United States of America v. District of Columbia

An Assessment of Saint Elizabeths Hospital's Progress
as of July 31, 2008
In Meeting the Requirements for Reform

Janet Maher
June Walden-Yeager
Compliance Office
July 31, 2008

Saint Elizabeths Hospital
Progress and Action Steps to Implement DOJ Recommendations

V. Integrated Treatment Planning

Summary of Progress

1. The Hospital revised its treatment planning policy and incorporated all recommendations from the Baseline Report. See Tab # 1 (Treatment Planning Policy). It is still in the initial phases of implementing the Policy; training on the new policy has not yet occurred.

2. The Hospital modified its treatment plan form to ensure it is consistent with the revised Treatment Plan Policy. See Tab # 2 (Revised Comprehensive IRP form). The form will be introduced in August. The Hospital also developed its initial treatment plan form. Tab # 3 (Revised Initial IRP form).

3. The Hospital drafted a Treatment Planning Conference Template that establishes the sequencing of treatment plan conferences and ensures key factors such as the "6 Ps" and use of medication are addressed in each conference. See Tab # 4 (Treatment Plan Conference Template). The clinical administrators and senior staff were involved in the Template's development and implementation has begun. Each treatment team has been provided a copy of the conference template.

4. The Hospital recently created a template for progress notes which will be used for the treatment mall and other treatment providers, which is being reviewed by the consultant. See Tab # 5 (Monthly Progress note form). It has been circulated for use as a pilot while awaiting feedback. The note is available in an electronic form and the fields adjust based upn the length of the note.

5. The Hospital modified its IRP Process Monitoring tool to be consistent with the revised Policy and the Conference Template. See Tab # 6 (IRP Process Monitoring Tool). The Hospital then piloted the tool through observing 20% of scheduled treatment plans in April and May and reviewing relevant aspects of the chart (i.e., Assessments, Progress Notes and IRPs). Results are reflected in the specific sub-cells below. See Tab # 7 (Report on IRP Observations). The tool does not yet include a full set of operational instructions or indicators, but a consultant to assist staff in their development has been hired. Please note that the IRP Process Monitoring Tool was revised and the amended tool was used in June observations, but that data is not yet available.

6. The Hospital has not yet begun to utilize the clinical chart audit tool. It is working with the Consultant to refine the tool, and develop indicators and operational instructions before implementation. In addition, the Hospital elected to finalize the Assessment policy and forms before finalizing the tool. See VI, Summary of Progress below.

7. The Civil and Forensic Divisions maintain data about treatment plan participation. Because data in the self-assessment was not consistent with the self-reported data, the Hospital began conducting monthly audits of the Civil and Forensic Divisions self-reports, to include one record per month of reported treatment plans. In general, the audits reveal that the medical record documentation does not support the self-reported data about treatment plan participation. The primary issues involve participation of the patient and attendance by all disciplines at the treatment plan, as treatment plans are often missing signatures of patient or some disciplines. While the results

are shared monthly with the Civil and Forensic Directors, the results of these audits are included in the Trend Analysis beginning in April/ May. See Tab # 8 (Trend Analysis, April - May). The audits will be phased out in August, 2008 as the IRP process observations are underway.

8. The Hospital retained a consultant to assist in refining the IRP process and clinical audit (and other required) tools. The consultant began work in June, and will continue to work with Hospital staff on perfecting instruments and related documents. Tab # 9 (Angela Adkins Contract).

9. No training of staff in treatment planning occurred between March and the end of July, 2008 due to difficulties in getting a contract in place; ultimately, in June, 2008, although the contract was completed, the identified vendor elected not to proceed. Alternative trainers were quickly identified, and contracts are being negotiated. The Hospital staff met with the trainers on July 25th to set up the training plan. Tab # 10 (PO for Treatment Planning Training Development). As of the writing of this report, two units (one in civil and one in forensics) had received partial training in treatment planning, but none has occurred since the DOJ visit. Assuming a contract is finalized in early August, the new contractor has the capacity to train 4 teams beginning in August, 2008 and 4 additional teams beginning in September, 2008.

V. Integrated Treatment Planning.

By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.

Findings

See sub cells.

Compliance Status: See sub cells.

V.A. Interdisciplinary Teams

By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:

Findings

See sub-cells for findings and status.

Compliance Status: See sub cells.

V.A.1

Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;

Findings

The Hospital has taken steps to move toward implementation of this requirement, but has not yet implemented it. The Hospital revised its treatment plan policy and IRP forms to focus on ensuring treatment is individualized and integrated. Tab # 1, (Treatment Planning Policy); Tab #s 2, 3 (IRP forms). The policy requires the completion of case formulations, interdisciplinary integration of assessments and individualized assessments. The Hospital also developed a treatment plan conference template, incorporating recommendations from the consultant, that provides structure for the sequencing of the conference and will improve consistency across units. Tab # 4 (Treatment Planning Conference Template). It is obtaining technical assistance in evaluating the IRP form, and implementation of the tools systemically across units is expected to begin by August; until all units are trained in treatment planning, however, compliance is not likely.

As noted in the summary of progress, the Hospital's Performance Improvement Department (PID) is piloting an IRP process tool and observing treatment plans, and available data will be reported in the related sub cells. See Tab # 7 (Results of IRP process monitoring). Further, the indicators and operational instructions still need to be developed. The Hospital is working with the Consultant on these issues.

Observations of treatment plans reveal that treatment planning yet is not individualized or interdisciplinary in nature, outcome focused or based upon a case formulation. As of July 15th, only two of the 20 treatment teams have had any training in treatment planning, but no training has occurred since March, 2008. The interruption in training was due to difficulties in finalizing a contract for treatment planning and the withdrawal of the expected contractor. A new contractor has been identified, and the Hospital is working with the potential contract to develop a training plan; training is expected to begin in August, 2008. See PO for Treatment Plan Training Development Tab # 10. The contractor has capacity to begin training 4 teams, with 4 additional teams to begin training in September, 2008.

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

Recommendations			***Responsible Party***
1 *Same as in V.A.2 to V.A.5*			***CVC; JH; AF; PID; AS; BG; Trg;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.A.2 to V.A.5. *Status: Same as in V.A.2 to V.A.5.*			
2 *Same as in V.B, V.C, V.D and V.E.*			***PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.B, V.C, V.D and V.E *Status: Same as in V.B, V.C, V.D and V.E*		Same as in V.B, V.C, V.D and V.E	

V.A.2

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

Findings

Six new psychiatrists have accepted offers and have start dates between July 1, 2008 and September 30, 2008. Of the six, two will be assigned to forensic units, and the remaining four to civil units, with two assigned to the admissions units. That will bring the civil services largely into compliance, as the only unit without a full time psychiatrist will be RMB - 2, as the part -time psychiatrist recently resigned. Forensic services, however, will still not meet the required staffing on admission units or on several post-trial units.

Four clinical administrator psychologist team leader positions were announced and two selections have been made for forensic services effective 7/20/08. Upon filling of the remaining two vacancies, all treatment teams will have a treatment team leader that is either a psychiatrist or psychologist.

See Tab # 11 (HR report).

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

Recommendations	***Responsible Party***
1 *Hire adequate psychiatrists and licensed clinical psychologists to assure compliance with*	***CVC; Psychology***

this aspect of the DOJ agreement.

	Action Step and Status	Target Date	Relevant Document(s)	Department Responsible Staff
1	Enhance recruitment activities for psychiatrists and psychologists	9/30/2008	HR report, Tab # 11 PD for clinical administrator psychologist, Tab # 12 ; Vacancy Ann Psychiatrist Tab # 13 ; Vacancy Ann Clinical Administrator Psychologist Tab #14 Psychiatrist Recruitment Plan, Tab #15	Medical HR Director; Director; Director of Psychology
	Status: Six psychiatrists have accepted offers and will start between 7/1/2008 and 9/30/08. An additional offer is outstanding. Three psychologists were hired since 3/1/08 and recruitment is on-going for two additional clinical administrator psychologists.			
2	Produce bi-weekly recruitment status reports for Exec. Staff, using newly created HR database.	7/15/2008	HR Report, Tab # 11	HR Director
	Status: Produce bi-weekly report: A report showing the status of each clinical vacancy is produced at least bi-weekly and provided to the Executive Staff. It also includes new hires and separations. A comprehensive HR database is in the final stages of development and will have the capability of producing targeted reports focusing on specific occupations.			
3	Assess recruitment activities on a quarterly basis and refine strategies as needed	9/30/2008	Annual recruitment plan, Tab # 16	HR Director
	Status: HR developed an annual recruitment plan which is assessed on an on-going basis			

V.A.2.a

assume primary responsibility for the individual's treatment;

Findings

Through the treatment planning conference template, the Hospital clarified the expectations around the role of the treatment team leader. See Tab # 17 (Treatment Conference Protocol). The data from the pilot IRP observations shows that in 91% of treatment plan observations, a person was identified to be responsible for the scheduling and coordination of the conference. See Tab # 7 (Results of IRP Observation). As was the case in February, those treatment team leaders which have had some treatment planning training are more effective in leading the conferences and in those teams, assessments are occurring before the treatment plan conferences, but to date, only 2 of 20 teams have had the benefit of any treatment planning training, so that is not yet the norm. Further, in most treatment plan conferences or plans, there is not yet the interdisciplinary integration of assessments leading to individualized interventions.

Compliance Status: No progress is made toward the June 25, 2010 compliance date.

Recommendations	Responsible Party
1 *Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences.*	***CVC; JH; AF; AS; BG; Sam Feinberg***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize contract for consultation and training on Treatment Planning. *Status: No training since March, 2008 as previous vendor declined contract; new vendor identified and contract negotiations underway.*	7/25/2008	Tab # 10, (PO for Mary Thornton governing treatment plan training plan development)	DMH Contracts
2	Provide Executive Staff, Program related Senior Staff and Clinical Administrators orientation and overview of treatment planning initiatives ***Complete***	6/30/2008		Chief of staff
3	Expand training on treatment planning gradually throughout summer and fall to include at least 50% of treatment teams by end of calendar year, and all treatment teams by March, 2009 *Status: Contract to permit expansion to more teams in negotiations. Expect signed contract by August and training to start in August. Please note that prior vendor declined contract offer so no training has occurred since March, 2008*	3/31/2009	PO to develop treatment planning training, Tab # 10	Chief of staff

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise treatment planning policy to incorporate recommendations and obtain Executive staff approval. ***Complete*** *Status: Policy was revised and approved by Executive staff*	7/31/2008	Treatment plan policy, Tab # 18	Director, Policy; CEO

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Create treatment plan protocol that reflect recommendations and policy	7/16/2008	Treatment planning conference protocol, Tab # 17	Chief of staff
	Complete *Status: Conference protocol was drafted and staff are using it. Consultant A. Adkins provided comments which were incorporated.*			

3 *Provide treatment teams with training in how treatment planning is different from both assessment and treatment.* ***Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Contract with vendor to provide competency based training to treatment teams that differentiates assessment, treatment planning and treatment	8/1/2008	PO for development of treatment plan training, Tab # 10	DMH Contracts; Chief of Staff
	Status: Vendor identified and negotiations underway			
2	Develop schedule with selected vendor to ensure at least 50% of treatment teams begin training by December, 2008, and remainder by March 31, 2009	12/31/2008	None at this time	Chief of Staff; Civil and Forensic Directors
	Status: Civil and Forensic Directors are working with Chief of Staff to identify teams for which to prioritize training			
3	Begin training for 4 teams; 4 additional teams to begin training in September, 2008	8/1/2008	None at this time	Chief of Staff, Forensic and Civil Directors
	Status: Training is scheduled to begin August, 2008			

4 *Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room.* ***Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Contract with vendor to provide competency based training to treatment teams that differentiates assessment, treatment planning and treatment.	8/1/2008	PO for development of treatment planning training, Tab # 10	DMH Contracts; Chief of Staff
	Status: Vendor identified and negotiations underway			
2	Develop schedule with selected vendor to ensure at least 50% of treatment teams begin training by December, 2008, with remaining teams to begin training by March 31, 2009	12/31/2008	None at this time	Chief of staff; Civil and Forensic Directors
	Status: Civil and Forensic Directors are working with Chief of Staff to prioritize which teams should be trained first			

	Target Date	Relevant Document(s)	Responsible Staff
3 Begin training for 4 teams in July, 2008, expand to 4 additional teams by September, 2008.	8/1/2008	None at this time.	Chief of staff, Forensic and Civil Directors

Status: Training to begin week of August, 2008

V.A.2.b

require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;

Findings

In most case, the individual is attending the treatment plan conference, but the degree of participation varies widely. There remain issues with obtaining the patient's signature on the plan, even when they attend the conference. See audit results included in April/May Trend Analysis, Tab # 8, pps. 20-21. Through the IRP conference observations (about a 20% sample), it appears that in only 59% of the conferences, the patient attended, but in over 30%, the patient's presence was not indicated. The treatment team's efforts to facilitate meaningful patient participation was rated as marginal to fair. See Tab # 7 (Results of IRP Observations).

Family participated in only 3% of the observed conferences. It is noteworthy that the high rate of cancellations/rescheduling of treatment plan conferences (27%) as well as the practice on some units to schedule multiple conferences for the same time may adversely impact the participation of family or other non-Hospital staff.

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

Recommendations	***Responsible Party***
1 *Provide treatment teams with training in effective ways to engage individuals and their families in the treatment planning conference.*	***Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See V.A.2.a		See V.A.2.a	

Status: See V.A.2.a

2 *See cell V.A.2.a, Recommendation 4.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See V.A.2.a, Recommendation 4.		See V.A.2.a, Recommendation 4	

Status: See V.A.2.a, Recommendation 4

V.A.2.c

require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;

Findings

The IRP process audit shows that progress notes/assessments are not being completed by any discipline on a consistent basis prior to the treatment plan. Data shows that progress notes (not even assessments) were completed prior to the treatment plan conference by registered nurses in 31% of cases, by psychiatry in 19% of cases, and by social work in 13% of the cases. See Tab # 7 (IRP Process Results). The data on the later two disciplines is slightly skewed because in several cases reviewed by reviewers, there were only covering social workers and psychiatrists at the time of the review.

On one of the units with some training on treatment planning (RMB 2), the assessments are largely completed prior to the conference using the "6Ps", and the clinical staff are presenting their assessments during the first phase of the IRP conference, before the patient arrives. Further, the IRP conference template has now been finalized and will now be used by treatment teams to provide some consistent structure across units. Combined with additional

training now being made available, improvement in all aspects of treatment planning is expected.

A progress note template for use by all disciplines was drafted and introduced for use in July, 2008. Tab # 5 (Progress Note Template).

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

Recommendations				***Responsible Party***
1 *See cell V.A.2.a, Recommendations 1 through 4.*				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 See action steps and status related to cell V.A.2.a, Recommendations 1 through 4.		See V.A.2.a		
Status: See status related to V.A.2.a				
2 *Develop and implement a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about next steps when treatment has been successful or further assessments/changes to treatment when treatment has been unsuccessful. .*				***CVC;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Develop Progress note template that can be used by all Mall groups and other groups as well.	6/30/2008	Progress Note Template, Tab # 5	Chief of staff	
Complete *Status: Progress note template drafted and in use.*				
3 *Develop and implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates:* *a The name of the group/individual treatment;* *b The name of the group/individual treatment provider;* *c The name of the individual patient;* *d The short-term goal for which the individual has been assigned to the modality;* *e The number of attended sessions and offered sessions;* *f The quality of the individual's participation; and* *g The individual's progress toward achieving the stated short-term goal*				***CVC;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Develop progress note template for use by Treatment mall and other groups.	6/30/2008	Progress Note template, Tab # 5	Chief of staff	
Complete *Status: Progress note template drafted and in use.*				

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop progress note template. ***Complete***	6/30/2008	Progress note template, Tab # 5	Chief of staff
2	Develop auditing tool and operational instructions that reflect requirements of progress notes as defined by template. *Status: Consultant A. Adkins will assist in auditing tool development , consultation began June, 2008. Hospital is working with consultant to prioritize tool development but no substantive actions have occurred.*	9/15/2008	See list of all tools to developed and priorities, Tab # 19	QID Director
3	Train auditors on auditing tool and begin progress note audits. *Status: No action taken. Audits will begin once tool developed.*	10/14/2008		QID Director
4	Collect and analyze data from audits and issue reports to Senior staff; First report within 45 days of 1st audit. *Status: No action taken*	11/17/2008		Director, Monitoring Systems

5 *Train all auditors to acceptable levels of reliability.* ***PID; with assistance***

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

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

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

V.A.2.d

require that the treatment team functions in an interdisciplinary fashion;

Findings

The treatment teams largely continue to operate in multi-disciplinary fashion rather than inter-disciplinary fashion. Under the anticipated new contract for treatment planning training, trainers will do some work with disciplines in an effort to strengthen assessment skills, but will largely work with individual treatment teams as units, which is expected to improve capacity to integrate assessments. In addition, the IRP process observation tool is being evaluated by the consultant Angela Adkins to enhance the capacity to evaluate this requirement.

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

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

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

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify previously provided IRP process tool to reflect recommendations and findings for baseline report.	4/30/2008	See revised IRP Process tool, Tab # 6	QID Director
	Complete *Status: Tool revised and piloted.*			
2	Pilot revised tool and modify as needed; Status Consultant A. Adkins will assist in developing tools, indicators operational instruction; Consultation began 6/2008.	6/2/2008	Revised IRP process tool, Tab # 6	QID director
	Complete *Status: IRP tool was piloted and revised, but no indicators or operational instructions are yet completed.*			
3	Train auditors on new tool.	6/16/2008	IRP process monitoring Training materials, Tab # 20	QID director
	Complete *Status: Auditors trained. In an effort to improve inter-rater reliability, auditors conducted a group observation of a treatment planning conference.*			
4	Begin auditing process and provide report to senior staff	6/16/2008	Results of first months audit, Tab # 7	QID Director; Director, Monitoring systems
	Complete *Status: This audit will constitute a baseline. While teams have been provided with treatment planning conference template, treatment planning training has not occurred for 18 of 20 units.*			

3 Train auditors to acceptable levels of reliability on the above-described tool. ***PID; Angela***

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

Status: See action steps to V.A.2.d. recommendation #2

4 See cell V.A.2.a, Recommendation 9. ***PID;***

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

Status: See action steps relating to cell V.A.2.a.

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Collect data and analyze for the hospital administration on bi-monthly basis on ongoing basis; Trend Analysis includes updated information on participation. Additional information will be included and/or additional reports published as audit process continues. Upon initiation of AVATAR Phase II in Winter 2008-2009, additional data sources will be available. ***Complete***	7/16/2008	Monthly Trend Analysis (Feb/Mar) Tab # 21 Monthly Trend Analysis (April/May) Tab # 8	OMS Staff
2 Providing technical assistance to the Administration for data review ***Complete*** *Status: This is ongoing process*			OMS Staff
3 Analyze results of IRP monthly treatment planning process audits and provide report to senior staff. First audits using revised tool completed in June, 2008, for 20% sample. ***Complete***		IRP process results, Tab # 7	OMS Staff

V.A.2.e

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

Findings

There has been significant progress in expanding the cadre of psychologists in the Hospital and in expanding the scope to involve more direct responsibility to each unit of the Hospital. Each unit in both forensic and civil services has a psychologist assigned to it. See Tab # 22 (Psychology staff assignment roster for all units). The Hospital is currently recruiting for 2 clinical administrator psychologists who can serve as treatment team leaders (2 such positions were recently filled).

Civil Services created a behavioral management unit on RMB-3, and a psychologist is permanently assigned to that

unit. The psychologist on the unit is working to develop behavioral plans, and is receiving individual support from the Consultant Daniel Arnheim in developing plans, strengthening functional analyses capacity and in working with the staff to understand plan implementation. Consultant Adkins is also expected to work with staff on that unit to enhances skills around positive behavioral supports, including documenting behavioral observations and introducing de-escalating techniques.

All patients on admission are now receiving a psychological screening which assesses risk and cognitive functioning. See Tab # 23 (Initial Psychological Assessment).

In addition, a consultant, Dan Arnheim, has been hired to work with psychology staff around the fundamentals of positive support plans. Tab # 24 (Consultant contract, Dan Arnheim)

These steps are foundational to improve and ensure appropriate behavioral supports and that they are integrated with psychiatric interventions. With these critical steps now in place, improvement in meeting this requirement is expected.

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

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Psychological evaluations will be signed by the team leader following discussion with the treatment team to assure that behavioral recommendations are integrated with psychiatric recommendations	8/29/2008	Contract with Dan Arnheim, Tab # 24	Medical Director, Director of Psychology; Chief of staff
	Status: Contract with Dan Arnheim, behavioral consultant, will include training psychology staff on how to focus discussion in treatment planning on the integration of behavioral and pharmacological interventions.			
2	Training on treatment planning will include a component on building the treatment team's capacity to appropriately integrate psychiatric and behavioral treatment modalities.	8/31/2008	Copy of Arnheim PO, Tab # 24 ; Copy of PO for Mary Thornton related to Development of treatment planning training Tab # 10	Beth Gouse
Complete	*Status: Contract with Daniel Arnheim, Ph.D. has been finalized and behavioral treatment training to begin in July. Training on treatment planning in development.*			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Psychologists are assigned to the majority of treatment units and it is expected there will be a psychologist on each unit by October 2008. This will provide for regular opportunity to review whether patients with behavioral problems need to have a behavioral support plan implemented.	10/31/2008	Ward assignments by discipline, Tab # 25	Medical Director, Rose Patterson

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

2 *Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant above.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Improve staffing. See V.A.2 rec.1.		See V.A.2	

Status: See V.A.2

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Identify contractor with capacity to work with treatment teams around behavioral supports and integration into treatment plans to supplement treatment planning training.	9/30/2008	PO for development of treatment planning training, Tab # 10 ; Angela Adkins contract, Tab # 9	CEO

Status: PO in place to develop treatment planning training plan; training will begin for 4 units by August 31, 2008. Contract with Angela Adkins in place and she will work with RMB 3, the behavioral unit.

V.A.2.f

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

Findings

PID began IRP observations in May for a 20% sample of scheduled treatment plan; the revised tool includes timeliness of IRP scheduling, all treatment plans and assessments. See Tab # 6 (Treatment Plan Process tool)

The recent IRP process observations showed a cancellation rate of 27%. Timeliness data is not yet available.

The Treatment Planning Policy was revised to update the requirements of the Agreement (initial treatment plan within 24 hours, comprehensive within 5 business days, IRP review at day 30, day 60 and sixty days thereafter). See Tab # 1 (Treatment Plan Policy)

All units now have clinical administrators who are responsible for scheduling of meetings, which should improve performance on this requirement, rated at 91% in the most recent IRP process observations.

