silverware, glass containers, mirrors, etc)* ***** Deaths statistics include deaths of Inpatients and forensic outpatients , the latter are not part of DOJ SA* ***See Tab # 142 UI Monthly Report*** The Hospital's PID completed a review of frequency of assaultive behavior at the Hospital for the period of September 2010 to November 2010. The analysis included a review of UI reports and clinical records for the day of the assault. The review found that 5 individuals were responsible for 34% of the assaults, that in 30% of the assaults, staff were the targets, that a slight majority of the assaults occurred on the evening shift, with day shift a close second. The report also looked at the injury risk and found that when an individual in care was involved in an assault, 42% required treatment for an injury and that when a staff member was assaulted, 46% required treatment for an injury. The study also found that 15% of assaults were follow-ups to earlier assaults, suggesting that disputes were not fully resolved and the intervention methods may need to be adjusted; that the review of the medical record notes indicated a reason for the assault even though the cause in 34% of assaults was identified as unknown in the UI report; and that assaults may also indicate a lack of follow up by staff. ***See Tab # 139 Performance Improvement Projects, Frequency of Assaultive Behavior at SEH.*** The results were presented to PIC. It should be noted also that subsequent to this study, the Hospital began Collaborative Problem- Solving training as a way to improve staff interactions with individuals and reduce conflicts, which is completed on three units with a fourth in training as of the writing of this report. All units will be trained. ***See Tab # 82 Collaborative Problem-Solving Outline.***
XII.E.1.b	staff involved and staff present;	**Recommendation:** 1. Consistently review the incident history of named staff members in incident investigation reports to assist in identifying patterns of behavior. SEH Response: Ongoing. 2. Just as the hospital creates a listing of individuals involved in multiple incidents, create a similar list of staff members involved in multiple incidents on a periodic basis. SEH Response: Ongoing. ***See Chura Advanced Documents Tab # 17***
XII.E.1.c	individuals involved and witnesses identified;	**Recommendations:** 1. Hospital leadership, after considering the recommendations aimed at reducing violence presented by the various committees and as a result of studies (see XIIE), should develop an action plan for implementation of those they believe are do-able in the near future and likely to be effective. SEH Response: See XII.E.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's findings:

Category	Sep-10	Oct-10	Nov-10	Dec-10	Jan-10	Feb-10	Mean-P	Mean-C
Unique Patients Involved by # of Total UIs involved	**100**	**112**	**110**	**114**	**107**	**128**	**107**	**112**
1 Incident	*50*	*73*	*63*	*68*	*53*	*72*	***68***	***63***
2 Incidents	*27*	*22*	*19*	*26*	*23*	*27*	***22***	***24***
3 Incidents	*12*	*7*	*13*	*10*	*11*	*9*	***8***	***10***
4~5 Incidents	*5*	*5*	*5*	*5*	*12*	*11*	***7***	***7***
6~10 Incidents	*2*	*2*	*8*	*3*	*7*	*9*	***3***	***5***
>=11 Incidents	*4*	*3*	*2*	*2*	*1*	*0*	***1***	***2***
Pts involved >=4UIs (#)	*11*	*10*	*15*	*10*	*20*	*20*	***11***	***14***
(%)	*11*	*9*	*14*	*9*	*19*	*16*	***10***	***13***
Unique Patients Involved as Alleged Aggressor for >=1 UI*	**33**	**30**	**37**	**38**	**39**	**42**	**32**	**37**
1 Incident	*21*	*19*	*24*	*26*	*25*	*29*	***20***	***24***
2 Incidents	*8*	*6*	*5*	*5*	*7*	*3*	***6***	***6***
3 Incidents	*2*	*4*	*3*	*5*	*4*	*3*	***3***	***4***
4~5 Incidents	*1*	*0*	*2*	*1*	*2*	*4*	***2***	***2***
6~10 Incidents	*0*	*1*	*2*	*1*	*1*	*3*	***1***	***1***
>=11 Incidents	*1*	*0*	*1*	*0*	*0*	*0*	***0***	***0***
Total Patient Records by Role**	**242**	**244**	**262**	**218**	**240**	**269**	**195**	**246**
Alleged Aggressor	*59*	*49*	*83*	*66*	*68*	*83*	***54***	***68***
Alleged Victim	*39*	*30*	*45*	*36*	*40*	*51*	***30***	***40***
Involved	*138*	*159*	*129*	*113*	*128*	*127*	***103***	***132***
Witness	*2*	*4*	*3*	*1*	*3*	*5*	***3***	***3***
Other/ Not Identified	*4*	*2*	*2*	*2*	*1*	*3*	***5***	***2***

Severity															
Severity	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Total**	**Average**	**Percent**
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**
High	21	20	61	42	62	38	47	36	70	52	53	59	**561**	**47**	**24.1**
Medium	44	43	82	77	81	114	113	129	120	92	113	97	**1105**	**92**	**47.5**
Low	48	59	64	53	68	68	52	42	46	51	48	61	**660**	**55**	**28.4**
Total	***113***	***122***	***207***	***172***	***211***	***220***	***212***	***207***	***236***	***195***	***214***	***217***	**2326**	***194***	**100**

Tab # 142 UI Monthly Report

XII.E.1.d	location of incident;	

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
Recommendations:
1. Implement plans to provide teams with house-specific incident data on a regular periodic basis.

SEH Response: Since May 2010, the teams are provided with house-specific incident data in the Unusual Incident Monthly Report. See Tab # 142 Unusual Incident Monthly Report (March through August 2010). In addition, PID and OSR staff are reviewing data with their units as part of House support project. See Tab # 139 Performance Improvement Project List.

Facility's findings:

<table>
<tr><th>Unit</th><th>Sep-10</th><th>Oct-10</th><th>Nov-10</th><th>Dec-10</th><th>Jan-10</th><th>Feb-10</th><th>Mean-P</th><th>Mean-C</th></tr>
<tr><td>1A (Allison)</td><td>14</td><td>11</td><td>12</td><td>10</td><td>11</td><td>5</td><td>14</td><td>11</td></tr>
<tr><td>1B (Barton)</td><td>12</td><td>3</td><td>12</td><td>6</td><td>6</td><td>9</td><td>7</td><td>10</td></tr>
<tr><td>1C (O'Malley)</td><td>6</td><td>7</td><td>4</td><td>14</td><td>8</td><td>15</td><td>4</td><td>9</td></tr>
<tr><td>1D (Dix)</td><td>19</td><td>11</td><td>42</td><td>32</td><td>9</td><td>10</td><td>18</td><td>21</td></tr>
<tr><td>1E (Hayden)</td><td>7</td><td>7</td><td>12</td><td>9</td><td>16</td><td>33</td><td>16</td><td>14</td></tr>
<tr><td>1F (Shields)</td><td>11</td><td>9</td><td>13</td><td>12</td><td>14</td><td>20</td><td>12</td><td>13</td></tr>
<tr><td>1G (Howard)</td><td>13</td><td>5</td><td>12</td><td>9</td><td>11</td><td>9</td><td>6</td><td>10</td></tr>
<tr><td>2A (Gorelick)</td><td>6</td><td>2</td><td>4</td><td>4</td><td>6</td><td>3</td><td>6</td><td>4</td></tr>
<tr><td>2B (Nichols)</td><td>0</td><td>4</td><td>6</td><td>2</td><td>4</td><td>0</td><td>4</td><td>3</td></tr>
<tr><td>2C (Blackburn)</td><td>3</td><td>5</td><td>12</td><td>11</td><td>17</td><td>14</td><td>5</td><td>10</td></tr>
<tr><td>2D (Franz)</td><td>11</td><td>9</td><td>22</td><td>5</td><td>10</td><td>12</td><td>9</td><td>12</td></tr>
<tr><td>Annex A/B</td><td>2</td><td>3</td><td>4</td><td>0</td><td>5</td><td>0</td><td>5</td><td>2</td></tr>
<tr><td>TLC-Intensive</td><td>2</td><td>3</td><td>5</td><td>1</td><td>9</td><td>5</td><td>6</td><td>4</td></tr>
<tr><td>TLC-Transitional</td><td>1</td><td>4</td><td>5</td><td>2</td><td>3</td><td>4</td><td>7</td><td>3</td></tr>
<tr><td>SEH Other</td><td>5</td><td>7</td><td>8</td><td>9</td><td>8</td><td>4</td><td>12</td><td>7</td></tr>
<tr><td>Non-SEH</td><td>5</td><td>2</td><td>8</td><td>4</td><td>6</td><td>3</td><td>5</td><td>5</td></tr>
<tr><td>Grand Total</td><td>117</td><td>102</td><td>181</td><td>130</td><td>143</td><td>146</td><td>133</td><td>137</td></tr>
</table>