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

Recommendations	Responsible Party
1 *Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences.*	***PID;***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify closed discharge review tools to include assessment of IRP	6/16/2008	Revised discharge records review tool Tab # 27	QID Director
	Complete *Status: Tool modified, then slightly revised after initial reviews using new tool. Data from review using new tool is not yet available.*			
2	Conduct review of 20% of charts of patients discharged in April and May, 2008 and publish results	7/16/2008	Report on results of discharged records review, Tab # 28	QID Director; Director, OMS
	Complete *Status: Records reviewed, results published.*			
3	Conduct observations of 20% of treatment plans scheduled in month of June and produce report	7/16/2008	Report of results of active case treatment plan observations, Tab # 7	QID Director
	Complete *Status: Attempts made to review 20% of all treatment plans scheduled. High rate of cancellations (27%).*			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue to use graph and charts in the monthly trend analysis	7/15/2008	Monthly trend analysis for Feb/March, Tab # 21; Trend Analysis for April/May, Tab # 8	OMS
	Complete *Status: Trend analysis continues.*			
2	Ensure results of active and closed record audits include graphs and are trended	7/15/2008	Report of discharge case reviews, Tab # 28 Report of Active Cases, Tab #.7	
	Complete *Status: Ongoing*			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide all reports to Senior staff, and post reports on the internet; .	7/21/2008	Trend analyses, Tabs # 21, 8	OMS Director
	Complete *Status: Reports are provided to senior staff; Posted on internet as well*			

4 *Train auditors to acceptable levels of reliability.* ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Enter into contract with Consultant to work with staff to develop capacity to train auditors.	6/24/2008	Contract with Angela Adkins, Tab # 9	Chief of staff, DMH contracts
Complete *Status: Consultation began 6/2008.*			
2 Consultant to work with QID director to develop training skills that will ensure auditing results are reliable	9/30/2008		QID director; Chief of staff
Status: Consultation began but focus on training has not yet begun. In the meantime, small cadre of IRP process reviewers were trained; training include group observation of single treatment plan.			
3 Develop indicators and operational instructions, working with consultant	8/29/2008		Chief of staff
Status: IRP process observation tool provided to consultant. Working with consultant to prioritize development of instructions and indicators.			

6 *See cell V.A.2.a, Recommendation 9.*

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

V.A.3

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

Findings

No training in treatment planning has occurred since March, 2008 due to contractual issues and the withdrawal of the contractor, but a new trainer has been identified and negotiations are underway for a new contract, with training anticipated to begin by the end of July, 2008. Tab # 10 (PO for Treatment plan training development). The contract has greater capacity than the initial contract and is sufficient in scope to allow up to 10 treatment teams to begin training before the end of the year. A training plan will be developed with the vendor and provided to the review team upon completion.

Compliance Status: No progress has been made in training, but the ability to now move forward exists.

Recommendations ***Responsible Party***

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

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

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,

Findings

IRP process monitoring shows that IRP conferences include core treatment team members as follows: 59% patient, social worker 66%; RN 81%; psychiatrist 84% and clinical administrator 94% of the time. Tab # 7 (Results of IRP process monitoring observations). Data should improve as psychiatry, nursing and all clinical administrator

as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and

positions get filled.

Staffing gains have created the capacity for each unit to have an assigned psychologist. Further, 11 additional nurse manager positions, and with the additional six psychiatrists starting by September 2008, staffing will be near expected levels in all disciplines but rehabilitation specialists. In March, 2008, 19 clinical positions, including a number of rehabilitation specialist positions were abolished; and those positions may be necessary in order to meet the treatment hour requirements of the Agreement.

See Tab #11 (HR staffing report) for staffing information.

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

Recommendations — ***Responsible Party***

1 Provide data on the hospital's current progress toward achieving stable core team membership. — ***CVC; JH; PID; AS; JH for data***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Fill critical vacancies in nursing, psychiatry, psychology and social work	7/31/2008	HR hiring status report Tab # 11 ; List of core team members by unit Forensic, Tab # 25; Civil, Tab # 25	HR Director, Medical Director; Civil and Forensic Services Directors
	Status: Recruitment continues for these positions. Candidates were selected for an additional seventeen nursing positions. Open continuous vacancy announcements are active for most clinical positions.			
2	Provide bi-weekly HR report to managers in order to track vacancies and recruitment	7/7/2008	Report dated June 23, 2008 Tab # 11	HR Director
	Complete *Status: Produce bi-weekly report: A report showing the status of each vacancy is produced at least bi-weekly and provided to the Executive Staff. It also includes new hires and separations. A comprehensive HR database is in the final stages of development and will have the capability of producing targeted reports focusing on specific occupations.*			
3	HR will provide on-board strength analysis by month for all clinical position types for FY 2008 through June 30, 2008.	7/7/2008	Copy of analysis Tab # 29	HR Director
	Complete *Status: Will be provided monthly*			
4	HR will provide a listing of all active Hospital positions for FY 2008 as of June 30th.	7/7/2008	Listing of active positions Tab # 30	HR Director
	Complete *Status: 75 positions were abolished this fiscal year leaving 1001 FTE positions available for recruitment*			

2 Recommendations regarding the level of staffing for psychiatrists can be found in cell VIII.A.3. ***AF; AS; patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 HR will provide a report that lists all positions hired during FY 2008 through June 30th. Report will be updated every two weeks ***Complete***	7/7/2008	Report of hires in FY 2008, Tab # 31	Human Resources
2 HR will provide a report listing all vacancies during FY 2008 though June 30th.	7/7/2008	List of psychiatrist positions from schedule A. Tab # 32	Human Resources

Status: Six new Medical Officers (Psychiatrists) will join the medical staff between July 1 and September 30, 2008 and the Hospital is continuing to recruit for additional psychiatric staff.

V.A.5

meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.

Findings

See findings in V.A.2.f.

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

Recommendations ***Responsible Party***

1 See recommendations in cell V.A.2.f.

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

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

V.B. Integrated Treatment Plans

By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:

Findings

See sub-cells for findings.

Compliance Status: See sub cells for findings.

V.B.1

where possible, individuals have input into their treatment plans;

Findings

The treatment conference template provides some guidance to treatment teams about engaging patients in the treatment planning process, and the IRP process monitoring tool also has been modified to address this requirement. See Tab # 4 (Treatment Planning Conference Protocol) and # 6 (IRP process monitoring tool). Operational instructions for the IRP process tool have not yet been developed, but the Hospital is working with the consultant to develop these. Finally, a treatment plan manual is under development and is expected to be completed by September, 2008; it will be made available to the reviewers at that time.

Although treatment planning indicators and operational instructions are not finalized, PID attempted to assess the quality of patient participation in treatment planning through the piloting of the new IRP process tool. The observations revealed that the treatment team's involvement of the patient in his/her own treatment planning was

rated as marginal to fair, indicating substantial work is needed to make the patient a more meaningful participant in treatment planning.
See Tab # 7 (IRP process monitoring report)

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

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

Recommendations | ***Responsible Party***

1 *Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectations regarding the process of engagement of individuals in their IRPs.* — ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete treatment plan conference template; finalize treatment plan policy;	6/30/2008	Treatment conference protocol Tab # 4	Chief of staff
	Complete *Status: Template is being reviewed by consultant and modifications will be made as appropriate.*			
2	Create tip sheets for case formulation, engagement of individuals and stages of change to include in treatment plan manual;	9/26/2008	Tip Sheets for Case Formulation and Stages of Change, Tab # 33	Chief of staff
	Status: Tip Sheets created for Case Formulation and Stages of Change. Sheet for Engagement of Individuals is forthcoming			
3	Purchase person centered treatment planning book for all units;	7/31/2008		COO
	Status: Books have been ordered			
4	Create treatment planning manual to include policy, conference template, tip sheets, and other key items to assist staff.	8/20/2008	None at this time.	Beth Gouse
	Complete *Status: Draft manual being reviewed and changes are expected*			

2 *Develop and provide a training module focused on Engagement of Individuals. The purpose is to ensure that the individuals provide substantive input in the formulation and revisions of treatment objectives and interventions.* ***Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Enter into contract with vendor to provide treatment planning training that includes engagement of individuals in their treatment plan;	7/16/2008	Copy of PO for development of treatment plan training schedule Tab #10	DMH contracts; Chief of Staff

Complete *Status: Contract negotiations underway. Expected to be finalized by August, 2008 and training to begin in August, 2008.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Monitor patient engagement through treatment plan conference observation	6/30/2008	IRP observation tool, Tab # 6 ; IRP Observation results Tab # 7	QID director

Status: Tool is being used but ward staff have not been trained, so first is baseline report

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Once training begins, collect information that reflects content of training, instructor qualifications and participant lists	9/10/2008	none	Chief of staff

Status: Training has not yet begun; Material will be provided as available

4 *Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop training database to document competency-based training results for all aspects of training (annual, bi-annual, new employee, and subject specific training recommended by DOJ;	9/15/2008	None at this time	Training, PID

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Develop and generate summarized training results;	12/31/2008	None at this time	PID, Training

Status: no steps yet taken.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Provide and present aggregate data twice a year .	12/31/2008	None at this time	PID

Status: no steps yet taken.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
4	See recommendation from V.A.2.D.Recommedation 5		None at this time	

Status: See recommendation from V.A.2.D.Recommedation 5

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Incorporate recommendations of DOJ into revised IRP process monitoring tool	6/2/2008	Revised IRP process monitoring tool, Tab # 6	QID Director
	Complete			
2	Work with consultant to develop operational instructions and indicators and perfect tool	8/13/2008	none yet	QID Director
	Status: Consultant on board as of June 23, 2008. Will provide comments and recommendations on tool, which will be implemented as appropriate.			
3	Pilot tool and report results.	6/2/2008	Tab # 7 (Results of IRP process monitoring)	
	Status: Tool has been piloted and revised based upon initial feedback. Results of first review are available.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify team of reviewers and train same.	6/2/2008	IRP process monitoring training materials, Tab # 20	PID,
	Complete *Status: Small cadre of staff identified and trained.*			
2	Conduct monthly reviews, starting with 20% sample and report on same to Senior staff	6/30/2008	Report with results of IRP reviews, Tab # 7	QID director
	Complete *Status: Reviews ongoing, sample size is 20%*			

V.B.2

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

Findings

Please see sub-cells for findings.

Compliance Status: See sub cells for compliance findings.

V.B.2.a

initial assessments are completed within 24 hours of admission;

Findings

New initial assessment forms have been completed for social work, rehabilitation services, nursing, psychology and psychiatry See Tab # 34 (Social work initial assessment) , Tab # 35 (Rehabilitation Services), Tab #36 (Nursing), Tab # 23 (Psychology), and Tab #38 (Psychiatry). Each discipline elected to first use the form on some units as a pilot of various lengths to ensure the form meets the needs and, in most cases, the form is still in the pilot phase.

The IRP process tool was revised to evaluate compliance with timely completing initial and other assessments for

each discipline. However, data is not yet available on the timeliness of assessments. There is data available which shows marginal compliance with discipline completion of progress notes prior to treatment planning, ranging from 31% for nursing to 13% by social work. See Tab # 7 (Report of IRP Process Observations).

No clinical audits have been done. A clinical audit tool that will evaluate the content of the discipline assessments is under review by the consultant, and the Hospital expects to incorporate her recommendations as appropriate. The Hospital is working with the consultant on establishing priorities for the development of the tools. The incoming Medical Director will be recruiting for a Manager of Peer Review and Standards to manage the clinical review process.

The Assessment policy and Treatment Planning policies have been revised to include DOJ recommendations and are attached in Tabs # 39 (Assessment Policy) and Tab # 1 (Treatment Plan Policy). The changes include a new initial IRP that include a single plan from the psychiatrist, nurse and general medical officer.

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy to incorporate timeliness and content requirements.	6/15/2008	Assessment policy Tab # 39	Director, Policy
Complete *Status: Timeliness and content requirements have been incorporated into Assessment policy document. Consultant A. Adkins is reviewing discipline specific assessment forms and will provide comments. The discipline specific steps set out below may be modified based upon consultant's comments.*			
2 Approval by Exec staff	7/16/2008	Assessment policy Tab # 39	CEO
Complete			

Recommendations	***Responsible Party***
2 *Develop self-assessment monitoring tools to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment).*	***CVC; JH; AF; PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Social Work will develop a new Social Work Initial Assessment and guidelines for its use.	5/30/2008	Social Work Initial Assessment and Guidelines Tab # 34	Wilhoit / Richardson
Complete			
2 Train social work staff in use of new Social Work Initial Assessment	5/30/2008	Training Attendance Sign-in Sheet Tab # 40	Wilhoit / Richardson
Complete *Status: New instrument reviewed with social work staff*			

#	Action Step	Date	Evidence	Responsible
3	Pilot Social Work Initial Assessment on selected civil admission units (RMB 5 & 6) and forensic pre-trial admission units (JHP 6 & 7) for two weeks. *Status: Pilot underway*	6/16/2008	none	Wilhoit / Richardson
4	Based upon results of pilot, revise Social Work Initial Assessment if indicated.	7/30/2008		Wilhoit / Richardson
5	Implement revised Social Work Assessment hospital wide	8/4/2008		Wilhoit / Richardson
6	Develop self-assessment monitoring tool to assess timeliness and quality of Social Work Initial Assessment ***Complete***	5/30/2008	Social Work Peer Review and Supervisory Monitoring Tool. Tab # 41	Wilhoit / Richardson
7	Revise self-assessment monitoring tool if indicated *Status: On-going*	7/30/2008		Wilhoit / Richardson
8	Implement monthly self-assessment monitoring on 20% of all Social Work Initial Assessments *Status: not yet initiated*	8/4/2008		Wilhoit / Richardson
9	Rehabilitation Services will develop a new Rehabilitation Services Initial Assessment and guidelines for its use. ***Complete***	3/31/2008	Rehabilitation Services Initial Assessment and Guidelines Tab # 35	Coleman / Robinson
10	Train Rehabilitation Services staff in use of new Rehabilitation Services Initial Assessment ***Complete***	4/30/2008	Training Attendance Sign-in Sheets, Tab # 42	Coleman / Robinson
11	Pilot Rehabilitation Services Initial Assessment on selected civil admission units (RMB 5 & 6) and forensic pre-trial admission units (JHP 6, 7 & 9) for a minimum of 12 weeks *Status: Initial Assessment has been piloted for 6 weeks as of June 13th*	8/29/2008	none	Coleman / Robinson
12	Based upon results of pilot, revise Rehabilitation Services Initial Assessment if indicated. *Status: not yet completed*	9/15/2008		Coleman / Robinson
13	Implement revised Rehabilitation Services Assessment hospital wide	9/29/2008		Coleman / Robinson

	Action Step	Date	Evidence	Responsible
14	Develop self-assessment monitoring tool to assess timeliness and quality of Rehabilitation Services Initial Assessment	3/31/2008	Rehabilitation Services Peer Review and Supervisory Monitoring Tool, Tab # 43	Coleman / Robinson
	Complete *Status: May need to be implemented pending outcome of pilot*			
15	Pilot self-assessment monitoring tool on 50% of assessments conducted in Action Step 11. Revise self-assessment monitoring tool if indicated	9/15/2008		Coleman / Robinson
16	implement monthly self-assessment monitoring on 20% of all Rehabilitation Services Initial Assessments	9/29/2008		Coleman / Robinson
	Status: not yet begun			
17	Revise Initial Nursing Assessment	6/9/2008	Nursing Assessment Tab # 36	CVC/JH/DK/DJ
	Complete			
18	Submit revised Nursing Assessment to Dr. Gouse	6/10/2008		CVC/JH/DK/DJ
	Complete			
20	Develop Nursing Assessment guidelines	7/3/2008	Nursing Assessment Guidelines, Tab # 45	CVC/JH/DK/DJ
	Complete			
21	Develop Self-auditing Tool	7/15/2008	Nursing Self-auditing tool, Tab # 44	CVC/JH/DK/DJ
22	Revise NSP 300-Documentation of Nursing Process	7/3/2008	Copy of NSP 300 Tab # 45	CVC/JH/DK/DJ
	Complete			
23	Train Nursing Staff	8/29/2008		CVC/DK/DA
	Status: Not yet completed			
24	Three month pilot of new assessment tool on Admission Units	8/29/2008		CVC/JH/DK/DJ
	Status: Not yet initiated			
25	Department of Psychology will develop an Initial Psychological Assessment	6/2/2008	Copy of initial psychology assessment Tab # 23	R Patterson
	Complete			

#	Action Step	Date	Evidence	Responsible
26	Psychology will obtain the necessary assessment tools for distribution to staff who will pilot the IPA	6/30/2008		R Patterson
	Complete *Status: Funds were finally earmarked and order was sent*			
27	IPA will be piloted in at least 2 admission areas - for 3 weeks	7/31/2008		R Patterson
	Complete *Status: Awaiting arrival of the testing supplies*			
28	Changes made to IPA based on results of pilot, if needed	8/22/2008		R Patterson
29	Psychology Assessment Committee will present an in-service to staff re: proper use of the results of the IPA	8/26/2008		R Patterson
30	Develop guidelines for use of IPA	8/22/2008		R Patterson
	Status: Not yet started			
31	Develop self-auditing tool for IPA	8/31/2008		R Patterson
	Status: not yet started			
32	Do a peer review on 20% of IPA completed in September and October	11/15/2008		R Patterson
	Status: not yet started			
33	Psychiatry will develop a new Initial Assessment and guidelines for its use.	7/16/2008	New psychiatric initial assessment form # 38	Medical Director
	Complete			
34	Train psychiatrists in use of new Initial Assessment	8/22/2008		Medical Director
35	Pilot psychiatry Initial Assessment on selected units	8/29/2008		Medical Director
36	Based upon results of pilot, revise psychiatric Initial Assessment if indicated.	9/10/2008		Medical Director
37	Implement revised psychiatric Assessment hospital wide	9/30/2008		Medical Director
38	Develop self-assessment monitoring tool to assess timeliness and quality of psychiatric Initial Assessment	10/30/2008		Medical Director, Manager of Peer review and Standards
39	Revise self-assessment monitoring tool if indicated	11/28/2008		Medical Director
40	Implement monthly self-assessment monitoring on 20% of all psychiatry Initial Assessments	12/19/2008		Medical Director

3 Present monitoring data regarding the timeliness and quality of each disciplinary assessment based on at least 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment). ***CVC; JH; AF; PID; (content)***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in V.B.2.a.			Discipline chiefs
2	With Office of Monitoring Systems, analyze and report data to senior staff, Medical Staff Executive Committee and discipline chiefs. *Status: Within 45 days of the review*			Discipline chiefs, Director, OMS

4 Ensure that the initial treatment plans are completed with an inter-disciplinary input, including, at a minimum, psychiatry, nursing and medicine. ***CVC; JH; AF; PID; change policy***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise Treatment Planning policy ***Complete***	6/15/2008	Treatment Planning policy Tab # 1	J. Taylor
2	Final approval of policy	7/16/2008	Treatment Planning policy Tab # 1	CEO
3	Develop revised initial treatment plan form	7/16/2008	Revised initial treatment plan form Tab # 3	Chief of staff
4	Work with Consultant to develop audit tool to monitor appropriate content of completion of initial treatment plan. *Status: Consultation began June, 2008. Priority list of tools being developed.*	10/31/2008		QID director
5	Begin auditing to evaluate whether requirements for initial IRPs is being met; . *Status: Will begin within 45 days of completion of audit tool*	12/1/2008		Medical Director

V.B.2.b

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

Findings

The revised treatment plan policy incorporates a requirement for completion of the treatment plan within 5 business days. Tab # 1(Treatment Planning Policy) A new initial treatment plan has been developed that integrates the nursing, psychiatric and general medical officer treatment interventions into a single document. See Tab # 3 (Initial Treatment Plan form). A treatment plan manual is being developed and is expected to be completed and available to staff by late September, 2008.

The IRP process observations include a review of the medical record to assess the timeliness of initial assessments and initial treatment plans, however, timeliness data is not yet available. The cancellation rate during the rating period was 27%. The IRP process monitoring tool does not evaluate content, which will be evaluated once the clinical audit tool is completed and auditors are trained.

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

Recommendations				Responsible Party
1 *Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectation that the comprehensive IRPs are completed within five days of admission.*				***BG;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Finalize revisions to treatment plan policy.	7/16/2008	Approved treatment plan policy # 1	Director, Policy; CEO	
Complete				
2 Develop treatment planning manual.	7/31/2008	None at this time	Chief of Staff	
Status: Consultant is assisting in development of manual. Some aspects are completed, but additional work is needed. This will be provided once the manual is completed.				
2 *Develop a clinical auditing tool with indicators and operational instructions to monitor the timeliness of the initial and comprehensive IRPs.*				***PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Consultant to review draft clinical chart audit tool for comments and suggestions, and consultant to provide guidance on development of operational instructions	7/9/2008	Draft clinical audit tool Tab # 46	Chief of staff	
Status: Draft tool is under review by consultant for comment.				
2 Revise clinical chart auditing tool to be consistent with policy and to incorporate suggestions as appropriate	8/25/2008		QID director	
Status: Not yet begun				
3 Train clinical chart auditors and implement audits	9/30/2008			
Status: Not yet begun				
3 *Present chart auditing data (March to August 2008) based on at least 20% sample regarding the timeliness of the comprehensive IRPs.*				***PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Train clinical chart auditors and begin audits by September 30, 2008	9/30/2008		QID, Medical Director, Discipline Directors	
Status: No clinical chart audits have begun				

V.B.2.c

treatment plan updates are performed consistent with treatment plan meetings.

Findings

The IRP process tool has been revised to track the timeliness of the IRP. Tab # 6 (IRP Process Monitoring Tool). It also tracks whether someone has been identified to schedule and coordinate the IRP conferences. Data shows that in 91% of the cases reviewed, there was clear accountability for the scheduling and coordination of treatment plans. See Tab # 7(Results from IRP Observations)

Changes were made to the IRP Process observations to ensure the written treatment plan reflects the discussion that occurred a the treatment plan, but that change was only made in July, so data is not yet available.

The treatment planning policy time frames meet the requirements of the Agreement and a new requirement has been added so that clinical administrators at least monthly document in the record the patient's progress in the goals, objectives and in response to interventions. Tab. # 1 (Treatment Planning Policy)

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

Recommendations				***Responsible Party***
1	*Ensure that the self-assessment process observation tool includes an indicator and operational instruction that addresses the identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews*			***PID;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise IRP process monitoring tool to incorporate DOJ recommendations.	6/2/2008	IRP process monitoring tool, Tab # 6	QID director
	Complete *Status: Tool includes evaluation of whether someone is responsible for scheduling conference*			
2	Work with consultant to develop operational instructions and indicators that conform to policy.	8/29/2008		QID Director
	Status: Ongoing .			
2	*Monitor this requirement using the process observation tool based on at least 20% sample (March to August 2008).*			***PID;***
	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Requirement monitored for 20% sample of treatment plans scheduled.	6/30/2008	Results of IRP Process Observations, Tab # 7	QID director
	Complete *Status: Monitoring used draft tool. Twenty percent sample completed.*			
2	Provide results to senior staff	8/1/2008	Results of IRP Process observations, Tab # 7	

V.B.3

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

Findings

IRP process monitoring tool now tracks whether and to the extent patients are informed of the side effects of medication. See Tab # 6 (IRP Process Monitoring Tool). Data is not yet available on whether this is occurring on a consistent basis, although it did not occur in any treatment plan conference monitored by the compliance office.