This was also reviewed as part of the Frequency of Assaultive Behavior at SEH study completed by PID. See Tab # 139 PI Project List, Frequency of Assaultive Behavior review
</td></tr>
<tr><td>XII.E.1.e</td><td>date and time of incident;</td><td>
Recommendation:
1. Continue current practice of identifying factors that contribute to aggression and characteristics of incidents of aggression.

SEH Response: Ongoing. See also discussion of High Risk Indicator Tracking and Review Policy at XII.A. See Tab # 151 High Risk Tracking and Review Policy, and Tab # 56 Risk Indicator UI Tracking Reports The Hospital has somewhat modified
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		the follow up in tracking the 3 or more major UIs in 30 day period initiative. Under the policies, treatment teams are expected to review those individuals who have three or more UIs in a 30 day period; the Director of Psychiatric Services will also review cases of three or more major UIs. The Director of Psychiatric Services usually waits 5 days after being notified that an individual has met that indicator to allow the treatment team time to meet and address the issues. He then is expected to follow up by reviewing the record and talking with the treatment team to ensure an appropriate response by the team. ***See Tab # 151 High Risk Indicator Tracking and Review Policy*** PID also did a study during this rating period around UIs and Time. The study found that the peak times for violence were at 9 a.m. 1-2 p.m. and 5-7 p.m. Weekends had the fewest incidents. ***See Tab # 139 PI Project List, UIs and Time***
XII.E.1.f	cause(s) of incident; and	**Recommendations:** 1. Continue the work of identifying factors that contribute to violence in the hospital. SEH Response: The Hospital continues to track and monitor Individuals who are involved in multiple incidents through its Unusual Incident Monthly Report and high risk indicator system. ***See Tab # 142 Unusual Incident Monthly Report.*** The Hospital has somewhat modified the follow up in tracking the three or more major UIs in 30 day period initiative. Under the policies, treatment teams are expected to review those individuals who have 3 or more UIs in a 30 day period; the Director of Psychiatric Services will also review cases of three or more major UIs. Generally, the Director of Psychiatric Services waits 5 days after being notified that an individual has met that indicator to allow the treatment team time to meet and address the issues. He then follows up by reviewing the record and talking with the treatment team to ensure an appropriate response by the team. This is now included in the High Risk Tracking and Review Policy. ***See Tab # 151 High Risk Tracking and Review Policy, Tab # 149 Summary of High Risk individuals in care.*** See also XII.E., XII.E.1.a, and XIII.A. ***See also Tab # 138 VRI initiative materials.***
XII.E.1.g	actions taken.	**Recommendation:** 1. Move beyond planning to implementation of actions taken in response to incident patterns and trends and include audits of the actions effectiveness. SEH Response: The Hospital began implementation of its High Risk Indicator Tracking and Review Policy in March 2011. In addition, it continues its monitoring of individuals involved in 3 or more UIs in a 30 day period. Under the policies, treatment teams are expected to review those individuals who have three or more UIs in a 30 day period; the Director of Psychiatric Services will also review cases of three or more major UIs. Finally, it implemented a database which tracks recommendations/corrective actions by, *inter alia*, implementation status and sustainability. ***See Tab # 149 Summary Of High Risk Indicator Lists***
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	**Recommendation:** 1. Continue current practice. SEH Response: Ongoing.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	be documented in the individual's medical record with explanations given for changing/not changing. the individual's current treatment regimen.	2. Ensure the High Risk Indicator Tracking and Review policy being drafted clearly states for treatment teams the hospital's expectations for referencing incidents in an individual's IRP and revising the IRP as necessary. SEH Response: Completed. ***See Tab # 151 High Risk Indicator Tracking and Review Policy.***
XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Recommendation:** 1. Take steps to move the plan forward for identifying individuals in high risk situations and securing an appropriate clinical review and response. SEH Response: Ongoing. Eight categories of behavioral high risk indicators and eight categories of medical high risk categories were identified. Treatment teams and PID staff identified 123 individuals who met the criteria in one or more categories.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.	**QUALITY IMPROVEMENT**	
	By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	
XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Recommendation:** 1. Complete work as planned on the High Risk Indicator Tracking and Review policy. SEH Response: Completed. Policy was finalized on February 28, 2011. Individuals meeting the high risk criteria were identified by March 20, 2011, and PID is tracking the policy's implementation. ***See Tab # 151 High Risk Indicator Tracking and Review Policy.*** 2. Implement the plan for monitoring high risk indicators as outlined on the deployment schedule when approvals have been obtained. SEH Response: The Hospital finalized its High Risk Indicator Tracking and Review Policy. ***Tab 151 High Risk Indicator Tracking and Review.*** Under the finalized policy, standards were created to identify and track individuals who fall within 8 categories of behavioral high risk and 8 categories of medical high risk. The policy specifies the criteria for an individual to be placed on any of the lists and criteria to be removed from a list. Individuals in care who meet the criteria were identified in early March, 2011 and the lists are monitored by PID – a specific database is being created to manage this oversight. The lists will be modified as new cases are identified and as others fall off. The Policy also provides for a three-tier review and intervention system. The treatment teams provide the first level of intervention by identifying cases where individuals meet a criterion and thus should be placed upon a list; the IRP is also to be updated. The second level intervention is by the Director of Psychiatric Services who must review any case in which an individual meets certain high risk thresholds (3 or more r/s or emergency involuntary medication administrations in a 30 day period or 3 or more major UIs of any type in a 30 day period). The third level intervention is by a newly created Clinical Consultation Team (CCT) which must review the care of an individual who meets a high risk threshold more than once in a six month period, or requires placement on the lists for a second time in a three month period. The review by the Clinical Consultation Team includes findings, conclusions, and recommendations to the treatment teams to reduce the risk status of the individual and shall be documented by minutes. As of the writing of this report, the membership of the CCT has been identified, but it has not yet met as no cases yet meet the criteria for third level review. The CCT includes the Director of Medical Affairs, the President of the Medical Staff, the Director of Psychology, the Director of Clinical Operations, the Director of Treatment Services and the Chief Nurse Executive. The Director of PID is the ex officio chair. The Hospital continues to publish its PRISM monthly report (***See Tab # 53 PRISM Report)***, its annual Trend Analysis (***See***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 155 Trend Analysis) and is also publishing each month a report on documentation relating to medication administration. ***See Tab # 102 Medication Administration Documentation Data.*** The PRISM Report tracks admissions, discharges, transfers, 30 day readmission rate, UIs, elopements, patient injuries, staff injuries, ADRs, likely emergency involuntary medications, and restraint and seclusion. Use of seclusion and restraint remain far below the national public rate, the 30 day readmission rate, after a spike in September 2010, shows readmissions are also below the national public rated. Elopements were down in November through January, but increased in February 2011. Physical assaults reached their highest level in over twelve months in February 2011 and the number of patients injured in February was also the highest in a year. This may be due to high acuity of patients and staff shortages due to hiring restrictions caused by the budget crisis. PID also conducted a special study relating to falls (***See Tab # 100 Analysis of Falls)***, and also reviewed data concerning assaults and time and location of UIs, all of which were presented to PIC. ***See Tab # 139 Performance Improvement Project List, UIs and Time, and Frequency of Assaultive Behavior at SEH.***
XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Recommendations:** 1. Ensure that the High Risk Indicator Tracking and Review policy presently being developed addresses the role of psychology services in the treatment of individuals who reach risk triggers. SEH Response: The Director of Psychology serves on the CCT. 2. As planned, following the completion and approval of the High Risk Indicator Tracking and Review policy, build the technology infrastructure to support the data gathering and notification to treatment teams, and provide training to all levels of staff necessary for effective implementation. SEH Response: Policy is completed, training of psychiatrists, medical officers, nurse managers and clinical administrators completed. Overview of policy was presented at all staff meeting, all shifts. Individuals who meet the various indicators have been identified. PID is monitoring the various lists. **Analysis/Action Plan**: The Hospital continues to monitor key indicators each month and produces the PRISM report. ***See Tab # 53 PRISM report.*** The annual Trend Analysis was also completed during this review period. ***See Tab # 155 Trend Analysis.*** The Director of Psychiatric Services reviews the care of those individuals who reach the threshold of three major UIs in a month, and the recommendations are entered into a progress note in Avatar and also captured in a tracking spreadsheet. During the last review period, a study of psychiatric emergencies was undertaken and the recommendations were made. One of the recommendations was for units to review their rules. This was done in the Fall, 2010 at a clinical leadership meeting, and each unit made modifications; most modifications related to visitation and food***. See Tab # 140 Unit Rule Modification summary list.*** In addition, PID, partnering with the Office of Consumer Affairs, is doing additional analysis around food related issues, including surveys of individuals in care and observations of food service. ***See Tab # 139, Performance Improvement Project List.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		PID also completed an analysis of the incidence of falls. The analysis revealed: ▪ Most of the falls occurred with individuals in care. ▪ Most of the falls occurred inside hospital buildings rather than on the grounds. ▪ One of the hospital's two geriatric units was both the location of the highest number of falls and had the highest number of individuals who experienced falls throughout hospital premises. ▪ Of the falls that were thoroughly documented, slightly more than half occurred on shifts that met required staffing levels. ***See Tab # 100, Falls Analysis.