In addition, the IRP conference protocol template sets forth the standards expected in discussing medication with patients. Tab # 4 (Treatment Plan Conference Template).

DC law provides that patient's have the right of informed consent prior to receiving mental health support and services. See Tab # 47 (DC law and regulations concerning Informed consent). The Hospital did not have a clear

written practice or protocol around obtaining or documenting informed consent, but recently revised the IRP forms to ensure the patient has given informed consent. Tabs # 2, 3 (IRP Form) In addition, PID staff are monitoring discussions with patients about medication through the IRP process observations, but that is still not often covered during treatment plan conferences as of this date.

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Requirement is included in process monitoring tool until clinical chart audit begins..	6/25/2008	IRP process monitoring tool, Tab # 6	QID staff
Status: 20% sample of scheduled treatment plans were reviewed.			
2 Report results of whether patients are being informed of medication risks and benefits.	7/16/2008	Results of IRP process observations, Tab # 7	
Status: Results are provided			

Recommendations	***Responsible Party***
2 *Present clinical chart audit data based on at least 20% sample (March to August 2008) regarding compliance with this requirement.*	***CVC; JH; AF; PID;***

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

3 Provide the facility's procedure regarding the process and content of informed consent. ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify IRP forms to provide informed consent at time of treatment plan conference and have patient sign IRP form	9/1/2008	DC regulations around informed consent for consumers Tab # D.C. Regulations # 47	Chief of staff
Status: No process is yet in place			
2 Revise treatment plan form to provide for documentation of informed consent	8/27/2008	Revised IRP form Tabs # 2 & 3	Chief of Staff

V.B.4

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

Findings

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

Compliance Status: See related sub cells.

Recommendations — ***Responsible Party***

1 Same as in V.D.1, V.D.2 and V.D.3 ***JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same action steps as in V.D.1, V.D.2 and V.D.3		Same as in V.D.1, V.D.2 and V.D.3	
Status: Same as in V.D.1, V.D.2 and V.D.3			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same action steps as in V.D.4 and V.D.5		Same as in V.D.4 and V.D.5	
Status: Same as in V.D.4 and V.D.5			

V.B.5

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

Findings

The Hospital policy titled "Seclusion and Restraint for Behavioral Reasons" requires the Medical Director to review incidents of use of seclusion or restraint 1) for more than 12 hours; 2) more than twice in a 24 hour period; and 3) 3 or more 3 times in a thirty day period. Under current procedures, the Medical Director gets a daily report of use of seclusion and restraint. See Tab # 48 (Seclusion and restraint policy)

The Compliance Officer audited 14 patient records of seclusion or restraint over a three month period. Documentation in three records (out of 8 eligible) reflected that the treatment team consulted with the Medical Director, although it was not always at the initial trigger that the consultation was sought. An interview with the Medical Director suggests that there were additional cases in which consultation was sought, but not documented. See Tab # 49 (Restraint and Seclusion Audit Data Analysis)

The Hospital has not developed or implemented a comprehensive system of risk management triggers and thresholds and levels of intervention and review. This is in part due to the lack of an automated data system so tracking triggers would require an extensive manual system. It is anticipated to be developed as the AVATAR system is rolled out.

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

Recommendations				*Responsible Party*
1 Same as in XII.E.2.				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Same action steps as in XII.E.2. *Status: Same as in XII.E.2*		Same as in 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;

Findings

Forensic Services implemented its policy of ensuring all post-trial cases are presented to the Forensic Review Board at least once per year. Tab # 50 (Forensic Services Policy regarding Review Board Review). It also modified the template for FRB reports to include at the beginning of each report risk factors leading to initial hospitalization and current risk factors, as well as ensuring these are addressed in the body of the report and in the conclusion. In addition, it has developed a system to document and track the implementation of FRB recommendations.

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

Recommendations				*Responsible Party*
1 Develop a template for all FRB clinical reports that is more clearly focused on the assessment of risk factors. Identify a section early in the report that describes the risk factors that were responsible for the individual's forensic hospitalization, and any risk factors that have developed while the individual has been hospitalized and impact movement to a less restrictive level of care. Treatment while hospitalized can then address progress in managing/ameliorating those risk factors and what interventions have been successful/unsuccessful in that regard. Finally, the individual's current status on each risk factor can then be addressed, as well as treatment strategies for ameliorating current risk.				***JH;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Modify Forensic Review Board (FRB) format to identify, in the beginning of report, risk factors responsible for initial hospitalization and risk factors currently present that impact on progression to less restrictive environment. Presence or absence of risk factors to be prominent in body of report with conclusion of report summarizing current status of risk factors, successful and unsuccessful treatments and plans to further reduce risk factors. ***Complete***	5/16/2008	Revised Forensic Review Board Policy FS 302-02.4, Tab # 50	R. Morin	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Revise FRB policy to be consistent with new FRB report format. **Complete**	6/6/2008	Revised Forensic Review Board Policy FS 302-02.4, Tab # 50	R. Morin / J. Prandoni
3	Train Forensic Clinical Administrators to utilize new FRB Report format. Training to include Chief of Post Trial Branch reviewing all FRB reports prior to presentation to FRB and providing feedback to clinical administrators. *Status: In process, training begun June 4, 2008*	8/29/2008		R. Morin

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise FRB Policy to require all persons adjudicated NGBRI or committed pursuant to the Miller Act and being treated on an inpatient basis be presented to FRB a minimum of once a year. **Complete**	4/1/2008	Revised Forensic Review Board Policy FS 302-02.4, Tab # 50	R. Morin
2	Revise FRB Policy to ensure that FRB recommendations are documented in the medical record and that the treatment team's response to the recommendations is also documented in the medical record. **Complete**	6/6/2008	Revised Forensic Review Board Policy FS 302-02.4 (See subsections G and H and Attachments), Tab # 50	R. Morin

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop internal monitoring system to ensure treatment teams respond to FRB recommendations. **Complete** *Status: Revised Forensic Review Board Policy FS 302-02.4 (Section I), Tab #*	5/15/2008		R. Morin

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Incorporate internal monitoring system into FRB Policy.	6/6/2008	Revised Forensic Review Board Policy FS 302-02.4 (Section I), Tab # 50	R. Morin / J. Prandoni
	Complete			
3	Institute quarterly monitoring of all treatment team response to FRB forms (Form SEH 302.02.08B) for those cases in which treatment team has 30+ days to respond to the recommendation.	9/15/2008	Review tracking form to be developed prior to 9/9/08 (Not available yet)	R. Morin
	Status: First Quarterly Review to be completed by Target date, Reviews ongoing.			
4	Refer all cases in which an inadequate response to FRB recommendations are found to Forensic Clinical Administrator for corrective action. Corrective actions to be reviewed in subsequent monitoring.	9/19/2008	Review tracking form to be developed prior to 9/9/08 (not yet available)	R. Morin
	Status: Feedback from first Quarterly Review to be provided to clinical administrators by target date.			

V.B.7

treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;

Findings

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

Compliance Status: See related section

Recommendations — ***Responsible Party***

1 *The review of non-pharmacological treatment interventions is addressed in subsections V.E.3, V.E.4 and V.E.5 and in section VIII (Specific Treatment Services). Please refer to those sections for compliance findings and recommendations.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in V.E.3, 4 and 5 and Section VIII		See V.E.3, 4 and 5 and Section VIII	
	Status: See V.E.3, 4 and 5 and Section VIII			

V.B.8

an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and

Findings

The Hospital approved a policy on Inter unit Transfers that specifies documentation content and time requirements, but it is in the early stages of implementation . See Tab # 51 (Transfer of Patients policy). Additionally, an audit tool to track compliance with the policy has been drafted and will be provided to the consultant for comments. See Tab # 52 (Inter-unit transfer audit tool). Indicators and operational instructions have not been developed nor has an audit been conducted.

No data is available to report.

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

Recommendations — ***Responsible Party***

1 Ensure that Policy #602.1-08, Assessments includes requirements regarding the timeliness of Inter Unit Psychiatric Assessments and their content. The content must address the following:

***Responsible Party:** CVC; PID; BG; CVC to develop tracking of interunit transfers*

- *a Identifying data;*
- *b Anticipated benefits of transfer;*
- *c Brief history;*
- *d Brief course, including medical;*
- *e Review of risk factors;*
- *f Current diagnosis;*
- *g Barriers to discharge; and*
- *h Plan of care*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Assessment policy to include requirements for timeliness and obtain approval by Exec staff.	6/15/2008	Assessment policy, Tab # 39	Director, Policy; CEO
	Complete *Status: Timeliness requirements have been incorporated into assessment policy document.*			
2	Develop policy on Patient Transfer to outline content requirements.	7/15/2008	Patient Transfer policy document, Tab # 51	Director, Policy, CEO
	Complete *Status: Policy and transfer summary form has been developed with content requirements.*			

2 Develop and implement a self-assessment inter-unit transfer tool to ensure timeliness and proper content of these assessments.

***Responsible Party:** PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft audit tool and submit for review by consultant; obtain assistance with operational instructions development.	7/31/2008	Draft Patient Transfer Audit Tool, Tab # 52	QID director
	Status: Draft audit tool will be forwarded to consultant. She will provide comment and assist in development of operational instructions and indicators			
2	Finalize audit tool by incorporating recommendations of consultant			QID director
	Status: Will begin within 30 business days of final tool			
3	Train auditors and begin audits	10/8/2008		QID director
	Status: Status will begin within 30 business days of final tool.			

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
4 Analyze data and provide report	11/21/2008		Director, Monitoring Systems
Status: Status report within 45 days of audit.			

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

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

V.B.9

to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart.

Findings

See findings in V.B.1-8. The IRP process monitoring tool tracks the existence and timeliness of discipline assessments and progress notes as well as IRPs, and IRP participation, but does not evaluate the content. See Tab # 6 (IRP process monitoring tool).

Rehabilitation Services and Social work developed audit tools to evaluate content and quality of treatment plans and discipline roles, but only Rehabilitation services conducted an initial peer review. Tab # 43 (Rehabilitation Services Audit Tool), Tab # 41 (Social work Audit tool), and Tab # 53 (Results of Rehab Services initial audit). Neither tool yet contains indicators or operational instructions. The consultant retained to assist on tool development will be working with each discipline to support their development of appropriate tools.

Medication guidelines have been developed. Tab # 54 (Medication Guidelines).

An automated information system which will permit data collection by practitioner across all aspects of care is expected to be rolled out in phases. Beginning July, 2008, Phase 1 will include laboratory, pharmacy admission and billing, and Phase II all other aspects of the clinical record. The Hospital hired crystal report writers that will assist in developing reports that will allow for assessment on timeliness of assessments and treatment plans in an on-going manner.

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

Recommendations — ***Responsible Party***

1 See corresponding sections of the Agreement that address items 1 through 8 outlined by this expert consultant above.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps relating to corresponding sections of the Agreement that address items 1 through 8.			
Status: See action steps relating to corresponding sections of the Agreement that address items 1 through 8.			

V.C. Case Formulation

By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case

Findings

See individual cells for findings.

Compliance Status: See individual cells for findings.

formulation for each individual based upon an integration of the discipline-specific assessments of the individu

V.C.1

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

Findings

Case formulations are not yet occurring, and the section of the IRP that is to reflect the integration of assessment is largely still just a short summary of the discipline assessments. This is in part because training for staff on implementing this requirement was interrupted due to contractual issues. However, a new vendor has been identified, but the contract specifics are still being negotiated. The new contract is expected to expand training to 4 teams in August, and then to 4 additional teams by September. It is expected that 50% of all teams will be trained by the end of the calendar year, and the remaining teams trained by March 31, 2009. In addition to working with the teams as teams, the contractor is expected to work with disciplines as a group around individualizing assessments and interventions. See Tab # 10 (PO for Treatment Planning Training Development)

As noted, the Treatment Planning policy was modified to provide additional guidance about case formulations, and the IRP form also modified. Tab # 1 (Treatment Planning Policy) and Tabs # 2, 3 (IRP form). In addition, a treatment planning manual is being developed and will be reviewed by the consultant. The Hospital is purchasing a sufficient number of person centered treatment planning books to be available on each unit.

The Hospital is working with a consultant to address the issues raised in the report around the content of the clinical audit tool but to date no revised draft is ready. It continues to work with the consultant around the clinical chart audit tool and development of indicators and operational instructions. No clinical chart audits have occurred.

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

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

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

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Contract with consultant to conduct treatment planning training for 50% of units by December 31, 2008; Remaining units to be trained by March 31, 2009. *Status: Status contract negotiations underway. Possible trainers identified and training is expected to resume in August, 2008.*	7/31/2008	PO for development of treatment plan training, Tab # 10	DMH contracts
2	Begin staff training by August 15, 2008	8/15/2008		Chief of staff
3	Develop schedule that ensures all staff are trained by March 31, 2009	9/19/2008		Chief of staff

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Obtain training outline, summary of qualifications of trainers and list of participants *Status: Will be provided once training begins*	9/10/2008		Chief of staff

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

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

5 *Develop and implement a clinical audit tool that contains complete indicators and operational instructions.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Submit draft clinical chart audit tool to consultant for review and comments; obtain assistance in developing operational instructions and indicators. *Status: Review on-going by consultant*	6/25/2008	Draft clinical audit tool, Tab # 46	Chief of staff
2	Incorporate comments, finalize tool indicators and operational instructions. *Status: Status will follow receipt of consultant's comments.*	8/29/2008		QID director
3	Train auditors and begin reviews	9/30/2008		QID director, Discipline chiefs, Medical Director
4	Hire Manager of Peer Review and Standards to manage clinical audit and peer review processes *Status: PD is under development and expected to be complete by August 15, 2008.*	9/30/2008		Medical Director; COO

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

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

V.C.2

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

Findings

Same as V.C.1

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

Recommendations	***Responsible Party***
1 Same as above.	

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

V.C.3

include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;

Findings

Same as V.C.1

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

Recommendations	***Responsible Party***
1 Same as above.	

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

V.C.4

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

Findings

Same as V.C.1

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

Recommendations	***Responsible Party***
1 Same as above.	

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

V.C.5

Findings

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

Same as V.C.1

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

Recommendations	Responsible Party
1 Same as above.	

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

V.C.6

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

Findings

Same as V.C.1

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

Recommendations	Responsible Party
1 Same as above.	

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

V.C.7

make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.

Findings

Same as V.C.1

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

Recommendations	Responsible Party
1 Same as above.	

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

V.D. Individualized Factors

By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:

Findings

See individual sub-cells for findings.

V.D.1

develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;

Findings

The majority of treatment plans are not individualized and do not reflect individualized needs of patients. Treatment plans continue to have goals that are generic such as "patient will not have any assaults", "patient will be free from delusions", "patient will complete ADLs" or "Patient will accept medications." Three plans that were reviewed from one unit all had the same intervention "monitor mental status, prescribe and adjust medications as needed". Many plans do not include enrichment activities. Goals continue to include such statements as "Patient will not be a management problem on the unit."

The Hospital's strategy to improve in individualizing treatment is through the treatment planning training and providing additional guidance in the treatment plan manual that will be provided to staff. At this juncture however, given the interruption in training, little, if any, progress has been made. The lack of real progress does not appear to be due to resistance, but to administrative barriers that appear to have been resolved.

Some actions of the Hospital provide foundational support for progress in the near future. Improved assessment tools from all disciplines just finalized will assist in evaluating the patient's mental status, functional and cognitive capacity, strengths and interests which should lead to more realistic goals and objectives and more individualized interventions. Tab # 38 (Psychiatric Assessment form), Tab # 23 (Initial Psychological Assessment form), Tab # 36 (Nursing Assessment form), Tab # 34 (Social Work Assessment form, Tab # 35 (Rehabilitation Assessment Tool).

The Hospital has not yet implemented major changes to the treatment mall that would support practice reform, but recognizes the need to do so. It is hiring a Treatment Mall administrator, who will lead the change to a curriculum based program. Some modifications to the individual treatment programs at the mall have been made to better group patients with similar functional levels, and a community reentry group was developed, but there is much left to do. Implementation of AVATAR that will provide patient profile data will also provide critical baseline data for better planning of patient needs.

Some monitoring has begun. The IRP process monitoring tools attempts to capture and measure if the treatment conference reflects efforts to individualize the goals, objectives and interventions, although modifications will be made based upon recommendations of the consultant; the tool does not evaluate if all plans include treatment, rehabilitation and enrichment activities. See Tab # 6 (IRP Process Monitoring tool); Tab # 7 (Summary of IRP Observations). Operational instructions and other comments are pending from the consultant, and will be incorporated as appropriate.

The clinical audit tool is pending review and will be provided as soon as it is completed..

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

Recommendations — ***Responsible Party***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Incorporate consultant recommendations about treatment plan policy into the Treatment Planning policy document and obtain approval by Exec staff	6/15/2008	Treatment Planning policy, Tab # 1	J Taylor; CEO

Complete *Status: Consultant recommendations have been incorporated into the draft Treatment Planning policy document.*

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize contract(s) to ensure that treatment planning training meets requirements of Agreement	7/31/2008	PO for development of treatment plan training, Tab # 10	DMH contracts; Chief of Staff
	Status: Vendor identified and negotiations underway.			
2	Begin training and continue so that 50% of units are trained in individualized treatment planning by Dec 31, 2008.	12/31/2008		Chief of Staff; Civil and Forensic Directors
	Status: Began on two units but suspended in March; will restart in August			
3	Complete treatment planning training on all units by March 31, 2009	3/31/2009		

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

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

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

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

5 *Revise the process observation and clinical chart audit tools to include indicators and operational instructions to address this requirement.* ***AF; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop contract with consultant to provide technical assistance on revising draft clinical audit tool and IRP Process, indicators and operational instructions.	6/30/2008	Angela Adkins Contract, Tab # 9, Draft IRP process tool, Tab # 6; Clinical audit tool Tab # 46	Chief of staff
Complete	*Status: Consultant on site beginning June 24, 2008. Clinical audit tool under review.*			
2	Provide tools to consultant for review and comment	7/16/2008		Chief of Staff, QID director
	Status: Process observation and clinical chart audit tools provided June, 2008. Will complete modifications within 15 business days of comments			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Finalize tools, indicators and operational instructions, incorporating consultant's comments as appropriate	8/29/2008		Chief of staff

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Begin IRP process monitoring using draft tool and instructions.	6/30/2008	Results of ITP audit, Tab # 7	QID Director
	Status: Completed 20% sample. Results attached. No clinical audit has occurred			
2	Provide results regularly to senior staff.	8/14/2008		ID Director

7 Ensure that individuals diagnosed with cognitive impairments receive appropriate cognitive remediation interventions. ***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise initial psychological assessment to screen for cognitive impairments. **Complete**	7/31/2008	Copy of initial psychological assessment form, Tab # 23	R Patterson
2	Revise treatment mall referral form to incorporate psychology screening assessment recommendations and findings. **Complete**	10/15/2008		CVC
3	Using data from patient database around diagnosis, and results of assessments, psychology to work with treatment mall administration to develop appropriate curricula.	12/31/2008	Clinical Profile on Inpatient Population, Tab # 55	CVC; R Patterson
4	Psychology to provide in house training for nursing and medical staff providing services for cognitive impaired patient population.	11/7/2008		Medical Director
5	Collect data as available (Phase II of AVATAR) to monitor cognitive diagnoses.	2/27/2009		

V.D.2

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

Findings

Same as V.D. 1.

No systemic method of measuring compliance with the requirement is in place at this time (i.e., no clinical audit is occurring), but a review of a small sample of charts by the compliance office suggests that the Hospital is not yet implementing a process that reviews goals of hospitalization across the domains described in this section of the Report. In the sample of charts reviewed, goals remain generic "Patient will comply with medication"; "Patient will not be a management problem on the unit". Discharge criteria are often "patient will be stable and comply with medication" or "Patient will no longer be dangerous to self or others."

This will need to be a focus of the treatment planning training contract.

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

Recommendations			***Responsible Party***
1 *Same as above.*			***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above.			
2 Hire 8-10 Avatar user support staff including 2 Crystal Reporters to develop user friendly management reports for tracking active treatment hours. *Status: The interviewing process began on 7/7/08. The Hospital has identified two User Support Analyst and 1 Crystal Developer. The Contract action package for three contractors was submitted to the Contracts Administration by 7/11/08.*	7/11/2008		Lois Branic / Sharmaine Allen
3 Develop reports for treatment mall activities and attendance reports. The Avatar application will be able to track treatment and their attendance after August, 2008. These management reports will be developed in Crystal Reports and will be provided on a weekly basis. Develop Reports for treatment and attendance reports *Status: A Management Report Development Plan for all Avatar Management reports will be drafted for review and prioritization by the Avatar Steering Committee*			

V.D.3

write the objectives in behavioral and measurable terms;

Findings

Same as V.D.1.

No systemic method of measuring compliance with the requirement is in place at this time, but a review of a small sample of charts by the compliance office suggests that the Hospital is not yet routinely implementing a practice of ensuring treatment plans include specific objectives that reflect the functional capacity of the patient and will advance the goals of the treatment plan. Patient objectives are often focused on medication compliance, complying with ward rules or resisting assaultive behavior.

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

Recommendations	***Responsible Party***
1 *Same as above.*	

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

V.D.4

provide that there are interventions that relate to each objective, specifying who will do what and

Findings

Same as V.D.1-3.

within what time frame, to assist the individual to meet his/her goals as specified in the objective;

There has been some effort to address the availability of appropriate interventions and to better match the patient to an intervention. There is a new treatment mall referral form that includes additional information about the individual's stage of change readiness assessment and functional level, which is intended to better assess the patient's functional level and place him/her in a more appropriate group. Tab # 56 (Treatment Mall referral form). A community reentry program was introduced. Tab # 57 (Community Reentry Program Description). Other refinements were made to the treatment mall programs to better group patients with others of a similar functional level. See Tab # 58 (Descriptions of Psycho-social Rehabilitation Program, Co-occurring Disorders Program; Geriatric Program, Behavioral management program) Consultant Angela Adkins is expected to provide support to treatment mall staff as the work to implement a manual based system. Finally, staff developed a new progress note template that will provide consistent information to the treatment teams. Tab # 5 (Progress Note Template).