*** The Hospital's PID did a review of frequency of assaultive behavior at the Hospital for the period of September 2010 to November 2010. The analysis included a review of UI reports and clinical records for the day of the assault. The review found that 5 individuals were responsible for 34% of the assaults, that in 30% of the assaults, staff were the targets and that a slight majority of the assaults occurred on the evening shift, with day shift a close second. The report also looked at the injury rate and found that when an individual in care was involved in an assault, 42% required treatment for an injury and that when a staff member was assaulted, 46% required treatment for an injury. The study also found that 15% of assaults were follow-ups to earlier assaults, suggesting that disputes were not fully resolved and the intervention methods may need to be adjusted; that the review of the medical record notes indicated a reason for the assault even though the cause in 34% of assaults was identified as unknown in the UI report; and that assaults may also indicate a lack of follow up by staff. ***See Tab # 139 Performance Improvement Projects, Frequency of Assaultive Behavior at SEH.*** The results were presented to PIC. It should be noted also that subsequent to this study, the Hospital began Collaborative Problem-Solving Training as a way to improve staff interactions with individuals and reduce conflicts, which is completed on three units with a fourth in training as of the writing of this report. All units will be trained. ***See Tab # 82 Collaborative Problem- Solving Outline.*** PID has begun a baseline review of assaults within 24 hours of their occurrence. Finally the PID has planned a study of STAT medication usage. Preliminary data may be available by the time of the May site visit. During the last review period, senior clinical leadership also began meeting to address the treatment of personality disorders at the Hospital which are contributing to the high number of assaults. As a result of this work, DBT group therapy has been added to the TLC menu of groups, and the Medical Director for DMH is leading a community initiative to develop DBT treatment capacity in the community. PID and the Office of Statistics and Reporting also support the various audits under the Agreement. PID and OSR staff conduct the transfer, discharge, restraint/seclusion audits, observe IRP conferences, do data related data analysis and special studies. PID has identified projects either underway or set to begin this Spring. See ***Tab # 139 Performance Improvement Projects***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.B.1	disseminating corrective action plans to all persons responsible for their implementation;	**Recommendations:** 1. Document the decisions from the hospital leadership's discussions of the variety of recommendations presented to the leadership to reduce the level of violence in the hospital. SEH Response: ***See Tab # 138 VRI Initiative Materials.*** The leadership endorsed the RA Peer Specialist (RAPS) pilot program previously described in this report. In addition, the Hospital finalized and implemented its high risk indicator tracking and review policy. It has created a clinical consultation team to provide expertise to treatment teams in addressing high risk behaviors or issues. It is training all units on Collaborative Problem- Solving, (3 units have been fully trained), an approach found effective in dealing with those with explosive behavior. Finally, it is purchasing new curricula for non-violent crisis intervention that has more of a focus on prevention and de-escalation. These initiatives were presented at various all staff meetings by PID and the President of the Medical Staff.
XIII.B.2	monitoring and documenting the outcomes achieved; and	**Recommendations:** The High Risk Indicator Tracking and Review policy presently being drafted should include a multidisciplinary consultation process. The drafting and approval of this policy and its implementation are essential for the hospital to meet this requirement of the Settlement Agreement. SEH Response: Completed. ***See Tab # 151 High Risk Tracking and Review Policy.*** The Policy includes review by the Director of Psychiatric Services of cases that meet the high risk threshold for thresholds involving a psychiatric/behavioral issue and review by the Director of Medical Services if the threshold involves a medical risk category. Further, the policy creates a clinical consultation team that reviews any cases of an individual who meets the high risk threshold more than once in a six month period, remains on the high risk list for six consecutive months or requires placement on the lists for a second time within a six month period.
XIII.B.3	modifying corrective action plans, as necessary	See cell above. The Hospital has created a database that tracks recommendations emanating from various hospital committees, special studies, and investigations. PID manages the database, and tracks the status of approved recommendations. ***See Tab # 139 PID Project List, Screenshots of Recommendation Tracking Database.***
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Recommendation:** 1. Continue to work toward the implementation of measures to reduce the level of violence in the hospital. SEH Response: See VRI Discussion above. 2. Continue work on the Risk Indicator tracking and review system to bring it into full implementation. The hospital's CAP requires the development of policies and procedures identifying the process that will occur when high risk indicators are identified and for monitoring the response. As indicated, initial work on the policy has begun.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Completed. Implementation began in March, 2011.
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation	See XIII.B.3
XIII.C.2	monitoring and documenting the outcomes achieved; and	See XIII.B.3
XIII.C.3	modifying corrective action plans, as necessary.	See XIII.B.3
XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Recommendation:** 1. Continue making progress toward implementation of the various Performance Improvement recommendations and plans described in earlier cells.. SEH Response: See discussion in subcells above