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

Recommendations	***Responsible Party***
1 *Same as above.*	

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop progress note template that reviews short term goals in conjunction with mall therapies.	6/30/2008	Progress Note template, Tab # 5	Chief of staff
Status: Draft complete and under review by consultant; Template note is being piloted.			
2 Enter in contract with consultant to provide treatment planning training for staff.	8/8/2008		AS
Status: Negotiations underway			
3 Enhance treatment mall program through development of written curricula based upon clinical profile of patient population.	12/31/2008	Tab # 61 (Patient Data base screen shots); Initial report of clinical profile of inpatient population, Tab # 55	CVC; PID
Status: Patient database that includes diagnosis of patients developed and in use. First report of data complete. Additional reports will follow. The information has not yet been used to inform treatment mall group development or curricula.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop mall template note	6/25/2008	Progress note template, Tab # 5	Chief of staff

Complete

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	With technical assistance from consultant, modify chart audit tool to incorporate review of treatment mall notes and therapies. Develop related indicators and operational instructions	9/24/2008	Draft clinical chart audit tool, Tab # 46	QID; Chief of Staff
	Status: Technical assistance initiated June 24th, 2008. Expect comments from consultant by end of July, 2008.			
2	Train auditors, conduct audits and report results.	11/17/2008		Medical director, Chief of staff
	Status: Not yet begun. Will be initiated within 45 days of tool finalization.			

5 *Train auditors to acceptable levels of reliability.* ***PID;***

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

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

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

V.D.5

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

Findings

The Hospital is unable to provide data on the number of hours of active treatment each patient is receiving, although it is aware that patients are not getting 20 hours per week. Currently, 147 patients are attending the treatment mall, and if all groups were occurring, those patients would be receiving 19 hours of active treatment at the mall per week. However, the Trend Analysis includes an analysis of group cancellations in the treatment mall, and it reports a significant percentage of mall groups are cancelled, further reducing the number of hoursof active

treatment provided to each patient. See Tab # 8 (Trend Analysis, April/May).

While it will not be the complete solution, Phase I of AVATAR will include the ability to track hours of treatment scheduled and attended, by client, at the treatment mall. This will give us an opportunity to better assess the hours provided for each patient at the mall. Phase II of Avatar will include treatment plans and should allow the Hospital to track the hours in non mall treatment interventions as well as other aspects of clinical care, and will allow the Hospital to track its performance on this requirement. In the meantime, the treatment plans are now expected to reflect the length of time as well as frequency of each intervention.

Staff shortages are impacting the provision of treatment hours; 19 direct care positions were eliminated in the Spring, which will make it difficult to have a sufficient number of rehabilitation specialists, nurses and other clinical staff to meet this requirement. The Hospital continues to have over 100 vacancies; the Mayor has committed to reconsider the elimination of the positions and provide additional positions if the Hospital's vacancy rate is reduced.

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

Recommendations — ***Responsible Party***

1 Develop and implement a system to track active treatment hours scheduled per week. — ***CVC; AS; Eric Strassman***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Utilize AVATAR scheduling module to schedule and track interventions.	7/22/2008	Avatar Training Manual pps.. 273-277, Tab # 59	Sharmaine Allen
	Status: The scheduling module will be implemented in AVATAR during phase 1 - 07/22/08			
2	Train users in the AVATAR system.	7/31/2008		Sharmaine Allen Eric Strassman
	Complete			
3	Hire crystal report writers and develop necessary Crystal Reports to allow tracking of scheduled and attendance.	9/26/2008		COO
	Status: Director hired, interviews underway for report writers.			
4	Obtain technical assistance from A. Adkins to review treatment mall curriculum and make adjustments as recommended.	11/30/2008	Treatment Mall Program Descriptions, Tab # 58	Chief of staff
	Status: Some adjustments have been made in Treatment Mall program, but curricula not developed nor has manual been developed			
5	Hire Treatment Mall administrator	8/15/2008		CVC
	Status: A selection certificate was issued to management and interviews are being scheduled..			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement scheduling component of Avatar system (Phase I).	7/22/2008	Avatar Training Manual pps. 273-277, Tab # 59	COO
	Status: The AVATAR application will be implemented on July 22,2008. The application will be able to capture the total number of active treatment hours that patients receive.			
2	Hire 8-10 Avatar user support staff including 2 Crystal Reporters to develop user friendly management reports for tracking active treatment hours.	7/31/2008		COO
	Status: Job Announcements were posted on three major recruitment websites (monster; hotjobs and washingtonpost). Resumes are being reviewed and interviews conducted.			
3	Develop necessary reports to reflect patient attendance and participation.	10/31/2008		COO

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement Avatar system (Phase I).	7/31/2008	Avatar Training Manual pps. 273-277, Tab # 59	COO
	Status: Avatar went live on July 22, 2008. Data will not be available until system is in place and data reports are developed.			
2	Hire 8-10 Avatar user support staff including 2 Crystal Reporters and 1 Reports Manager to develop user friendly management reports for tracking active treatment hours.	7/31/2008		COO
	Status: Announcements were posted on three major recruitment websites (monster; hotjobs and washingtonpost). Resumes being reviewed.			
3	Develop reports for treatment scheduling and attendance hours.	9/30/2008		COO

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Study three wards in each civil and forensic services for 30 days to monitor attendance at treatment activities and track reasons why patient does not attend.	11/21/2008		Director Civil and Forensic Services
	Status: Not yet begun			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Review data collected and address barriers to attendance at treatment activities.	12/31/2008		Director Civil and Forensic Services

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop tool, with technical assistance from consultant.	12/31/2008		CVC
	Status: Consultant on board. Has visited Treatment Mall, but no other steps taken to implement this recommendation.			
2	Implement Phase II of AVATAR to track treatment interventions and link to treatment plan interventions and active treatment.	2/27/2009		AS
	Status: Not yet underway.			
3	Hire 8-10 Avatar user support staff including 2 Crystal Reporters and 1 Reports Manager to develop user friendly management reports for tracking active treatment hours and objectives	2/27/2009		AS
	Status: Recruitment is underway.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop instrument, with technical assistance from consultant to allow monitoring of mall alignment.	1/31/2008		Director, Civil Services
	Status: No data collection has begun.			
2	Begin monitoring.	2/15/2009		Director, Civil Services
	Status: Not yet begun.			

V.D.6

provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.

Findings

Same as in V.D.1 through 5.

Compliance Status: See related sections

Recommendations — ***Responsible Party***

1 Same as in V.D.1 through V.D.5

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

V.E. Treatment Planning Is Outcome-Driven

By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:

Findings

See sub-cells for findings.

Compliance Status: See related sections

V.E.1

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

Findings

The Hospital conducted IRP process observations for a 20% sample of scheduled treatment plans that provides some information about the team's setting and revising of objectives during treatment plan conferences. Observations indicate that objectives are not specific, often are not behavioral in nature and are not measurable. Further, in many cases, based upon conferences attended by the compliance office objectives are not realistic and require the patient to achieve objectives that are not realistic (i.e., refrain from assaultive behavior), although this is not an issue for the team that has had intensive training around treatment planning . See Tab # 7 (Results of IRP process observations).

The revised Treatment Plan Policy requires that the IRP be outcome driven, reviewed at specific intervals, and revised as needed based upon the individual's response to treatment. Tab # 1 (Treatment Planning Policy). This policy and related treatment plan manual will provide better structure for treatment teams.

The clinical audit tool is under review by the consultant and changes will be incorporated as appropriate.

The contract for treatment plan training should include training around setting and revising of objectives.

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the Treatment Planning Policy to incorporate requirements for foci, objectives, and interventions.	6/15/2008	Treatment Planning policy, Tab # 1	J Taylor; CEO
Complete *Status: Requirements have been incorporated into Treatment Planning policy document.*			

Recommendations	Responsible Party
2 Ensure that the training modules regarding Foci/Objectives/ Interventions and Stages of Change provide guidance regarding the processes of reviewing and revising the IRPs.	***AF; BG; Trg; Mike***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with consultants to provide training to at least 50% of units by December 31, 2008 on treatment planning, and all units by 3/31/09.	7/31/2008	PO for development of treatment planning training, Tab # 10	DMH Contracts
Complete *Status: Contract negotiations are underway.*			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Ensure training materials reflect DOJ requirements regarding goals, objectives and interventions and stage of change.	8/29/2008	Training materials (not yet available)	Chief of staff
	Status: Training materials not yet available.			
3	Train clinical administrators and senior staff on overview of stage of change.	6/2/2008	Handout from stage of change orientation, Tab # 60	Medical Director
	Status: Senior staff provided overview on stage of change. Additional training to be incorporated into treatment planning training.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Secure a contract with a vendor to assist the hospital in developing discipline specific tools and revising existing tools.	6/25/2008	Contract with Angela Adkins, Tab # 10	COO; Chief of Staff
	Complete			
2	Modify IRP process tool and begin utilization as pilot. Incorporate consultants comments upon receipt.	6/2/2008	IRP process monitoring tool, Tab # 6	QID director
	Complete			
3	Review clinical chart audit tool and modify per consultant's recommendations	8/20/2008	Clinical chart audit tool, Tab # 46	QID Director; Chief of Staff
	Status: Clinical chart audit tool has been provided to consultant for TA.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Pilot process monitor tool for 20% sample, and report results	7/24/2008	IRP process tool, Tab # 6; Report of IRP Observations Results, Tab # 7.	QID director
	Status: Initial observations complete. Results attached.			
2	Modify draft clinical audit tool and begin audit.	10/24/2008		Medical Director, Discipline chiefs, QID director
	Status: Clinical chart audit tool under review by consultant.			

V.E.2 **Findings**

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

The Treatment Planning Policy was revised to require treatment planning conferences every 60 days (after the first 60 days) and that each month, in the monthly progress notes the clinical administrator should address the effectiveness/accuracy of goals, objectives and interventions. Tab # 1 (Treatment Plan Policy)

As the Treatment Planning Policy was just amended to requires reviews every 60 days, it has not yet been implemented, so staff have yet to begin scheduling to meet the 60 day time frames. The Hospital is projecting that the 60 day time frame will be implemented over several months beginning September 2008.

The clinical audit tool and the IRP Process tool are under review by the consultant for assistance in refining the tools and developing indicators and operational instructions.

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify Treatment Planning policy and obtain Executive Staff approval.	6/15/2008	Treatment Planning policy, Tab # 1	J Taylor
Complete *Status: Requirements have been incorporated into the Treatment Planning policy*			

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

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

V.E.3

review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;

Findings

See V.E.3

Compliance Status: See V.E.3

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Incorporate requirements into the Treatment Planning policy.	6/15/2008	Treatment Planning policy, Tab # 1	J Taylor
Complete *Status: Requirements have been incorporated into the Treatment Planning policy*			

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

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

Status: See V.E.1 recommendation 2.

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

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

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

V.E.4

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

Findings

The Treatment Plan policy and the IRP Process Monitoring Tool have been revised to include/reflect requirements around discharge planning. See Tab # 1 (Treatment Plan Policy), Tab # 6 (IRP Process Monitoring Tool). The clinical chart audit tool is being reviewed by the consultant and her comments will be incorporated as appropriate. However, discharge criteria in IRPs remain formulaic, as IRPs often read "Patient will be discharge when no longer dangerous to self or others" or "Patient to be discharged when stable and medication compliant."

Data from the recent discharge records review show that effective discharge planning as a component of the IRP is occurring in only 33% of cases. Tab # 28 (Discharge record review results)

Additional training is needed in formulating discharge criteria as well as in reporting on progress toward discharge. The contract for training in treatment planning is expected to have a specific module addressing discharge planning, including setting discharge criteria and documenting progress toward same.

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

Recommendations — ***Responsible Party***

1 *Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge.* ***CVC; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include training on discharge planning in treatment planning training contract.	7/31/2008	PO for development of treatment planning training, Tab # 10	DMH

Status: Contract with Mary Thornton in final stages of negotiations. Expect it to be signed August, 2008.

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Collect data from trainers and provide to DOJ. *Status: Will be provided as training occurs.*	9/30/2008		Chief of Staff

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Institute training database to audit all training activities. *Status: A program analyst from OMS has begun working with Office of Training to develop data base that captures training classes and dates as well as competency determinations.*	9/30/2008		PID
2	Enter data relating to staff and training courses. *Status: Will begin upon establishment of data base.*	10/31/2008		Training
3	Review the competency based training data and analyze them for assessing compliance	11/15/2008		Training
4	Work with trainers to ensure training is competency based, and that results are maintained on all core staff.	10/31/2008		Training; Chief of staff

4 *Revise current process observation and clinical chart audit tools to address requirements of this agreement regarding discharge planning.* ***PID; PID with Angela***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise IRP process tool to capture required information. *Status: Tools under review by consultant.*	6/27/2008	IRP process tool, Tab # 6	QID director
2	Work with consultant to perfect both tools to adequately assess discharge planning *Status: Tools under review by consultant.*	9/30/2008		QID Director
3	Provide results of discharge record review and discharge planning sections of IRP Process observations	7/31/2008	Results from discharge record review, Tab # 28 ; Results from IRP process monitoring tool relating to discharge planning, Tab # 7	OMS

5 Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008). **CVC; JH; AF; PID;**

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct IRP process assessment utilizing 20% sample of scheduled treatment plans and report results.	7/31/2008	IRP process tool, Tab # 6 and Results of IRP Observations, Tab # 7	QID director
	Complete *Status: Tool is under review by consultant*			
2	Within 45 days of finalizing clinical chart audit tool, train reviewers and begin audits	10/31/2008		Med Director, Discipline Chiefs
3	Hire Manager of Peer Review and Standards to manage clinical chart audits and peer review.	9/30/2008		Medical Director
	Status: Position description is under development			

V.E.5

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

Findings

A progress note template has been developed for reports on the patient's response to the Mall therapies and began to be used in July, 2008, and a system has been created by the Mall administration to ensure notes are timely filed in the patient's records. Tab # 5 (Progress note template) The new template specifically requires the treatment provider to link the patient's progress to treatment goals and provides the provider with the ability to make recommendations. Additionally, implementation of Phase II of AVATAR will include a clinical progress note documentation capacity, which will ensure information is immediately available to staff.

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

Recommendations — ***Responsible Party***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in Section V.A.1 to V.A. 5			
	Status: See in Section V.A.1 to V.A. 5			

2 Same as V.E.4

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

3 Develop and implement a mechanism for review by the treatment teams of progress notes developed by Mall facilitators that specify the individual's progress in Mall interventions. **CVC; JH; AS;**

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement the Avatar application (Phase II).	12/31/2008		Eric Strassman, Mark Larkins
	Status: The ability to update progress notes in the Avatar application is scheduled for Phase II of the implementation- scheduled to go live in Winter 2008.			

#	Action Step	Date	Evidence	Responsible
2	Develop progress note template.	6/13/2008	Progress Note template Tab # 5	Beth Gouse
	Complete *Status: Is being piloted, and is under review by consultant to obtain comments.*			
3	Develop system to ensure mall progress notes are filed in clinical record in timely manner.	7/31/2008	Treatment planning conference protocol. Tab # 4	CVC
	Complete *Status: System was developed and is being implemented. Treatment planning manual being developed includes a treatment planning conference protocol which cues treatment team to review progress notes from treatment mall.*			
4	Include non ward based treatment mall staff in treatment plan training	8/8/2008	Treatment planning conference protocol, Tab # 4.	CVC; JH; Chief of staff
	Status: Treatment plan schedules are now on the global shared drive so that treatment providers are aware of the schedule. In addition, the treatment planning conference protocol cues the treatment team leader to gather information from additional members unable to be present for the scheduled meeting.			

VI. Mental Health Assessments

Summary of Progress

1. The Hospital modified its Assessment policy to meet the standards of the DOJ Agreement. See Tab # 39. Implementation will begin in August, 2008. The Policy sets out clear content standards for assessments.

2. The Hospital modified the discipline initial assessment forms for psychiatry, psychology, social work, nursing and rehabilitation services to incorporate Policy changes and the recommendations from the baseline report. Training and implementation is set for July and August, 2008. See Tab #s 38,23, 34, 36 and 35.

3. The Hospital created a patient database to bridge the period until AVATAR is fully implemented. See Tab # 61 (Screen shots). The patient database, if completed by the treatment team, includes basic demographic information, diagnoses, medication, risk assessment results, and results of co-occurring disorder assessments and allows the Hospital to run reports and analysis of this information. The database has limitations. It is dependent on manual entry of data, and it is not possible to assess quality or accuracy of the data entered, which will still require review of the clinical charts. However, it provides some data and capacity for analysis of diagnosis, medication use and several other indicators.

4. The Hospital continues to monitor and report on the timeliness of discipline assessments through the new IRP process monitoring tool. It is reviewing an approximate 20% sample of scheduled treatment plans each month, using a pilot tool, and is reporting data. See Tab #s 6, 7.

5. Except for Rehabilitation Services, the Hospital has not begun clinical chart audits that will evaluate the quality of assessments. A draft tool is complete, but it needs additional work, and the Hospital retained a consultant to provide technical assistance.

6. Treatment planning training which included training on assessments was interrupted due to a contract issue. A new trainer has been identified and the Hospital met with the trainer on July 25th to develop a training plan and schedule. It is expected that the contract will include training on the role of assessments in treatment planning. See Tab # 10 (Purchase Order for treatment plan training).

7. Psychologists are now completing admission assessments on all newly admitted patients that includes a risk assessment component and a cognitive functioning screening. See Tab # 23. (Initial Psychological Assessment Form). This information will assist in identifying appropriate treatment interventions.

8. Psychiatric, psychological and nursing staffing have all significantly improved since the Baseline visit. Six additional psychiatrists will begin during the period of July - September, 2008. Three psychologists have been hired, and 56 additional nursing staff.

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

Findings

See sub cells below.

Compliance Status: See sub cells below.

medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.

VI.A. Psychiatric Assessments and Diagnoses

Findings

See sub-cells below

Compliance Status: See sub cells below.

VI.A.1

By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;

Findings

The Hospital policy on Assessments has been revised and each discipline's initial assessment forms have likewise been modified. See Tab # 39 (Assessment Policy), Tab # 38 (Initial Psych Assessment form), Tab # 36 (Initial Nursing Assessment form), Tab # 34 (Initial Social Work Assessment form), Tab #23 (Initial Psychological Assessment form), Tab # 35 (Initial Rehabilitation Services form). The Policy sets out specific requirements for the content of assessments/reassessments as well as the time frames in which assessments/reassessments must be completed. It also specifies that a risk assessment must be completed within the first 24 hours. See also VI.A.2 through VI. 6.

See also Treatment Planning Policy as it relates to case formulations. Tab # 1 (Treatment Planning Policy)

There is no data around psychiatric completion of assessments. The IRP Process Monitoring Tool survey shows psychiatry completed progress notes before the treatment plan in only 19% of cases reviewed. In a number of charts, psychiatric assessments/progress notes could not be located at all.

There is no information about the quality of content of the Assessments as the clinical chart audit process has not yet begun.

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop and incorporate recommendations into Assessment policy document and obtain Exec staff approval.	6/15/2008	Assessment policy, Tab # 39 .	J Taylor: CEO

Complete *Status: Recommendations have been incorporated into Assessment policy draft document.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Format all discipline assessments in easily usable format and in way to allow data collection.	6/30/2008	Psychiatry assessment form Tab # 38; Initial social work assessment, Tab # 34; Initial Psychology Assessment, Tab # 23; Rehab Assessment Tab # 35; Nursing Assessment Tab # 36	PID
	Complete			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include timeliness of assessments in IRP process tool.	6/27/2008	IRP process tool, Tab # 6	QID director
	Complete *Status: Timelines of assessments is included in IRP process tool, which is under review by consultant. Tool was piloted and results pending*			
2	Upon finalization of assessment policy, and with assistance from consultant modify draft clinical audit tool to address discipline content requirements.	8/29/2008		Chief of Staff; QID director
	Status: Consultant is reviewing IRP process and clinical tools, as well as discipline specific assessment forms.			
3	Train and begin auditing for IRP process.	6/27/2008	IRP Process Monitoring tool, Tab # 6; IRP process results report, Tab # 7	QID director
	Complete *Status: Initial training occurred; additional training will be provided once tools finalized.*			
4	Train and begin audits for content.	10/15/2008	Rehab services audit results tab # 53	Medical Director, Discipline Chiefs
	Status: Rehab services has begun audit and has initial report			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete revision of assessment policy. **Complete**	7/16/2008	Revised Assessment policy, Tab # 39	PID/CEO
2	See action steps in section VI.A.1 recommendation 2.			

VI.A.2

By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;

Findings

The initial psychiatric assessment form has been revised to include a more specific risk screening within the first 24 hours. See Tab # 38 (Initial Psychiatric Assessment form). Risk also will be screened in the first 3 business days through a psychological risk screen. Tab # 23 (Initial Psychological Assessment form). The Hospital will be recruiting for a Manager of Peer Review and Standards who will coordinate the clinical reviews required by the Agreement.

Through the patient database, the Hospital has data about risk assessments. The data must be viewed with caution however, for several reasons. First, the Hospital is likely underreporting the number of completed risk assessments, as the database only reflects information that was entered, so if a risk assessment was completed and is in the chart but the information was not entered into the database, that information is not captured. Further, the information does not capture the quality or accuracy of the assessment; that will require the completion of a clinical audit. The tool to complete that assessment is not yet developed, but the Hospital plans to work with the consultant for technical assistance.

The following data has been obtained from the patient database. As of 6/27/08, 215 active patients (80 civil and 135 forensic) had results of risk assessments recorded in the database. Of the 80 civil patients, 77% were assessed to be at some risk of danger to self and 72% at some risk of danger to others. Of the 135 forensic patients, 76% were assessed to be at some risk of danger to others and 36% at some risk of danger to self. See Tab # 62 (Risk Assessment Findings.)

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

Recommendations ***Responsible Party***

1 Same as IV.A.1

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

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

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

b Timeframes for risk factors;

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

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise initial psychiatric assessment form to address risk assessment.	6/30/2008	Psychiatric Assessment Form Tab # 38	Medical Director
Complete			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise psychiatric assessment form.	6/30/2008	Psychiatric Assessment form, Tab # 38	Medical Director
Complete			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Secure a contract with a vendor to assist the hospital in developing discipline specific monitoring tools and revising existing tools.	6/25/2008	Angela Adkins Contract Tab # 9	Medical Director
Status: A contract was signed with Angela Adkins in June 2008, who will assist in the development of new and refinement of existing assessment tools. Additional consulting help is needed and a statement of work detailing contract requirements and was submitted to the DMH Office of Contracts and Procurement on June 19, 2008.			
2 With technical assistance from consultant, develop monitoring tool, indicators and instructions to permit assessment of quality of discipline assessments.	8/31/2008		Medical Director
Status: Timeline prioritizing tool development is under development.			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID will analyze data and consult as appropriate with the risk manager.	10/31/2008	Results of initial Risk Assessment analysis, Tab # 62	PID, Risk Mgr

	Action Step and Status	Target Date	Responsible Staff
2	Ensure monitoring instrument includes indicators and criteria to evaluate quality and timeliness of risk assessment. Consider including it in initial chart audit; TA from consultant. *Status: No action to report*	8/29/2008	Chief of staff
3	Implement audit as part of clinical audit tool. *Status: No action to report*	10/31/2008	Medical director
4	Hire Manager of Peer Review and Standards to manage clinical audit. *Status: PD under development*	9/30/2008	Medical Director

VI.A.3

By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;

Findings

The Hospital created a patient data base to collect information about diagnoses, risk and medication until AVATAR is fully implemented. Use of the data base by physicians is not consistent, so while it has the potential to be a valuable source of data, it is known not to be updated in all cases. See Tab # 61 (Screen shots that describe patient data base). However, it does provide data that can be used to develop the clinical profile of the patient population. The data reflects that 94% of the patient population carries an Axis 1 diagnosis, that 52% carry an Axis II diagnosis, and that 79% carry an Axis III diagnosis. Data suggests that 98 patients carry NOS diagnosis on and 41 carry a R/O diagnosis on Axis I, while 28 patients carry an NOS diagnosis and 22 carry a R/O diagnosis on Axis II. However, we are not yet able to use this data to evaluate the length of time a patient may have carried such a diagnosis. That information should be available by the next report as AVATAR reports should be available.