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIV.	**ENVIRONMENTAL CONDITIONS**	
	By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	
XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Recommendation:** 1. Audit all hospital units and treatment areas to ensure that cut down instruments are accessible in an emergency. SEH Response: Nursing checked to ensure all cutdown instruments were available on emergency carts, and it has been added to the emergency cart checklist.
XIV.B	By 36 months from the Effective Date hereof, SHE shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Recommendation:** 1. Continue current practice. SEH Response: Current practice continues.
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.	**Recommendation:** 1. Investigate the practices for accounting for individuals and set expectations for a standardized method that is accurate and accountable. SEH Response: Nursing is reviewing this as part of review of the nursing assignment sheet and related nursing procedures. It is expected to be completed by May 16 visit. Staffing continues to be a challenge, particularly in nursing. The Hospital's ability to hire nurses to expand its workforce has been limited. As of the writing of this report, only 5 vacancies are approved to be filled due to due to fiscal limitations. 2. Consider the advisability of initiating accountable zone supervision during lunchtime at the Intensive TLC. SEH Response: Completed.
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	**Recommendation:** 1. Continue current practice. SEH Response: Level of practice continues.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	shall be inspected by the relevant local authorities.	
XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	**Recommendation:** 1. Continue current practice. SEH Response: Level of practice continues.
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.	**Recommendations:** 1. Implement, as resources become available, the plans to renovate the area where individuals living in Annex A and Annex B will be housed. SEH Response: Annex A and B have been closed due to census reduction. All individuals in care are now housed in the new hospital building.