The Hospital currently uses the DSM-IV as its diagnostic manual, and a List serve to create discussion and sharing about complex diagnostic cases in now operational. Tab # 37 (S Binks email - St. Elizabeths Diagnostic Manual (SEDM) Forum))

There is no audit/peer review tool developed for psychiatry, and no audit yet underway that assesses the quality or content of psychiatric assessments. It may be possible to modify the clinical chart audit tool in draft form to capture the relevant data, and the Hospital is working with the consultant on determining the best way to proceed. The Hospital is also creating a position titled Manager of Peer Review and Standards who will provide support to all the clinical review/peer review processes.

Compliance Status: The Hospital is in partial compliance for this indicator, due June, 2008.

Recommendations	Responsible Party
1 *Same as in VI.A.1 and VI.A.6.*	

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

2 *Ensure that the monitoring tools regarding psychiatric assessments and reassessments include indicators and operational instructions that address diagnostic accuracy, including that the diagnoses are consistent with the individuals' history and current presentation.* ***AF; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	With technical assistance from consultant, develop monitoring tools for review of psychiatric assessments and reassessments	10/31/2008	Psychiatric Assessment Form, Tab # 38 ; Clinical chart audit form draft Tab # 46	Medical Director; QID; chief of staff

Status: Revised psychiatric assessment form has been developed. Being reviewed by consultant. Clinical chart audit tool is in draft but will need revision and is being reviewed by consultant

3 *Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (March to August 2008).* ***AF; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps under VI.A.3 recommendation.	11/27/2008		Medical Director, QID
2	Summarize and report data monthly subsequent to audits.	11/28/2008		OMS

Status: None available

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Create patient database to serve as interim measure pending AVATAR implementation.	6/2/2008	Screen shots from patient database, Tab # 61 Clinical profile of inpatient population, Tab # 55	OMS

Complete *Status: Database complete, and provides some information about diagnoses. It does note provide capacity to assess if patient is properly diagnosed, but does give information about r/o and other differential diagnoses.*

VI.A.4

By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;

Findings

Same as above

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

Recommendations	*Responsible Party*
1 *Same as above.*	

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

VI.A.5

Findings

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;

Same as above.

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

The Hospital continues to struggle with identifying and building on patient strengths, though new assessment instruments developed by all disciplines are expected to impact positively this deficiency. Tab # 38 (Initial Psych Assessment form), Tab # 36 (Initial Nursing Assessment form), Tab # 34 (Initial Social Work Assessment form), Tab # 23 (Initial Psychological Assessment form), Tab # 35 (Initial Rehabilitation Services form). Other than Rehabilitation Services which has developed a tool that is being piloted, the Hospital has yet to develop peer review materials for disciplines that will capture this requirement, but is working with a consultant to develop an appropriate monitoring tool. A review of a small sample of charts suggest that this will need to be a focus of the treatment planning training, as in some cases strengths were overlooked (i.e., in one chart, the patient had some college education and work history, but neither was noted as a strength).

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

Compliance Status: Partial compliance.

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

VI.A.6

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

Findings

See sub cells

Compliance Status: See sub cells.

VI.A.6.a

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

Findings

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

Compliance Status: Partial.

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

VI.A.6.b

all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a

Findings

The revised Assessment policy and protocols from the Psychiatry Training Department require that psychiatrists write a note, rather than merely countersign trainee notes. Tab # 39 (Assessment Policy), Tab # 63 (Training Department Supervision standards). However, it is still common practice for attending doctors to merely countersign notes. The Hospital will monitor this requirement through the peer review/clinical audit tool that is under development.

note to accompany these assessments;

Compliance Status: Partial

Recommendations				Responsible Party
1 Provide the facility's procedure that ensures adequate supervision of trainees and appropriate communications between the trainees and attending physicians.				PID;
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Incorporate requirement into assessment policy.	7/15/2008	Assessment Policy, Tab # 39	CEO	
2 Train psychiatrists on this requirement.	8/22/2008		Medical Director	
2 Provide self-assessment data regarding implementation of this requirement.				AF;
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Include in clinical audit tool. *Complete*	8/31/2008	Draft clinical audit tool Tab # 46	Chief of Staff	
2 Obtain TA from consultant. *Status: Consultant is reviewing draft.*	7/24/2008		Chief of staff	
3 Revise tool as needed.	8/29/2008		QID	
4 Begin audits using revised tool.	9/30/2008		Medical Director	

VI.A.6.c

differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagno

Findings

The Hospital has created a patient data base to collect information about diagnoses, risk and medication until AVATAR is fully implemented. Use of the data base by physicians is not consistent, so while it has the potential to be a valuable source of data, it is known not to be updated in all cases. However, it does provide data that can be used to develop the clinical profile of the patient population. The data reflects that 94% of the patient population carries an Axis 1 diagnosis, that 52% carry an Axis II diagnosis, and that 79% carry an Axis III diagnosis. Data suggests that 98 patients carry NOS diagnosis on and 41 carry a R/O diagnosis on Axis I, while 28 patients carry an NOS diagnosis and 22 carry a R/O diagnosis on Axis II. However, the Hospital is not yet able to use this data to evaluate the length of time a patient may have carried such a diagnosis, or whether there is adequate support in the record for these diagnoses given the absence of clinical chart audits. More information and analysis should be available by the next report as development of these AVATAR reports should be complete and clinical chart audits should have begun.

Compliance Status: Partial.

Recommendations				Responsible Party
1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.				

2 *Provide CME training to psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders.* ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop capacity for CME training for psychiatry staff.	12/31/2008		Farooq Mohyuddin
	Status: CME application is being submitted in August 2008 and approval is expected in October 2008.			
2	As approval process is pending, begin development of training schedule.	10/8/2008		Farooq Mohyuddin

3 *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.* ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Will provide once application is approved and speaker is scheduled.			

4 *Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS* ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop patient database to collect diagnosis information	6/2/2008	Screen shots from patient data base Tab # 61 ; Clinical Profile of Inpatient Population Served, Tab # 55	OMS
	Complete *Status: Data base created and all doctors completed training*			
2	Bi-monthly report clinical profile data.	7/31/2008	Patient clinical profile data, Tab # 55	OMS
	Complete			
3	Medical Director and Director of Psychology review results and address diagnosis issues with treating doctors.	8/15/2008		Medical Director
4	Train doctors on r/o and NOS diagnosis.	10/1/2008		Medical Director

VI.A.6.d

each individual's psychiatric assessments, diagnoses, and medications are clinically justified.

Findings

Same as VI.A.1 through VI. A.6.

Compliance Status: Partial

Recommendations	*Responsible Party*
1 *Same as in VI.A.1 through VI.A.6.a and VI.6.c.*	

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

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

VI.A.7

By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.

Findings

The Hospital modified its Assessment policy to provide more specific guidance about the content of psychiatric reassessments. See Tab # 39 (Assessment Policy). However, the policy and new instruments are just being introduced in early August 2008, so the impact of the new requirements is not yet known. Clinical chart reviews have not yet begun so there is not data to measure compliance with this requirement. In large part there has not been a change in practice and the quality of reassessments often depends on the psychiatrist conducting the reassessment.

The IRP process observations indicated that psychiatric progress notes preceding the treatment plan conference could only be found in 19% of cases reviewed. Better data will be available once the clinical audit tool is completed and implemented.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	Responsible Party
1 Same as in VI.A.1.	

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

Recommendations	Responsible Party
2 Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above.	*AF; BG;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize revised assessment policy. ***Complete***	7/15/2008	Assessment policy, Tab # 39	J Taylor
2 Update new psychiatric assessment form that is consistent with policy. ***Complete***	7/31/2008	Initial Psychiatric assessment form Tab # 38	Chief of staff
3 Evaluate appropriateness of developing form for reassessments and develop as needed.	10/31/2008		Medical Director

VI.B. Psychological Assessments

Findings

See findings in specific sub-cells

Compliance Status: See specific findings.

VI.B.1

By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic

Findings

An additional two staff have been hired in the psychology department since March 2008, which increases the capacity of the Department to meet the need for the various kinds of psychological assessments. Tab # 22 (Psychology Department staffing). Time frames for the completion of psychological assessments are included in the Hospital's Assessment policy.

neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.

The Department has developed a database that tracks referrals which is on a shared drive accessible to department staff. Tab # 64 (Psychology referral tracking log). The Director of Psychology is developing protocols for various types of referrals that will establish time frames for completion of the assessments and a template for reports that respond to each type of referral, that will be consistent with the new Assessment policy parameters (begin Assessments within 15 days of referral and completed within 30 days). That work is expected to be completed by August 15, 2008, and should be provided to the reviewers at their next visit. Peer review forms that track the new templates will be developed by the end of September, so that peer review will begin in Fall, 2008.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Develop and implement a policy governing the appropriate timelines for the completion of referrals for all psychological assessments. Since the monitoring of all psychological assessments falls within the purview of the Psychology Department, the hospital should consider reorganization so that the neuropsychologist reports through the Chief of Psychology. — ***AF; Rose***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Time frames are reflected in the data base which tracks referrals and status of the referrals.	7/31/2008	Psychology referral log Tab # 64; Assessment policy, Tab # 39	Director Psychology
	Complete *Status: Referral database is completed; Assessment policy established time frames*			
2	Medical Director will evaluate reporting structure for neuropsychology.	7/31/2008		Medical Director
	Status: No decision has been made.			

2 Develop and implement a tracking system to determine when all referrals for any type of psychological assessment are made and track these assessments to completion. This process will help the Psychology Department and the hospital better understand its need for psychological services, so that an adequate number of psychologists can be hired. — ***AF; PID; Rose***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop psychology referral tracking system on Global Share drive.	6/30/2008	Copy of Psychology Referral Log, Tab # 64.	Director of Psychology
	Complete			
2	Until such time as AVATAR goes live, psychologists keep a loose leaf with all copies of referrals			
	Complete			

3 *Develop standard templates for all psychological screening and assessment reports that mirror the requirements of the DOJ agreement. At a minimum, address:* ***AF; R Patterson***

- *a* *The individual's identifying information*
- *b* *Precipitants to hospitalization*
- *c* *The reason for the referral*
- *d* *Relevant social, educational, employment and legal history*
- *e* *History of head or brain injury*
- *f* *Past mental health and substance abuse history*
- *g* *Risk for harm factors where relevant*
- *h* *The dates and results of previous psychological assessment*
- *i* *The psychological tools and measures employed in the assessment process*
- *j* *The results of all psychological tools and measures*
- *k* *Conclusions that directly address the referral question and draw a connection between testing results and other current and accurate data*
- *l* *Recommendations that flow logically from the conclusions or that provide clarification for the referral question*
- *m* *Any recommendations for further assessment*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Department of Psychology is developing a department manual; initial section will be the standard formats for psychological assessments.	8/30/2008		R. Patterson
2	Establish policies and procedures to the recommended areas.	8/30/2008		R Patterson
3	In-service will be provided for the department staff on new policies and formats.	8/26/2008		R Patterson
4	Templates will be implemented.	9/1/2008		R Patterson

4 *Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools) that address the psychological assessment process. At a minimum, monitor:* — ***AF; R. Patterson***

a All of the items indicated in the template outlined in Recommendation 3 above;

b Timeliness of the assessment process as per yet to be established policy guidelines

c The quality of each section of the evaluation

d The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record

e The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop monitoring tools that track established format for each kind of psychological assessment. *Status: New Initial psychology assessment form has been developed, but monitoring form not yet available.*	10/31/2008	None	R Patterson

5 *The auditing/monitoring data can be used as part of the peer review process for individual psychologists. Aggregate and trend as part of an ongoing performance improvement process that will help determine where needed intervention, training or supervision is best directed within the department.* — ***PID; Rose Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop policy and procedures for a peer review process based on the standard templates and timelines established for Psychological Reports. *Status: No information available.*	8/30/2008		R Patterson, QID
2	Conduct Peer review using the auditing tools.	9/30/2008		R Patterson
3	Publish results of the review and recommend corrective measures.	11/14/2008		R. Patterson; OMS

6 *Train auditors to acceptable levels of reliability.* — ***AF; R Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct in-service for psychology staff prior to peer review.	9/17/2008		R Patterson

7 *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* — ***AF; Rose; Angela***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Utilize consultant for technical assistance to Psychology Dept to develop operational instructions and indicators.	9/26/2008	Angela Adkins Contract Tab # 9	Director of Psychology

VI.B.2 **Findings**

By 24 months from the Effective Date hereof, all psychological assessments shall:

See sub-cells for findings.

Compliance Status: See sub cells.

VI.B.2.a

expressly state the purpose(s) for which they are performed;

Findings

The current practice continues to be to include in assessments the reason for the assessment.

Compliance Status: Substantial

Recommendations — ***Responsible Party***

1 Continue current practice with Risk Assessments and Neuropsychological Assessments. — ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Continue current practice. *Status: Current practice is continuing. Samples will be provided prior to September 22 visit.*			

2 See cell VI.B.1, Recommendation 4. An important item to monitor is that all psychological assessments clearly state the referral question, and that the referral question is directly answered in the assessment's conclusion section. — ***AF; Rose***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train psychologists to develop concise referral question(s) and assist of the treatment team.	8/26/2008	Memorandum advising staff of this requirement, Tab # 65	R Patterson
2	Include assesment of referral question in the monitoring process for psychological assessments.	9/30/2008		R Patterson

3 Have psychologists work with treatment teams informally or provide teams formal training in assisting them in how to structure appropriate referral questions. — ***AF; R Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure psychology staff discuss the referral process with any referring source to refine the questions prior to initiating assessment. ***Complete*** *Status: This is ongoing.*	6/25/2008		Director, Psychology
2	Train to Senior Staff on August 19, 2008 , in part, on how to make a referral and state reason for referral.	8/19/2008		Director, Psychology

---

VI.B.2.b

be based on current and accurate data;

Findings

Assessments/evaluations continue to be based upon current and accurate data.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Continue to use current and accurate data in arriving at their conclusions, as was evident in the great majority of reviewed assessments.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice. *Status: Practice continues*			

2 See cell VI.B.1, Recommendations 4, 6 and 7.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VI.B.1, Recommendations 4, 6 and 7.			

VI.B.2.c

provide current assessment of risk for harm factors, if requested;

Findings

Prior practice continues.

Compliance Status: Substantial

Recommendations	*Responsible Party*
1 Maintain current level of practice.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice. *Status: Current level of practice is maintained*			

2 See cell VI.B.1, Recommendations 4, 6 and 7.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VI.B.1, Recommendations 4, 6 and 7. *Status: See cell VI.B.1, Recommendations 4, 6 and 7*			

VI.B.2.d

include determinations specifically addressing the purpose(s) of the assessment; and

Findings

Prior practice around risk assessment continues. The Psychology Department is developing guidelines for the conclusion and recommendation sections of assessments, which are expected to be complete by end of August, 2008.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Develop clear guidelines for the Conclusions and Recommendations sections of all psychological assessments and screenings.	***AF; Rose***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a department manual; the 1st section to be completed will include templates for psychological evaluation formats and guidelines regarding what to address in each section. *Status: No progress to report.*	8/30/2008		R Patterson

2 *Provide directions on how the psychological assessment is to directly answer the referral question and make appropriate recommendations based on that answer.* — ***AF; Rose***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See response to VI.B.2.a recommendation 2. *Status: See response to VI.B.2.a recommendation 2.*			

3 *Auditing tools for monitoring the psychological assessment process must include items relevant to determining ongoing compliance with this element of the DOJ agreement. See cell VI.B.1, Recommendation 4.* — ***PID; Rose; PID-data***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VI.B.1. Recommendation 4 and 5. *Status: See VI.B.1. Recommendation 4 and 5.*			

4 *See cell VI.B.1, Recommendation 7.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See cell VI.B.1, Recommendation 7. *Status: See cell VI.B.1, Recommendation 7.*			

VI.B.2.e

include a summary of the empirical basis for all conclusions, where possible.

Findings

See cell VI.B.2.d

The Director of Psychology is developing capacity in the Department to ensure staff have access to, and utilize information in current research. Target date is August 30.2008.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 *See cell VI.B.2.d, Recommendation 1.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in cell VI.B.2.d, Recommendation 1. *Status: See cell VI.B.2.d, Recommendation 1.*			

2 *Provide directions on how the empirical basis for all conclusions is to be addressed in the assessment report.* — ***R Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Provide access to Psychology staff to current research; Policies under development will include direction to access this information for assessments and therapy *Status: No information to report*	8/30/2008		R Patterson

3 See cell VI.B.2.d, Recommendations 3 and 4.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in cell VI.B.2.d, Recommendations 3 and 4. *Status: See cell VI.B.2.d, Recommendations 3 and 4.*			

VI.B.3

By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.

Findings

The Department has not yet addressed this requirement, although staffing increases will assist it in meeting this requirement.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Develop and implement a timeline for the completion of this item of the agreement. — ***BG; R Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify individuals currently in hospital who had psychological assessment in past through review of available logs. *Status: This has not yet begun.*	11/28/2008		Rose Patterson
2 Ward based psychologist shall review previous assessment to assess if additional assessment is required. *Status: Not yet begun*	2/27/2009		Rose Patterson
3 A tracking log of the review of each person prior assessment, and recommendation as to whether a reassessment is needed, will be maintained in Psychology department. *Status: Not yet begun*	11/28/2008		Rose Patterson
4 Where needed, reassessment will be completed; if not needed, psychologist shall complete note in medical record. *Status: No update.*	6/30/2009		

2 Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment (see Cell VI.B.1). — ***Rose Patterson***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VI.B.3 recommendation #2. *Status: See VI.B.3 recommendation #2.*	11/28/2008		

VI.B.4

By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.

Findings

The Hospital's revised Assessment policy is complete and provides content requirements for psychological assessments. In addition, the policy provides for psychology screens on all newly admitted patients, that includes a risk screen as well as a cognitive impairment screen and the new psychological initial assessment form is complete. See Tabs # 39 (Assessment policy) and # 23 (Initial Psychological Screening form). In addition, as previously noted, the Director of Psychology is developing standards for each type of assessments that will apply to all assessments completed by psychology.

Each admission unit has a psychologist assigned to complete initial assessments.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 *Finalize and implement the draft policy.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Incorporate psychology assessment requirements into the Assessment policy.	6/15/2008	Assessment policy, Tab # 39	J Taylor
	Complete *Status: Psychology assessment requirements have been incorporated into the Assessment policy.*			
2	Develop procedures and train staff on when a referral to psychology is appropriate.	8/29/2008		Rose Patterson
	Status: This issue will be supported by the psychologist that is assigned to each unit, who will support the identification of patients who are in need of psychological assessments or testing. See also VI.B.2.a.			

2 *Give careful consideration to requiring that all new admissions receive at a minimum a cognitive screening in addition to the required risk assessment. Both chart reviews and discussion with psychology staff suggest that a high percentage of those individuals admitted to St. Elizabeths Hospital have some measure of cognitive impairment that will be an important determinant in providing adequate treatment and rehabilitation, as well as a prominent issue in discharge planning.* — ***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete an Initial Psychological Assessment form that assesses cognitive functioning and risk assessment on all new admissions. .	7/31/2008	Assessment Policy, Tab # 39; Initial Psychological Assessment form Tab # 23	Rose Patterson
	Complete *Status: New assessment form complete and assessment will begin in July*			

VI.B.5

By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological

Findings

Several steps were taken to address this requirement. Each unit now has a psychologist assigned to it to provide support which will increase communication. Tab # 22 (Ward staffing in Forensic and Civil Services). Second, the new psychology screening tool will specifically track the date the results were communicated to the team. Tab # 23 (Initial Psychology Assessment). Finally, the Assessment policy specifically requires that psychologists

assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.

communicate and interpret results for treatment teams along with the implications of the results. See Tabs # 39 (Assessment policy) and Tab # 23 (Initial Psychological Assessment).

No information is yet collected to evaluate whether recommendations are followed, or if not, it a note is included addressing a decision not to follow the recommendations.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	Responsible Party
1 Develop policies and procedures that address the process by which psychological assessment results are directly communicated to the treatment team and such communication is noted in the individual's medical record.	*AF;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include in the Initial Psychological Assessment Form the date that the results were discussed with the treatment team and signature from the team leader.	7/31/2008	Initial Psychological Assessment form, Tab # 23	Rose Patterson
	Complete *Status: This will begin to be utilized in July, 2008.*			
2	Utilize above procedure with all Psychological Assessments.	8/30/2008		R. Patterson

Recommendations	Responsible Party
2 Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations.	*CVC; JH; AF;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Incorporate in written procedure in Psychology expectation that staff members discuss issues with the treatment team; documentation requirements will be developed.	9/30/2008		R Patterson

Recommendations	Responsible Party
3 Monitor through chart auditing tools for fidelity to these processes.	*PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps VI.B.2.D.			
	Status: See action steps VI.B.2.D			

VI.C. Rehabilitation Assessments

Findings

See sub-cells below.

Compliance Status: See sub cells below.

VI.C.1

When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement

Findings

The Hospital's Assessment Policy provides for a Rehabilitation Assessment for every newly admitted patient. Tab # 39 (Assessment Policy). A new assessment form (Tab # 35) for Rehabilitation Services was developed and is being piloted through the completion an assessment on a random sample of newly admitted patients. Unfortunately, lack of staffing in rehabilitation services is preventing rehab assessments on all newly admitted

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.

patients as is expected. Nineteen clinical positions were abolished in the Spring, 2008 based upon the Hospital's vacancy rate, and 4-5 of those positions were for rehabilitation specialists.

In addition, an audit tool reflecting the revised assessment has been piloted and initial results obtained. See Tab # 43 (Rehab Services Audit Tool), Tab # 53 (Results of Initial Rehab Services Audit). The consultant is reviewing the tool and guidelines to perfect them and her recommendations will be implemented as appropriate.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 *Implement the newly revised Initial RT Assessment across all admission units. The newly designed assessment provides important material for the functional assessment of individuals that is critical to determining their level of care while in the hospital and upon discharge.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete a new diagnostic Rehab assessment tool with guidelines.	6/2/2008	Rehabilitation Services Diagnostic Tool and guidelines, Tab # 43	Coleman, Robinson

Complete *Status: Training on the use of the tool provided to staff by April. Piloted tool on the Civil Admissions wards 5 & 6 in late April until early June. As of May 13, 2008 seventeen assessments were completed on the admissions wards for the civil side. As of June 13, 2008, 21 assessments were completed on the Forensic pre-trial admission units.*

2 *Develop and implement an auditing tool that monitors the medical record for the presence, timeliness and quality of the Initial RT Assessment.* — ***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Audit tool for rehab assessments.	6/2/2008	Rehab Services Audit tool # 43	Robinson, Coleman

Complete *Status: Draft audit tool is completed and will be reviewed by consultant.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Conduct Initial Audits and provide results.	6/27/2008	Report of initial rehab audits, Tab # 53.	Robinson, Coleman

Complete *Status: Initial audits were conducted in May and June 2008. Results attached*

3 *Auditors must be trained to reliability.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train auditors using guidelines.	6/26/2008		Robinson, Coleman

Complete

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Work with consultant to review audit tools and guidelines, update tools as needed and retrain staff as needed	8/29/2008		Chief of staff; Coleman and Robinson

Status: Consultant is reviewing tools.

4 Provide operational definitions of all terms in a written format to aid in data reliability and validity. ***CVC; JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.1 recommendation 3. *Status: See VI.C.1 recommendation 3*			

VI.C.2

By 24 months from the Effective Date hereof, all rehabilitation assessments shall:

Findings

Please see findings and sub cells.

Compliance Status: See findings and sub cells.

VI.C.2.a

be accurate as to the individual's functional abilities;

Findings

The newly designed rehabilitation assessment is implemented but not all admissions are yet getting assessments due to staffing shortages. See VI.C.1.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Same as above.

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

VI.C.2.b

identify the individual's life skills prior to, and over the course of, the mental illness or disorder;

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessment due to staffing shortages. See VI.C.2.1.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Same as above.

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

VI.C.2.c

identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessments due to shortage of rehabilitation services staff. See VI.C.1.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Same as above.

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

1 Same as above.

Status: Same as above

VI.C.2.d

provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.

Findings

The newly designed assessment is implemented but not all admissions are yet getting assessments due to staffing shortages. See VI.C.1.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

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

VI.C.3

By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment.

Findings

Rehabilitation services has not yet begun to address this requirement, and thus no progress is being made. With the current level of staffing, this requirement will not likely be met. Additional positions will need to be identified as 3-4 rehabilitation specialist positions were abolished this Spring.

Compliance Status: No progress is being made toward the June, 2009 compliance date.

Recommendations			*Responsible Party*
1 Develop and implement a plan to address this issue.			***CVC; JH;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assign a rehab specialist to each unit.	6/27/2008	Tab # 25 (Staffing of Forensic and Civil units)	Coleman, Robinson
Complete *Status: Each unit has a specialist assigned, but due to shortages, some specialists are covering multiple units. Recruitment for additional specialists is underway*			
2 Rehab. Specialists will review prior assessments and update as needed.	12/31/2008		Coleman, Robinson
3 Fill all rehab specialist positions and identify additional positions for recruitment	8/29/2008		COO, Chief of staff
2 Utilize some version of the audit tool referenced in cells VI.C.2.a through VI.C.2.d for use in this review process.			***CVC; JH;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VI.C.2.a through C.2.d. *Status: See VI.C.2.a through C.2.d.*			

3 Develop and implement a plan for the provision of treatment mall services to all forensic individuals. ***JH; JH***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Recruit and hire nursing staff to fill vacancies in Forensic Services.	8/15/2008	Human Resources Schedule A (Tab # 66), List of Nursing Staff in Forensic Services. Tab # 67	D.J. and J.H.
Complete *Status: Forensic Services has hired 43 nursing staff and promoted 6 staff as of July 14, 2008. It now has a sufficient number of nurses to have one RN per unit on all shifts (excluding RDOs and leave.)*			
2 Recruit and hire Rehabilitation Services staff to fill vacant and new positions (Education Specialist, Music Therapist, and Vocational Rehabilitation Specialist). Positions based upon patient treatment needs in Forensic Services.	8/29/2008		C.R J.Gallo
Status: Vacancy announcements written and provided to Human Resources. Awaiting posting of positions and hiring certificates of qualified applicants to interview.			
3 Expand the variety of therapeutic activities available to forensic patients, their frequency, and times treatment activities are available to forensic patients in John Howard Pavilion.	8/29/2008		D.J., C.R, J.H.
Status: Nursing staff have received orientation to group work. New nursing staff members paired with experienced forensic nursing staff members. Nursing currently offering 153 active treatment groups on forensic inpatient units on weekdays between 8:00AM and 8:00PM. A limited number of weekend groups also are being conducted. Other services available include the gardening program, stamp program and pens and lens.			

VI.D. Social History Assessments

By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources,

Findings

The Social work initial assessment was revised and comments from the DOJ report were incorporated. The assessment provides for more narrative assessments rather than a checklist, and there is an expectation social workers will review for and resolve factual disparities in histories. See Tab # 34 (Social Work Initial Assessment). Guidelines were also developed and both documents are under review by the Consultant. See Tab # 34 (Guidelines for Social work initial assessment). Additionally, social work staff developed a list of information to be obtained upon a patient's admission, and presented it core service agency administrators. See Tab # 68 (List of Information to be collected upon admission). However, as of the writing of this report, the core service agencies are not providing the requested information on a consistent basis so resolving factual discrepancies is still challenging.

While social work staff were trained on the instrument, no substantive training around discharge planning or assessment has yet been provided, though these areas are expected to be covered in the treatment planning training contract. It is expected that this training will also strengthen the discharge planning parts of the IRP process. Training is needed as social work assessments still contain boilerplate language such as "patient will be discharged when no longer dangerous to self of others" or "patient will be discharged when stable."

The SWIA instrument was piloted in June, and Social work pilot peer review/clinical chart audits began the last week of July. Tab # 41 (SW peer review instrument) The draft instrument is under review by the consultant.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Revise the SWIA to include a narrative section following the section on Social History that indicates what attempts were made to reconcile conflicting information and the outcome of those attempts, as well as further plans to reconcile information if appropriate.	***CVC; JH; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Social Work initial assessment tool with guidelines. Train staff	6/2/2008	Social Work Initial Assessment Tool Tab # 34 and Guidelines Tab # 34	Wilhoit / Richardson
Complete *Status: The tool was piloted on the Civil admissions units 5 & 6 in early June 2008. The tool was piloted on the Forensic pre-trial admission units 6 and 7 in early June 2008*			
2 Develop a standard set of data that should be made available within 48 hours of patient's admission to hospital and provide same to community providers.	4/16/2008	Document "On Admissions Information Needed", Tab # 68	CVC
Complete *Status: Hospital staff met with CSA program managers about need for more information upon admission, but information is still not routinely being provided upon a patient's admission.*			
3 Meet with community, providers to announce information that will be needed by Hospital upon .	4/10/2008		CVC
Complete			

Recommendations	Responsible Party
2 Develop written guidelines for the SWIA that clearly articulate how individual social workers are to document their sources for conflicting data in the Social History section of the assessment. Simply providing check boxes for all sources of information does nothing to resolve conflicting information, and may in fact, increase confusion, for when multiple sources are checked, it could imply that conflicts were resolved.	***CVC; JH; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Redesign the Social Work Assessment Tool with a section on resolution of discrepancies in social history.	7/1/2008	SWI Assessment Tab # 34	SWIA is being reviewed by consultant for comments. Modifications will be made as needed.
Complete *Status: SWIA is being reviewed by consultant for comments. Modifications will be made as needed.*			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Redesign Social Work Peer Review Document which is also used as a Monitoring Tool used by Supervisors to assess performance.	7/1/2008	SW Peer review document, Tab # 41	Wilhoit / Richardson
	Complete *Status: See status above.*			
3	Pilot peer review monitoring tool.	7/31/2008		SWIA is being reviewed by consultant for comments. Modifications will be made as needed.
	Status: Pilot initiated last week of July			

3 *Develop and implement an auditing tool to monitor the presence, timeliness and quality of this and all sections of the SWIA.* ***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Social Work Peer Review Document and Supervisory Monitoring Tool.	6/25/2008	SW Peer review tool Tab # 41	Wilhoit / Richardson
	Complete *Status: Tool drafted and under review by consultant*			
2	Submit SWIA and peer review forms to consultant Adkins for comment and advice.	7/31/2008		Chief of staff
	Complete *Status: Peer review form being piloted.*			
3	Pilot tool by reviewing SWIA.	8/29/2008		Wilhoit / Richardson
	Status: Pilot began last week of July			

4 *Train auditors to acceptable levels of reliability.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Obtain assistance from consultant to strengthen training and ensure inter relater reliability	9/30/2008		Wilhoit; chief of staff
	Status: Contractor identified and consultation underway, but too early to begin training			

5 *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* ***CVC; JH; Angela***

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

VII. Discharge Planning and Community Integration

Summary of Progress

1. The Hospital approved a policy governing "Discharge Planning and Community Integration". The policy will be implemented in August. See Tab # 69 (Discharge Planning and Community Integration Policy).

2. The Hospital created a database in which it is tracking issues that are delaying/preventing discharge of patient's ready for discharge. That data is provided to DMH's Mental Health Authority periodically to help it plan for the necessary community services and supports that will support discharge of patients to an appropriate community setting. As of July 9, 2008, 57 patients have been identified as "ready for discharge" but remain hospitalized due to various barriers. See Tab # 70 (Discharge Barriers Identified for St. Elizabeths Patients). This shows no progress since the time of the February 2008 visit. According to the analysis, housing remains the most often cited barrier. The Department announced a new RFP for integrated community care that targets 30 hard to place Hospital patients. Tab # 71 (Community Care RFP).

3. No treatment plan training occurred between March and July, 2008. A new trainer has been identified and the Hospital held a planning meeting with her to set out the parameters of a contract. The contract is expected to include a module of on discharge planning.

4. The Hospital continues to review 20% of closed records through a Discharge Record review. Since the February 2008 Baseline visit, the monitoring tool was modified to incorporate recommendations from the Baseline report. See Tab # 27 (Discharge Records Monitoring Tool). See Tab # 28 (Results of Discharge Record review)

5. The SWIA tool was modified to incorporate DOJ recommendations, but no audit has yet occurred to measure if performance has improved around individualizing social work interventions related to discharge. See Tab # 34 (Social Work Initial Assessment); Tab # 41(Social work auditing tool).

6. The Hospital is monitoring patient participation in discharge planning in part through the IRP process monitoring tool. See Tab # 6 (IRP Process monitoring tool). See also Tab # 7 (Results of IRP process monitoring)

7. The Hospital developed a community reentry program as part of the treatment mall. See Tab # 72 (Program Protocol of Community Reentry Group) Two cohorts have completed the program. Of the first cohort of 12, 5 completed the program, 3 were discharge during the program period, 3 were withdrawn due to medical issues, and 1 left the program for a work assignment. Tab # 73 (Community Reentry Group Program Review Report). Data about the second cohort is not yet available.

VII. Discharge Planning and Community Integration.

Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental

Findings

See sub-cells below

Compliance Status: See sub cells for findings.

disabilities.

VII.A.

By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:

Findings

Meaningful discharge planning is still not occurring at the level expected, across all disciplines. Each disciplines assessment forms were modified to renew focus on discharge planning, but the forms are just being introduced to staff.

The Hospital revised its Discharge Record review instrument to incorporate comments from the April 2008 DOJ report, and then refined it again. See Tab # 27 (Discharge record review tool for period February to April review;) It also conducted a review of 20% of discharges from February to April, 2008 (Records were also reviewed for May-June period, but that data is not yet available. The revised tool is also found at Tab # 27). Data shows that additional work is needed in all areas in order to strengthen discharge planning. For example, the discharge record review shows that effective discharge planning began at admission in only 41% of cases, that meaningful patient participation occurred in only 33% of cases and that instruction sheets are provided to patients in only 59% of cases. See Tab # 28 (Discharge Monitoring Analysis Summary).

In addition, the Hospital created a database to collect key data on patients ready for discharge but for whom discharge could not be effected. The database allows the Hospital to identify and track barriers to discharge in a more systematic way, and then provide information to the Department for its use as it develops services and supports. There was initial resistance to its use, but social workers are now inputting information into the database. The most recent report of key barriers is attached at Tab # 70 (Discharge barriers) and shows housing as a key barrier, with many patients having multiple barriers adversely impacting discharge.

The Hospital and DMH are monitoring the discharge of Hospital patients. In May, the “ready for discharge” list was reduced to 29, but by early July, 2008, it spiked again at 57, reflecting that the community supports are not yet available in sufficient capacity. A new RFP for community care targeting 30 the most challenging patients to place was announced the end of July, 2008. See Tab # 71 (Community Care RFP).

See also findings in cell VI.D.

Compliance Status: Non-compliance, although recent changes to the discipline assessment instruments are expected to improve discharge planning.

Recommendations	*Responsible Party*
1 *Provide guidelines for how appropriately individualize the Discharge Plan of the SWIA to accurately reflect the relevant discharge needs of all newly admitted individuals. At a minimum indicate the likely discharge placement and the necessary community based supports and services that will be necessary to optimize community tenure.*	***CVC; JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify SWIA to include assessment of relevant discharge needs, and obtain technical assistance review by consultant.	7/31/2008	SWIA Tab # 34	Wilhoit / Richardson; Chief of staff
2 Include individualized discharge planning and assessment in treatment planning training. *Status: Training to begin in August, 2008.*	8/15/2008		

	Recommendations	Responsible Party
2	*Provide guidelines on how to integrate the above information from SWIA into the case formulation and long term goals of the individual's initial IRP. Utilize later treatment planning conferences to incorporate goals and objectives consistent with the development of a written Wellness and Recovery Action Plan that at a minimum addresses: the individual's strengths and acquired skills, warning signs for relapse regarding any and all aspects of the individual's diagnoses or risk factors; strategies to put in place when warning signs are encountered; supports and services which the individual will be provided upon discharge.*	***CVC; JH; BG; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train social work staff on treatment planning including focus on case formulation and long term goals. 5O% of civil and forensic social workers will be trained by 12/31 and remaining staff by March 31, 2009.	12/31/2008		Wilhoit / Richardson; Chief of staff
	Status: See recommendation 1.			

VII.A.1

those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;

Findings

The Social Work Initial Assessment was revised and comments from the DOJ report were incorporated. The assessment provides for more narrative assessments rather than a checklist, and there is an expectation social workers will review for and resolve factual disparities in histories. See Tab # 34 (Social worker Initial Assessment). Guidelines were also developed and both are under review by the Consultant. See Tab # 34 (SW Assessment guidelines). While social work staff were trained on the instrument, no substantive training around discharge planning or assessment has yet been provided, though these areas are expected to be covered by the treatment planning training contract. It is expected that this training, set to start in late July or early August, will also strengthen the discharge planning parts of the IRP process.

Social work peer review/clinical chart audits began in late July, using the draft tool, which is under review.

Compliance Status: Partial

	Recommendations	Responsible Party
1	*Revise the SWIA to include an analysis of individual strengths that are relevant to the individual's chosen discharge setting.*	***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Redesign Social Work Assessment to include individual strengths.		Revised SWIA Tab # 34	Wilhoit / Richardson
	Complete *Status: SWIA will be reviewed by consultant for comment and subsequent modification.*			

	Recommendations	Responsible Party
2	*Develop this section of the Assessment so that it is a narrative block rather than a check-off form.*	***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Redesign Social Work Assessment.		SWIA form Tab # 34	Wilhoit / Richardson
	Complete *Status: See VII.A.1*			

3 Develop and implement an auditing tool that monitors for the presence, timeliness and quality of this and all sections of the SWIA. ***CVC; JH; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop social work peer review tool that includes all aspects of recommendations.	6/19/2008	Social work peer review tool, Tab # 41	Wilhoit / Richardson
	Complete *Status: See VI.D.*			
2	Conduct peer review of 20% of cases.	9/30/2008		Wilhoit / Richardson
	Status: See VI.D. Peer review has not yet begun.			
3	Provide raw data to OMS for analysis and discipline chiefs to report on same	10/31/2008		Wilhoit / Richardson, OMS
	Status: See VI.D.			

4 Train auditors to acceptable levels of reliability. ***CVC; JH; PID;***

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

5 Provide operational definitions of all terms in a written format to aid in data reliability and validity. ***CVC; JH; PID; BG;***

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

VII.A.2

the individual's symptoms of mental illness or psychiatric distress;

Findings

See sub-cell VII.A and VII.A.1

According to the Discharge record review, only 41% of discharged records reviewed addressed the individual's symptoms of mental illness and treatment needed for skill development that would impact discharge. See Tab # 28 (Discharge Monitoring Analysis Summary)

A small sample of records (8) was reviewed by the compliance office in July. Social work assessments largely contained general and not patient specific statements around discharge: "patient will be discharge when stable" and "patient will be discharged when no longer a danger to self or others." There is no real focus on the symptoms or behavior that led to hospitalization or will need to be addressed to effect outplacement.

Compliance Status: Noncompliance

Recommendations — ***Responsible Party***

1 Revise the SWIA to address specifically the individual's symptoms of mental illness or psychiatric distress as it directly impacts on anticipated placement. ***CVC; JH; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Redesign Social Work Assessment.	6/4/2008	SWIA Tab # 34	Wilhoit / Richardson
	Complete *Status: SWIA revised and consultant will review for recommendations. Form is being piloted on several units.*			

2 See cell VII.A.1, Recommendations 3 through 5.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in cell VII.A.1, Recommendations 3 through 5.			

VII.A.3

barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and

Findings

See sub-cells VII.A and VII.A.1

In none of the small sample (8 charts), did the social work assessment address issues around unsuccessful prior placements.

Compliance Status: Noncompliance.

Recommendations — ***Responsible Party***

1 Revise the SWIA must to address those barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known. Provide integrative analysis of this issue in the SWIA. — ***CVC; JH; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise SWIA to identify known barriers to discharge. **Complete**	6/4/2008	SWIA Tab # 34	Wilhoit / Richardson
2 Create database that tracks relevant discharge information including issues preventing discharge and provide summary reports to Hospital management and authority. **Complete** *Status: Database was being utilized but use has been temporarily suspended.*	6/2/2008	See attached discharge database, Tab # 74	OMS

2 See cell VII.A.1, Recommendations 3 through 5.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VII.A.1, Recommendations 3 through 5.			

VII.A.4

the skills necessary to live in a setting in which the individual may be placed.

Findings

See sub cells VII.A and VII.A.1. The revised social work initial assessment form reflects this requirement.

The Discharge Monitoring review found only 41% of cases did the records suggest adequate attention to skill development to support discharge, and 22% found evidence of adequate rehabilitation. See Tab # 28 (Discharge Monitoring Analysis)

Compliance Status: Noncompliance

Recommendations — ***Responsible Party***

1 Revise the SWIA to provide a mechanism whereby individual social workers can discuss the skills necessary for the anticipated discharge placement. — ***CVC; JH; BG;***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Redesign Social work Assessment to include Discharge Criteria/identified community needs/support services required for sustained community living.	6/4/2008	SWIA Tab # 34	Wilhoit / Richardson
	Complete *Status: Consultant to review SWIA and make recommendation. Tool is in pilot phase*			
2	Use results from ITP process monitoring observations and discharge record chart reviews to inform social work supervisors on skills needed to be developed.	7/31/2008		Wilhoit/Richardson
	Status: Ongoing.			

2 *See cell VII.A.1, Recommendations 3 through 5.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See cell VII.A.1, Recommendations 3 through 5.			

VII.B.

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

Findings

Patients routinely attend treatment planning conferences, but the level of meaningful participation varies widely. The IRP process monitoring tool attempts to assess this in some manner, and the most recent data suggests that when patients attend the conference, they are not always provided the opportunity for meaningful input. The discharge monitoring review showed patient participation in discharge planning also to be deficient, with 33% of the cases meeting expectations and 44% partially meeting expectations (i.e., patient attended).

The Hospital developed a treatment planning conference template which provides guidance to treatment teams about the role of patients in treatment and discharge planning. See Tab # 4 (Treatment Plan Conference Template). As noted previously, training in treatment planning, the Hospital's key strategy in reforming practice, was interrupted from March until July, but appears now to be back on track as a new contract is expected and training expected to restart in early August. The interruption adversely affected the pace of progress in all aspects of treatment and discharge planning.

Compliance Status: Partial.

Recommendations	Responsible Party
1 *Provide hospital staff with training in how to effectively engage individuals in their own treatment and discharge planning.*	***BG; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include engagement of individuals in discharge planning in treatment planning training and train 50% of units by 12/31/08; remaining teams to be trained by March 31, 2009.	12/31/2008	PO for treatment plan training, Tab # 10	Chief of Staff, DMH contracts
	Status: Planning meeting for developing training plan for treatment plan training and contract discussions held July 25, 2008. Contract and initial training expected in August, 2008.			
2	Include discussion of patient participation on Patient Advisory Board meeting agendas for patient input.	9/2/2008		CVC, JH

2 Provide hospital staff with training in how to run effective and organized treatment planning conferences. See Cell V.A.2.a for further information. — ***CVC; JH; BG; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with trainers to provide treatment planning training to 50% of units by 12.31.08 and remaining staff by March 31, 2008.	7/31/2008	PO for development of treatment plan training, Tab # 10	DMH contract office, chief of staff
Status: Planning meeting to develop training plan and contract discussions held July 25, 2008. Contract and initial training expected in August, 2008.			
2 Begin training in August, 2008.			

VII.C.

By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:

Findings

The Hospital recently approved a Discharge Planning and Community Integration Policy that addresses the recommendations in the April, 2008 report but it has yet to be implemented. Tab # 69 (Discharge Planning Policy). Training in treatment planning did not occur for any staff between March and July, 2008.

The Hospital continues to conduct a review of a 20% sample of discharged patient records. The inclusion of a meaningful discharge planning as component of the IRP was met in only 33% of cases, and partially met in just 41% of cases. See Tab # 27 (Discharge record review instrument) and Tab # 28 (Results of discharge record reviews).

Compliance Status: Noncompliance

Recommendations — ***Responsible Party***

1 Develop policies and procedures that assure that all treatment plan documents include the anticipated place of discharge or level of necessary care, integral community-based services and supports, and current barriers to discharge to that setting, measurable interventions related to these barriers, the person responsible for delivering the intervention, and the timeframe for completion of the intervention. — ***CVC; JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise treatment planning policy and obtain approval by Exec staff	7/16/2008	Treatment plan policy Tab # 1; Revised IRP forms Tabs # 2, 3	J Taylor; Beth Gouse
Complete			

2 Provide training in developing this portion of the treatment plan in conjunction with in the hospital-wide treatment plan training recommended in cell V.A.2.a. Provide additional and more focused and specific training in this process to all social workers. — ***BG; Trg;***

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

VII.C.1

Findings

measurable interventions regarding his or her particular discharge considerations;

See VII. C.

Compliance Status: See VII.C.

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

VII.C.2

the persons responsible for accomplishing the interventions; and

Findings

See VII. C.

Compliance Status: See VII.C.

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

VII.C.3

the time frames for completion of the interventions.

Findings

See VII. C.

Compliance Status: See VII.C.

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

VII.D.

By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals

Findings

The Hospital created a community reentry program designed to develop skills that persons will need upon discharge. (This is addition to the previous activities that include community day treatment programs for some patients as well as recreational activities.) See Tab # 57 (Description of Community Reentry Program). The program is held 3 days a week and includes community trips as well as activities at the Hospital. The first cohort included 12 patients, 6 of who completed it. Three others were discharged while in the program, two withdrew due to medical issues, and 1 attended sporadically due to employment. Data about the second cohort is not yet available.

The Hospital is working with the Department of Mental Health to assess needs of discharged patients and effectiveness of services. The Authority is preparing an inventory of housing and supports. It also is reviewing those cases in which a person had three or more hospitalizations in a year to identify common themes. Tab # 77 (Review of cases in which patient has had three or more hospitalizations in one year). Finally, it is tracking how many patients discharged from the Hospital are seen within 7 days, and 30 days of discharge. Tab # 76 (Seen

within 7 Days of discharge data). Despite these efforts, there is no mechanism yet in place to monitor the effectiveness of transition activities or placement activities, though it is expected the Hospital will obtain assistance from its consultant on developing the capacity.

Compliance Status: Partial.

Recommendations				Responsible Party
1 *Provide an assessment of the discharge placements to which the hospital refers individuals to determine the specific skills that will be necessary for successful community living in those placements.*				***CVC; JH; MHA***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Develop inventory of housing and community support services.	10/31/2008		DMH Authority Alvin Hinkle	
2 Implement and continue review of cases with three or more hospitalizations within a year to identify trends or themes. Based upon assessment, modify contracts as needed. *Status: Project is ongoing*	6/27/2008	See Tab # 77 (Power point of data of cases involving 3 or more hospitalizations in a year)	DMH Authority	
3 Train hospital social work staff on levels of care of various housing and services. ***Complete*** *Status: Social workers trained on levels of care*	3/31/2008		Authority	
4 Review contract language concerning services to be provided patients upon release from hospital	12/31/2008		Authority	
2 *Provide an adequate number of mall groups that teach these skills with manual based curriculum.*				***CVC; Trg;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Collect data on patient diagnoses and provide data to give baseline information on patients' clinical profiles. *Status: Ongoing*	7/31/2008	Clinical Profile of Inpatient Population, Tab # 55	OMS	
2 Hire Treatment Mall administrator *Status: Interviews are underway.*	8/29/2008		CVC	
3 Obtain consultation on assessment of treatment needs based upon clinical profile of patient population and adjust groups accordingly.	12/31/2008		CVC	
4 Develop manual based mall curriculum.	3/31/2009		CVC	
5 Train group leaders on new curriculum and assess qualifications to lead interventions.	6/1/2009		CVC, Office of training.	

3 Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. ***CVC; Angela***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop priority list of auditing tools required by DOJ	8/15/2008		Chief of staff
2 Work with consultant to develop tool that monitors treatment mall groups.	5/1/2009		CVC

4 Train auditors to acceptable levels of reliability. ***CVC;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop capacity to train auditors, working with consultant	11/28/2008		Chief of staff, Training dept.
2 Begin process of training auditors in order reflected in priority list of auditing tools.	12/31/2008		Training dept

5 Provide operational definitions of all terms in a written format to aid in data reliability and validity.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop capacity to create operational instructions/definitions and create as needed.	11/28/2008		Chief of staff

Status: Consultant has begun consultation.

VII.E.

Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of

Findings

The Hospital modified and then piloted a revised Discharge Record review tool that looks at whether patients were referred to appropriate sets of services and supports. That tool is under review by the consultant for comments, but a pilot review was conducted.

Discharge monitoring found that in only 26 % of records reviewed included information that reflected services and supports appropriate to the patient's condition that will be effective at the time of discharge. (30% of records reviewed rated this as partially met). Tab # 28 (Discharge Record Review Analysis). Instructions sheets of follow up were provided to patients in 59% of records reviewed, but were not provided at all in 33% of records reviewed.

DMH does have specific continuity of care guidelines that establish the discharge planning process and expectations. Tab # 75 (Continuity of care guidelines) The DMH is tracking whether patients are seen after their discharge. FY 2007 data shows that 73% of patients are seen within 7 days, 1% seen between 8-30 days, 3% seen greater than 30 days, and 23 % are never seen. Tab # 76 (Continuity of care Data for St. Elizabeths). However, at this time, DMH is not tracking other aspects of continuity of care so there is no data available as to whether the discharge plan is implemented upon discharge.

The Hospital developed separate forms for discharge, transfer and death summaries, but only the transfer form is in use as the others will not be finalized until the related policy is approved . See Tab #s 78, 79, 80.

Compliance Status: Noncompliance

Recommendations	***Responsible Party***

1 *Develop separate forms for Transfer, Discharge and Death summaries.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop separate forms for transfers, discharges and deaths.	6/15/2008	See Transfer form Tab # 79; See draft forms for Discharge and Death, Tab #s 78, 80	J Taylor

Complete *Status: Developed three separate forms for Transfer, Discharge, and Death Summaries. Transfer form attached to Transfer Policy. Remaining forms not yet approved.*

2 *Clarify policies and procedures to assure that the Discharge Summary is to include documentation that the information about the discharge treatment needs of the individual has been communicated to the outpatient providers.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise current patient discharge policy.	9/15/2008	Discharge Policy, Tab # 69	J Taylor

Status: Policy approved

3 *Develop and implement an auditing tool to monitor each section of the Discharge Summary for compliance with the DOJ agreement.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise Discharged record review instrument. *Status: Instrument has been modified/*	7/30/2008	Discharge tool Tab # 27; Results of Discharge record audit, Tab # 28	QI director
2	Review tool upon completion of revised discharge policy and modify as needed.	10/15/2008		QI director
3	Provide report summarizing results	7/31/2008		QI Director

Complete

4 *Auditors must be trained to reliability.* ***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop training protocol that ensures inter-rated reliability. *Status: A small cohort of reviewers were trained on the Protocol, and the protocol was piloted. Some adjustments were made based upon feedback from the reviewers. Additional training will be provided once the tool is finalized, indicators and operational instructions are finalized.*	8/29/2008		QID
2	Work with consultant to assess rater reliability.	9/30/2008		Chief of staff, PID

5 Provide operational definitions of all terms in a written format to aid in data reliability and validity. ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide discharge record tool and guidelines to consultant for comment. ***Complete***	7/15/2008		Chief of staff
2	Work with consultant to develop operational instructions.	10/31/2008		Chief of Staff, QID

VII.F.

By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:

Findings

The Authority monitors discharge process and aftercare services in two ways. First, it is has an on-going review of cases in which a person is hospitalized three or more times in a year. See Tab # 77 (Pilot project). In addition, it collects data on whether persons are seen within 7 days, 30 days or not all post hospitalization. See Tab # 76 (Continuity of care data from DMH). That information is shared with executive staff of the Department.

However, DMH is not yet monitoring whether discharged patients are receiving the other supports recommended at discharge, the frequency of patients being seen in the context of each discharge plan, or other aftercare services.

Compliance Status: Noncompliance.

Recommendations — ***Responsible Party***

1 Develop and implement policies and procedures that specify which staff members are responsible for this aspect of community placement follow up, the timeliness by which data is to be collected and aggregated and an auditing tool that monitors compliance.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review continuity of care guidelines and modify as needed.	9/30/2008		DMH
2	Review contracts of providers to ensure appropriate community follow up of all services is required.	11/28/2008		DMH
3	Develop capacity to monitor compliance with contractual community service requirements.	11/28/2008		DMH
4	Conduct monthly reviews of 20% of all discharged patients in prior month to assess if patient was seen and if services identified by Hospital as needed have been provided and report results.	12/31/2008		DMH

2 Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop tools and ensure auditors are trained	12/31/2008		DMH

3 Present data to hospital administration and Social Work chiefs for appropriate follow-up action.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Present on a monthly basis to Hospital managers data around readmission rates and patient follow up.	6/30/2008		Authority
2 Social work to review data and determine if modifications needed to discharge process. If so, work with Authority to address issues.			

4 Submit a plan for how many additional staff are needed to implement the above recommendations and a timeline for hiring them.

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

VII.F.1

developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and

Findings

See VII. F

Compliance Status: See VII.F

Recommendations	*Responsible Party*
1 Same as above.	

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

VII.F.2

hiring sufficient staff to implement these provisions with respect to discharge planning.

Findings

See VII. F

Compliance Status: See VII. F.

Recommendations	*Responsible Party*
1 Same as above.	

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

VIII. Specific Treatment Services

Summary of Progress

1. The Hospital continues to implement some self-assessment activities that monitor the presence of discipline assessments. See Tab # 6 (IRP Process Monitoring Tool). See Tab # 7 (Results of IRP Process Monitoring).

2. The Hospital has not initiated clinical audits or peer review for disciplines other than rehabilitation services and is still working to perfect the clinical audit tools. Consequently, the quality of assessments upon which treatment recommendations are based has not been evaluated.

3. The Assessment and Treatment Planning policies have been revised to require regular updates of patients response to treatment. Implementation is expected in August.

4. The Hospital has made significant progress in Pharmacy services. The Department is now staffed by 8 pharmacists, medication guidelines have been developed, pharmacist monthly reviews of every patients record for medication issues began in July, and a campaign around ADR and medication variance reporting is underway. An automated information system for medication orders, pharmacy and laboratory was introduced in late July, 2008. The system will allow for better tracking of medication use and laboratory monitoring.

5. The Hospital has not yet developed a mechanism for monitoring long term use of certain medications and whether there is adequate documentation supporting decisions not to change medication to safer alternatives.

6. The Hospital is in the final stages of revising its mortality review system to include peer review, investigation and interdisciplinary review and external review. The revised system is expected to be finalized by end of September, 2008.

7. There has not been any significant progress in the development of behavior supports or plans. Civil Services created a behavior management unit (RMB 3) but staff have not yet been provided training on positive behavior support. Two consultants are expected to work with ward staff on implementing positive behavioral support.

8. The Co-occurring Disorder program has not progressed in a significant way. The Director resigned in July, but a cadre of staff are expected to graduate from the COSIG training program in August, 2008. An overview of stage of change was presented to Senior staff. Tab # 60 (Outline of stage of change power point). Stage of change is expected to be incorporated into the upcoming treatment plan training.

9. There have been some modifications to the treatment mall although it is still not manual- based with a curricula for the groups and is not functioning at the level required. A new referral form for treatment mall was developed in an attempt to elicit more information and better match patients with groups; based upon feedback from the pilot, the form is being modified again. With the opening of RMB 3 as a Behavior Management Unit, (Tab # 96) the Behavioral Management Program at the Treatment mall has been revised. It serves 11 patients and now hastwo tracks instead of three. Psychology is more involved in the program, and patients and staff worked together to develop group rules. It also modified the token economy program. The Cognitive Skill Development Program (22 patients) has three tracks. There also has been more involvement on psychology in that program but social work has reduced its commitment. The Co-occurring Disorder program serves 24 patients and now has two tracks that are based upon both stage of change and the level of functioning. The program is small compared with need. The Psycho-social program has 40 participants, and operates 4 tracks. There is also a community reentry group program described in Section VII. See Tabs # 58 (Description of treatment mall programs)

10. In an effort to strengthen nursing services, the Hospital is recruiting for a Director of Nursing, who will lead

	nurse education and development of nursing procedures. A new initial nursing assessment was developed and will be implemented in August; nursing diagnoses were discontinued. A second nurse educator was hired. Money was identified for training related to symptoms of physical illness and around seclusion and restraint and solicitations were announced. Nursing staffing has increased. See Tab # 11 (HR Report). A change of shift template was developed and will be implemented by August. Tab # 81 (Change of shift report). 11. The Hospital finalized its Tardive Dyskinesia policy and now requires AIMS tests at regular intervals. See Tab # 82 (TD policy). The policy was reviewed with Medical Staff by the Neurologist, but data is not yet available and there is no clinical monitoring occurring to track compliance. 12. The Infection Control Program has not made any progress. The infection control manual is not yet finalized, and there is not yet the capacity to identify or monitor key indicators. 13. An Environmental Survey was completed during this quarter and results provided to the Senior staff, infection control committee, and risk management and safety committee. See Tab # 83 (Environmental Survey). 14. A patient advisory committee was created for Civil services and meets monthly with leaders.
VIII. Specific Treatment Services. Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Findings** See specific sub-cells below **Compliance Status:** See sub-cells below.
VIII.A. Psychiatric Care By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	**Findings** See Sub-cells **Compliance Status:** See sub-cells.
VIII.A.1 By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	**Findings** See sub-cells **Compliance Status:** See sub cells.
VIII.A.1.a	**Findings**

documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;

See VI.a.1- 7. Review of records shows that Psychiatric assessment and reassessments are occurring but not as frequently as required by the Agreement nor do they consistently meet the quality expected. Data are not available however to assess the scope of the issue, but will be once clinical chart reviews begin.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 *Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. *Status: Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c*			

2 *Same as in VI.A.7.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7.*			

VIII.A.1.b

documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;

Findings

See VI.A.7. Some progress has been made, but there are still gaps in psychiatric documentation of significant developments in a patient's clinical status and psychiatric follow up with rationale. Data are not available however to address the scope of the issue, but will be once clinical chart reviews begin.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.c

timely and justifiable updates of diagnosis and treatment, as clinically appropriate;

Findings

See VI.A.7

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.d

Findings

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

See VI.A.7.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Same as in VI.A.7.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.e

assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;

Findings

See VI.A.7. An expanded section in the initial psychiatric assessment form is expected to improve practice on this requirement.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Same as in VI.A.7.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.f

documentation of, and responses to, side effects of prescribed medications;

Findings

See VI.A.7.

The campaign to improve reporting of ADRs should improve documentation around side effects of medication.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Same as in VI.A.7.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.g

documentation of reasons for complex pharmacological treatment; and

Findings

See VI.A.7

Phase I of AVATAR will allow for better monitoring of use of complex pharmacological treatment by patient and physician, but management reports will need to be developed to track this practice.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Same as in VI.A.7.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

VIII.A.1.h

timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.

Findings

The Hospital currently lacks the capacity to track STAT medication. Its capacity to track administration of STAT medication will be enhanced upon implementation of Phase I of AVATAR, on July 22, 2008 and when crystal reports are developed. No tool has yet been developed to assess use of STAT or PRN medications.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 Same as in VI.A.7.	*AS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.7. *Status: Same as in VI.A.7*			

Recommendations	*Responsible Party*
2 Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications.	*AF; PID; AS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review current medical records policy, pharmacy policy and involuntary administration of medication policy to determine if clarification is needed regarding PRN or STAT medication. ***Complete***	7/31/2008	Involuntary administration of medication policy, Tab # 84; Pharmacy Policy, Tab # 85	Medical Director
2 Implement AVATAR application relating to pharmacy *Status: Stat orders and medication are included in phase 1 around medication orders*	7/22/2008		COO; Medical Director
3 Develop report by patient and physician that will track use of STAT medication and PRN medication. *Status: A Management Report Development Plan for all Avatar Management reports will be drafted for review and prioritization by the Avatar Steering Committee.*	9/30/2008		Lois Branic / Sharmaine Allen
4 Monitor use of STAT and PRN medication through management reports	10/31/2008		Medical Director

3 Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff. ***AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Design a monitoring tool for record review based upon information from Crystal report to assess compliance with policy.	11/13/2008		PID
	Status: Advertisement for Crystal Report writers expect to fill position by July 31, 2008.			
2	Identify and train staff on tool and begin reviews, using 20% sample of prn orders and stat orders	12/10/2008		Medical Director

4 Provide monitoring data based on 20% sample (March to August 2008). ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Review and analyze the sample data and present summarized findings to Exec staff and Medical Staff Executive Committee.	1/30/2009		PID

VIII.A.2

By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:

Findings

See sub-cells

Compliance Status: See sub cells.

VIII.A.2.a

monitoring of the use of psychotropic medications to ensure that they are:

Findings

See sub cells.

Compliance Status: See sub cells.

VIII.A.2.a.i

clinically justified;

Findings

Medication guidelines have been developed and were made available to all physicians in early June, but it not yet clear the extent that they are being followed since no monitoring tool has yet been developed and audits have not yet begun. Tab # 54 (Medication guidelines). Beginning July 22, 2008, medication and laboratory orders are being made through the AVATAR system, so the Hospital will have the capacity to track medications by type, dosage, length of use etc (once reports can be developed). Also, beginning in July, 2008 with a full staff of 8 pharmacists, each patients medication will be reviewed monthly be a pharmacist. See Tab # 86 (Chart Review form). Information from the pharmacists' reviews will be systematically collected and reviewed by the Pharmacy and Therapeutics committee.

Summary data is now available about drug communications from Pharmacy to doctors. See Tab # 87 (Drug Alert Communications Analysis). The data shows there were 54 alerts involving 40 patients and 16 doctors during the first 6 months of CY 2008. Of those, 42 % involved clarification of dose or drug. See report for drug alert communications more specific results.

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	***Responsible Party***
1 Develop and implement monitoring tools with indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).	***AF; PID; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Establish guidelines for use of high risk medications.	6/30/2008	Medication guidelines Tab # 54	Medical Director
Complete *Status: Guidelines established.*			
2 Pharmacy, P & T Committee and QID develop monitoring tool and operational instructions to monitor compliance with guidelines..	10/31/2008		Medical Director; QID
Status: No action yet taken.			
3 Develop Crystal Report that will report patients prescribed high risk medications.	10/15/2008		COO
Status: A Management Report Development Plan will be developed by 8/30/08 for all Avatar Management reports will be drafted for review and prioritization by the Avatar Steering Committee. In the interim, information in the patient database will provide some data that can be used to monitor use of high risk medications.			
4 Train auditors and begin audits.	11/19/2008		Medical director

Recommendations	***Responsible Party***
2 Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008).	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.A.2.A recommendation 1.			PID, Pharmacy, and AF
Status: See VIII.A.2.A recommendation 1.			
2 Analyze the results of monitoring data.			PID, P and T Committee

Recommendations	***Responsible Party***
3 Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).	***AF; P&T Committee***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).			
Status: Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation)			

VIII.A.2.a.ii

Findings

prescribed in therapeutic amounts, and dictated by the needs of the individual;

Same as above

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Same as above.	

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

VIII.A.2.a.iii

tailored to each individual's clinical needs and symptoms;

Findings

Same as above

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Same as above.	

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

VIII.A.2.a.iv

meeting the objectives of the individual's treatment plan;

Findings

Same as above.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Same as above.	

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

VIII.A.2.a.v

evaluated for side effects; and

Findings

Same as above.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Same as above.	

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

VIII.A.2.a.vi

Findings

documented.

Same as above.

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Same as above.	

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

VIII.A.2.b

monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:

Findings

See sub-cells for findings.

Compliance Status: See sub cells.

VIII.A.2.b.i

develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;

Findings

Medication guidelines have been completed and are attached in Tab # 54. The guidelines for use of clozaril have been revised and sent to Pharmacy and Therapeutics committee for review and input.

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and clinical and laboratory screening and monitoring requirements.	*AF;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop individualized psychotropic medication guidelines.	7/22/2008	S.E.H Medication Guidelines Tab # 54	Harrison/Zerislassie/ P&T
Complete			

Recommendations	*Responsible Party*
2 Revise the clozapine guideline to ensure alignment with current generally accepted standards.	*AF;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Clozapine guideline.	7/22/2008		Medical Director, Harrison/Zerislassie/ P&T
Status: Drafted revision completed - being reviewed by Pharmacy and Therapeutics Committee.			

3 Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. — ***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update S.E.H Medication Guideline Manual regularly.	7/22/2008		Harrison/Zerislassie/ P&T
Complete *Status: Monthly review of S.E.H Medication Guideline Manual*			

VIII.A.2.b.ii

develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of

Findings

See sub-cell VIII.A.1.h.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Same as in VIII.A.1.h.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VIII.A.1.h.			
Status: Same as in VIII.A.1.h.			

VIII.A.2.b.iii

establish a system for the pharmacist to communicate drug alerts to the medical staff; and

Findings

The Pharmacy has the capacity and is communicating drug alerts to physicians. In addition, the Hospital developed a tracking system and has the capacity and is aggregating and categorizing those alerts in a systemic manner. See Tab # 87 (Summary of Drug Alert Information). This information will be presented to the Pharmacy and Therapeutics Committee on a regular basis.

Compliance Status: Progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Develop a tracking log regarding drug alerts that were communicated to the medical staff during the review period.	***AF; PID; PID with AF***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a Tracking Log for drug alerts.	7/31/2008	Drug Alert Form Tab # 88	Harrison/Zerislassie
Complete *Status: Tracking log is in draft. Expected to be finalized by July 31, 2008.*			
2 Work with PID, OMS to develop tracking log on drug alerts, and analyze same.	8/29/2008	Summary of Drug alert, Tab # 87	OMS
Complete			

VIII.A.2.b.iv

Findings

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.

The Hospital does not yet have a drug utilization policy and no drug utilization analysis in on-going. There is no Hospital wide ADR or Medication variance policy, although some tracking and analysis is on-going while the policy is being developed. See Trend Analysis, Tab # 8, 21. That data suggests that some units are not reporting ADRs or medication variances. In an effort to improve reporting, the Hospital is conducting an information campaign. See Tab # 89 (Campaign materials).

The Hospital is hiring "crystal report" developers who will develop the reports so that drug utilization, ADRs and medication variances data by medication, practitioner, unit, etc, can be obtained in a systemic manner and analyzed. In the meantime, pharmacy tracks all reports of ADRs and medication variances, which is then presented monthly to the Pharmacy and Therapeutics Committee. See Tab # 90 (ADR/MedVar reports to P & T since Feb 1). Psychiatric peer review has not begun and therefore there is no systemic review of ADRs. It is noteworthy that Pharmacy will begin monthly reviews of each patient's clinical chart and thus some additional information about ADRs or medication variances may be forthcoming.

The Hospital is currently revising its Mortality review system to include: 1) medical peer review; 2) Risk Manager investigation; 3) interdisciplinary review; and 4) external review. The policy is expected to be finalized by the end of September, 2008.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations				***Responsible Party***
1 *ADRs: a. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs:*				***CVC; JH; AF;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Campaign to increase reporting of Adverse Drug Reactions and Medication Errors	8/29/2008	Posters, newsletters, and Medmarx overview, Tab # 89	Harrison/Zerislassie/ P&T	
Status: Campaign started 6/16/08				
1 *ADRs: b. Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified above*				***AF; PID; AF with PID***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Develop an updated ADR policy.	9/15/2008	Pending	J Taylor	
Status: Policy is working with Pharmacy and researching ADR policy information				
2 Pharmacy will collect information about ADRs and will report same to P & T committee monthly.	6/30/2008		Pharmacy	
Status: Information is reported to P & T Committee monthly.				
3 Data collection tool will be developed and data collected will be analyzed and presented to P & T Committee.	9/30/2008		Pharmacy	
4 Pharmacy and Therapeutics committee to review DOJ recommendations and develop prioritization.	9/17/2008		P & T Committee.	

1** ADRs: c. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs* — ***AF; PID; AS; PID with AF

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Assist the pharmacy in improving ADR data collection from the MEDMARX and analyze the findings.	8/29/2008		PID, & Pharmacy
2	Implement AVATAR application *Status: . The system will have the functionality to report on ADRs; A management report will be developed pending hiring of crystal report writers*	8/29/2008		COO; Pharmacy

1** ADRs: d. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations* — ***P&T Committee

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish severity/outcome thresholds. *Status: No action taken.*	12/31/2008		Medical Director, P & T Committee
2	Develop system for intensive case analysis.	2/28/2009		Medical Director
3	Begin case analysis.	3/31/2009		Medical Director, Pharmacy and Therapeutics Committee

2** DUEs: a.Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines:* — ***AF; PID; AS; AF with PID; P&T Committee

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a DUE policy. *Status: Researching DUE policy and expect final policy by 9/15.*	9/15/2008	Pending	J Taylor
2	Implement the AVATAR *Status: The system will have the functionality to report on Drug utilization patterns; A management report plan will be developed to prioritize report development.*	9/30/2008		COO; Pharmacy
3	Pharmacy to evaluate medication use in context of medication guidelines, with consultation from P & T Committee.	9/30/2008		Pharmacy
4	Develop reports relating to drug utilization.	12/31/2008		COO

2 *DUEs: b. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses* — ***AF; AS; P&T Committee***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps VIII.A.2.b recommendation #2 *Status: See VIII.A.2.b recommendation #2*			

2 *DUEs: c. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance* — ***P&T Committee***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Drug utilization policy. *Status: Policy is expected by 9/15/08.*	9/15/2008		Taylor
2	P & T committee to make recommendations about the method and timing of a system to evaluate medications uses.	9/15/2008		P & T committee
3	See action steps for VIII.2.A.b recommendation 2 a			

2 *DUEs: d. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends* — ***PID; AS; P&T Committee***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	OMS to support Pharmacy and AVATAR system by developing analysis of available information at least quarterly	3/31/2010		Pharmacy, OMS
2	Develop Crystal Report needed to support data collection.	2/28/2009		COO

3 *MVR: a. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above* — ***AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Assist the Medical Director to design a user-friendly data tracking tool to collect MVR information.	10/31/2008		PID
2	Analyze the data from the tools and present summarized findings and results.	12/31/2008		PID, AF
3	Pharmacy/P & T Committee to lead policy development with support from PID.	9/15/2008		Pharmacy, PID
4	Data to be presented to Exec staff and P & T Committee.			

3 MVR: b. Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances ***AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Campaign to increase reporting of Adverse Drug Reactions and Medication Errors *Status: Campaign started 6/16/08*	6/27/2008	Posters, newsletters, and Medmarx overview, Tab # 89	T Harrison
2	Develop system to input medication variance reports that will allow for analysis of type, cause and staff involved.	9/19/2008		T Harrison; OMS
3	Develop reports that reflect data and analysis.	10/31/2008		T. Harrison; COO; OMS

3 MVR: c. Provide instruction to all clinicians regarding the significance of and proper methods in MVR ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop new Medication Variance Policy. *Status: No action taken yet*	10/15/2008		J Taylor
2	Train all clinical staff in medication variance policy and reporting.	12/31/2008		Pharmacy

3 MVR: d. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances ***AF; PID; PID with P&T Committee***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.A.2.b.iv.3.a *Status: See VIII.A.2.b.iv.3.a*			

3 MVR: e. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations ***AF; P&T Committee***

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

3 MVR: f. Ensure that MVR is a non-punitive process ***AF;***

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

4 Mortality reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: — ***AF; PID; PID with AF***

a Definitions of expected and unexpected deaths;

b Delineation of first response activities, including the roles/responsibilities of different parties in the facility;

c An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and death summaries;

d An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and

e Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise an integrated Mortality Review policy that includes peer review and incorporates the DOJ requirements to include an interdisciplinary review and external review.	9/15/2008		J Taylor
Status: Incorporating DOJ requirements into the existing Mortality Review policy.			
2 Assess sentinel event policy as well	9/17/2008		J. Taylor

VIII.A.3

By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.

Findings

Significant progress has been made on the psychiatric staffing levels with 6 psychiatrists set start between July and September, 2008. Of the six, two will be deployed to JHP (one on JHP 9 and one on JHP 8). The four other psychiatrists will be deployed to the civil side, with two going to admission units. Attached at Tab # 25 are the current (as of the date of this report) staffing for each of the twenty units, all disciplines. An updated staffing plan will be provided on the first day of the September 22, 2008 visit.

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

Recommendations — ***Responsible Party***

1 Identify and resolve barriers towards recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units. — ***AF; PJC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Prioritize filling clinical vacancies including psychiatrists.			James Gallo
Status: Six new Medical Officers (Psychiatrists) will join the medical staff before the end of the fiscal year and the Hospital is continuing to recruit for additional psychiatric staff. Two will be assigned to JHP and 4 to civil programs. With these psychiatrists, both civil admissions units will have 2 psychiatrists.			

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2 HR will provide bi-weekly the on board strength (separations vs. hires including projected hires) for FY 2008.	7/7/2008	Tab # 91 HR Report	James Gallo

Status: Ongoing

2 Provide summary data of case loads of current psychiatrists in all admission and long-term units. The case loads should be based on FTE status. ***AF; AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.A.3 at recommendation 1		See also attached ward staffing charts for civil and forensic services, Tab # 25.	

Status: Of the six new psychiatrists, 2 will be assigned to forensic wards 7 and 8; 2 will be assigned to Civil Admissions units, and 2 will be assigned to civil hospital as well. The AVATAR application will be able to report on caseloads for psychiatrists.

VIII.A.4

SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:

Findings

See findings in V.A.2.e and VI.A.7.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Same as in V.A.2.e and VI.A.7.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.A.2.e and VI.A.7.			

Status: Same as in V.A.2.e and VI.A.7

VIII.A.4.a

ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;

Findings

Same as above. The Hospital is only now expanding the use of behavior plans, and staff are in early stages of training on development and implementation of the plans. The assignment of psychologists to each unit is expected to improve communication between psychiatrist and psychologists and the rest of the treatment team.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Same as above.

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

Status: Same as above.

VIII.A.4.b

Findings

ensure regular exchanges of data between the psychiatrist and the psychologist; and

Same as above.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

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

VIII.A.4.c

integrate psychiatric and behavioral treatments.

Findings

Same as above

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

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

VIII.A.5

By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.

Findings

Same as in VI.A.7 and subsections VIII.A.1 and A.2.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations				Responsible Party
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				
Status: Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2				

VIII.A.6

By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.

Findings

Presently, substance abuse screenings are to be completed upon admission using the MIDAS tool. Data since March, 2008 shows a decline in the number of patients being screened using the MIDAS tool, from an average of 77% prior to March, 2008 to an average of 40% for the period of March to June, 2008. Tab # 100 (Substance abuse and smoking assessment review findings).

One issue with completion of the MIDAS was lack of clarity about who should perform the assessment. The Hospital amended its Assessment policy and now requires the psychiatrist during the initial psychiatric assessment to assess substance abuse disorders (alcohol, drugs, smoking). Tab # 39 (Assessment Policy). In addition, the initial psychiatric assessment form also prompts the psychiatrist to complete this assessment. Tab # 38 (Initial Psychiatric Assessment form).

The IRP process monitoring form currently evaluates whether the treatment team reviewed stages of change as it relates to substance abuse disorders as part of the treatment planning conference but data is not available as of the writing of this report. See Tab # 6 (IRP Monitoring Process form). In addition, the clinical chart audit tool evaluates the screening for substance abuse, but the Hospital is currently working with the consultant of refining the clinical audit tool and deciding whether to have a separate audit tool. The current draft (pre-consultant comments) is attached at Tab # 46 (Clinical chart audit tool).

The Director of Co-occurring Disorders Program resigned in July, 2008.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations			***Responsible Party***
1 *Present the facility's policy and procedure regarding the screening of substance use disorders.*			***AF; PID; AF with PID***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Assessment policy to include requirements around assessment for substance abuse. *Status: Completed.*	7/15/2008	Assessment Policy, Tab # 39	Medical Director; PID
2 Incorporate substance abuse screening questions into initial psychiatric assessment. *Status: Piloting of initial psychiatric assessment will begin August 1, 2008.*		Initial psychiatric assessment, Tab # 38	
2 *Develop and implement a substance use chart audit tool with indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP.*			***AF; PID; BG;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Make decision whether to include substance abuse standards in clinical chart audit tool; if so revise tool, if not develop new tool. *Status: Consultant on board to assist in evaluating current clinical chart audit tool and to provide technical assistance in development of tools*	9/25/2008		Medical director; Chief of staff, PID

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2 Finalize tool and begin audits.	11/3/2008		Medical director
Status: No progress			
3 Compile the data and analyze them for further review and presentation.	12/22/2008		OMS
Status: No progress			

3 Provide monitoring data based on at least 20% sample (March to August 2008). — ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze the monitoring data.	11/28/2008		PID & QIC
Status: No monitoring has begun yet.			

4 Same as V.D.1.

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

VIII.A.7

By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.

Findings

The Hospital revised its Tardive Dyskinesia policy, but in most cases, psychiatrists are not formally (and in writing) including the results of these examinations in the notes relating to risks and benefits of medication; if TD has been diagnosed, it is not addressed in the IRP on a consistent basis.. In addition, the Hospital created a patient data base to bridge the period until AVATAR is fully up and running. See # Tab 61 (Patient data base screen shots). The Hospital's patient database is tracking TD diagnosis, although it is still dependent on physicians entering this information, so it believes that the incident of TD remains underreported at this time. Data from the patient data base shows that 17 patients, or 4% of the patient population, have been diagnosed with Tardive Dyskinesia. Tab # 55 (Clinical Profile of Patient Population)

The Hospital has not yet created an auditing tool or indicators and does not yet monitor compliance with the TD policy.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	***Responsible Party***
1 Finalize the policy and procedure regarding TD, including the information suggested by this expert consultant above.	***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review and revise TD policy.	5/30/2008	Tardive Dyskinesia policy, Tab # 82	Medical Director; PID
Complete *Status: Policy completed.*			

2 Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement. ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	QID to work with Neurology to develop monitoring tool, with support from consultant. Also will develop operational instructions and indicators *Status: Not yet begun*	10/1/2008		Medical Director
2	Train auditors and begin audits *Status: No progress*	11/17/2008		medical Director

3 Provide monitoring data based on a review of a 100% sample (March to August 2008). ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	PID will analyze the collected data on TD using data in the Patient Data base until Phase II in AVATAR is implemented. *Status: Patient data base is operational, but data entry is still not reliable.*	8/29/2008	Clinical profile report, Tab # 55.	PID, AF

VIII.B. Psychological Care

By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.

Findings

See sub cells for findings

Compliance Status: See sub cells for findings

VIII.B.1

By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:

Findings

See sub cells for findings

Compliance Status: See sub cells for findings

VIII.B.1.a

ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment re

Findings

The Hospital undertook several initiatives to address this requirement, although at this time it is still does not have a clear mechanism in place to ensure patients in need of screenings for behavior plans are screened. Additionally, it is not auditing or monitoring records to evaluate whether the appropriate patients are being referred for PBSPs. Steps to address this requirement include the assignment of a psychologist to each of the civil and forensic admission units, who will conduct admission risk and cognitive screens and work with treatment teams to identify patients who would appropriate candidates for behavior plans. See Tab # 25 (staffing of psychologists). In addition, it created a Behavior Management unit (RMB 3) and assigned a psychologist to the unit full time who will assist staff in identifying patients on that unit who may be in need of behavioral plan. Training on the Positive Support Behavior model for psychology staff and RMB 3 staff just began, and it will be expanded to all staff. See Tab # 96.

In addition, the Hospital increased psychology staffing by filling 2 positions, and is advertising for two clinical administrator psychologist positions.

The Director of Psychology has advised psychology staff that seclusion and restraint should not be included in a Positive Support Behavior Plan. See Tab # 92 (Memorandum from Rose Patterson).

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

	Recommendations	***Responsible Party***
1	*Develop and implement a mechanism to ensure that all individuals who may be in need of Positive Behavior Support Plans/Behavioral Guidelines receive appropriate screening for such services. This will likely necessitate that psychologists provide an initial assessment of all newly admitted individuals and that the Department develops and implements a timeline for the assessment of those individuals who were admitted in the past and are still at the hospital.*	***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	The Psychology Department will develop a transfer summary for all patients transferred from the admissions/pretrial areas that will specifically address the need for any needed psychological assessment/behavioral plans. *Status: Not yet developed.*	9/30/2008		Dr. Patterson
2	The Psychology Department will re-evaluate all patients that are currently in the hospital for the need for further testing/behavioral plans.	12/30/2008		R. Patterson
3	Assessments/behavioral plans will be completed on those patients identified through the above referenced review.	3/27/2009		R Patterson

	Recommendations	***Responsible Party***
2	*It does not seem possible that the hospital would be able to achieve the above and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists.*	***AF; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Prioritize filling psychologist vacancies. *Status: The Hospital is actively recruiting for three psychologists and has filled 10 permanent clinical psychologist positions in FY 2008 to date. Four Clinical Psychology Interns are scheduled to report to duty on July 1. In addition, the Hospital is recruiting for 2 clinical administration psychologist.*	8/25/2008	Vacancy announcements for psychologists Tab # 93	James Gallo

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2 HR will provide the on board strength for psychologists (separations vs. hires including projected hires) for FY 2008. *Status: Ongoing.*	7/7/2008	See HR Report Tab # 91	James Gallo
3 The Psychology Department will submit a request to the hospital administration for sufficient additional psychology positions to correspond with the recommendation of the DOJ if needed; one psychologists for every ward of the Hospital and three additional psychologists with expertise in behavioral plan development..	8/29/2008		Dr. Patterson

3 Develop and implement an auditing tool that is used for the review of medical records to assure that when all newly admitted individuals are required to receive a psychological screening to determine the need for Positive Behavior Support Plans/Behavioral Guidelines, compliance with this requirement can be tracked. ***AF; PID; AF with PID***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include assessment of this requirement in psychology peer review process.	8/30/2008		Dr. Patterson

4 Develop and implement an auditing tool for the review of the records of those individuals already admitted to the hospital to determine if they would benefit from the use of Positive Behavior Support Plans/Behavioral Guidelines. Among the items that the tool must audit are: individuals with multiple acts of self-harm or aggression; individuals with multiple instances of seclusion and/or restraint; individuals who are not making appropriate progress toward discharge; and individuals who are subject to polypharmacy. ***AF; PID; AF with PID***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Behavioral Consultant will work with Dr. Patterson to develop method/tool for assessing patients	12/30/2008		R Patterson
2 Implement assessment tool as psychologists are hired to work on each ward.	3/27/2009		R Patterson

5 Train auditors to acceptable levels of reliability and provide operational definitions of all terms in a written format to aid in data reliability and validity. ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify staff to serve as auditors.	2/13/2009		R Patterson
2 Train on tools and instructions.	4/17/2009		R Patterson

6 *Establish by clear policy that the planned use of seclusion and/or restraint as part of a behavioral intervention is clearly prohibited.* ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise Seclusion and Restraint policy to include restriction into policy.	6/15/2008	Restraint and Seclusion for Behavioral Reasons, Tab # 48	J Taylor
	Complete *Status: Restrictive language has been incorporated into policy document.*			
2	Psychology Director to disseminate a memo and discuss with staff in Department Meetings that there is to be no mention of S/R as an integral part of behavioral programs.	6/30/2008	Copy of the memo to staff, Tab # 92	Dr. Patterson
	Complete			

VIII.B.1.b

ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the indiv

Findings

A review of 4 recent behavior plans suggest that the issues identified in the Baseline Report have not yet been corrected, although the Hospital has contracted for assistance to work with Psychology staff around development of behavior plans that meet the parameters set out on in the Report. See Tab # 9 (Angela Adkins contract); Tab # 24 (Dan Arnheim contract). Further, psychology department is finalizing standards for each kind of report, which is expected to address this requirement. It will then monitor reports against the developed standards.

Compliance Status: No progress is being made toward the December, 2008 compliance date.

Recommendations ***Responsible Party***

1 *Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. At a minimum, such plans include:* ***AF; Sam Feinberg***

- *a* *A description of the maladaptive behavior*
- *b* *A functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior*
- *c* *Documentation of how reinforcers for the individual were chosen and what input the individual had in their development*
- *d* *The system for earning reinforcement*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Hire Consultant and begin training Psychology staff.	6/27/2008	Copy of Contract for Dan Arnheim Tab # 24	Rose Patterson
	Complete *Status: Consultant has begun work. Chief Psychologist has shared the needed information with the consultant to ascertain that these issues are addressed in the training.*			
2	Training to begin in mid-July and will be ongoing.	7/30/2008		Rose Patterson

2 *The use of individualized token economies in the development of behavioral interventions is strongly discouraged, as the more individuals are placed on such plans the more unwieldy individualized token economies will be to implement. Rather, it is recommended that the hospital consider the adoption of a unit-based token economy in which all individuals are rewarded over the course of the day for generally accepted prosocial behaviors appropriate to specific time frames, e.g., attention to ADLS; meal attendance; mall attendance; and appropriate use of unstructured time. These systems are much easier to administer, and the hospital may find it advantageous to develop and pilot such a program on one unit or series of units as part of an overall plan of implementation.* ***CVC;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish a pilot ward-based token economy for RMB 3, the designated behavioral treatment ward.	7/1/2008	Copy of the token economy program description for RMB 3, Tab # 96	Dr. Michele Marsh with Dr. Patterson
	Complete *Status: Ongoing*			
2	Restart the Clinical Consultation Support Team (CCST) as a multi-disciplinary team, led by a licensed psychologist, Dr. Michele Marsh.	7/25/2008	CCST Appointment letters, Tab # 95	Dr. Marsh with Dr. Patterson
	Complete *Status: THE CCST did not function between March and July, as the prior team leader left the Hospital. It has been reconstituted.*			
3	Define the role of the ward psychologist regarding behavioral programming; .	9/30/2008		
	Status: The ward psychologist will be the liaison between the treatment team and the CCST regarding behavioral programs for patients assigned to their ward			
4	The Behavioral Consultant will provide training to the staff on RMB 3 in addition to training the Psychology Staff.	8/30/2008		Dr. Marsh with Dr. Patterson
	Status: This is intended to be ongoing beginning by 8/30/2008			

3 *Form one Positive Behavior Support Team. Led by a clinical psychologist skilled in behavior analysis and consisting of a registered nurse, 2 psychiatric technicians and 2 data analysts, this team will be the hospital's front line for the development of appropriate Positive Behavior Support Plans/Behavioral Guidelines. They will assist in the training of all clinical staff in the appropriate use of these technologies.* ***CVC; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify a unit in Civil Services that will serve as the positive support team and provide psychology support..	5/1/2008	Copy of program description with staffing, Tab # 96	CVC
	Complete *Status: RMB 3 identified. Psychologist assigned to unit.*			

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2 Consultants Angela Adkins/Dan Arnheim will work with RMB 3 staff on implementation of PBS *Status: This is on-going*	8/29/2008		Chief of Staff

VIII.B.1.c

ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;

Findings

See VIII.B.1.b

Compliance Status: No progress is being made toward the December, 2008 compliance date.

Recommendations — ***Responsible Party***

1 *See Recommendation 1 in cell VIII.B.1.b.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Recommendation 1 in cell VIII.B.1.b. *Status: See Recommendation 1 in cell VIII.B.1.b.*			

2 *Develop and implement a training program for nursing and level of care staff on the various means of positive reinforcement that are available in the hospital's therapeutic milieu.* — ***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify additional consulting assistance to train nursing staff on positive reinforcement.	9/30/2008		Dr. Patterson
2 Once consultant is arranged for, begin training, focusing first on staff on behavior units and behavior program in treatment mall and RMB 3.	10/31/2008		Dr. Patterson

VIII.B.1.d

ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment re

Findings

See VIII.B.1.a

Compliance Status: See VIII.B.1.a

Recommendations — ***Responsible Party***

1 *See cell VIII.B.1.a.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See cell VIII.B.1.a. *Status: See cell VIII.B.1.a*			

VIII.B.1.e

Findings

ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and

The Hospital developed a progress note template for use by the treatment mall and other disciplines to ensure the treatment team has accurate and current information about a patient's progress. Tab # 5 (Progress note template). The note can be used to report on the patient's progress toward achieving behavioral goals.

Compliance Status: No progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Develop a policy that directs psychology staff about when and how to monitor and document an individual's therapeutic progress(or lack thereof) when they are making use of Positive Behavior Support Plans/Behavioral Guidelines. At a minimum this documentation must occur monthly and most directly document the individual's progress toward achieving the behavioral goals for which the plan was created, including the decrease in targeted maladaptive behaviors and increase in adaptive behaviors.	***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain consultation on how to implement this recommendation.	8/22/2008		Rose Patterson
2 Based upon consultation, psychology will develop protocols for monitoring and documenting patients' responses to behavior plans	9/17/2008		Rose Patterson

Status: No progress to date.

Recommendations	*Responsible Party*
2 Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans.	***CVC; JH; AF; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training plan with consultant Angela Adkins.	9/30/2008		Chief of staff

Recommendations	*Responsible Party*
3 Develop and implement a Behavior Consultation Committee (BCC) for the regular review of individuals who are placed on Positive Behavior Support Plans. The BCC will also serve as a consultative committee to which treatment teams may come for clinical advice and consultation regarding individuals who are having difficulty progressing in treatment. The membership of the BCC is such to ensure that clinical and administrative decision makers are present so the necessary resources and support can be provided to help treatment teams implement suggested clinical strategies. At a minimum, membership would include the Executive Director (or delegate); the Medical Director (or delegate); the Chiefs of Psychology, Social Work, Nursing and Rehabilitation Therapy, and representatives of the Positive Behavior Support Team.	***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Restart the CCST (multidisciplinary team) to serve as consultative support to treatment teams with patients on positive support plans or who pose challenging clinical or behavioral issues.	2/13/2009	CCST Appointment letters Tab # 95	Drs. Patterson and Gouse

Status: Team identified and new chair appointed.

VIII.B.1.f

ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs.

Findings

There are currently 14 psychologists on staff. See Tab # 22 for (Psychology staffing) In addition, recruitment is underway for 3 additional psychologists as well as for 2 clinical administrator psychologists. If all positions are filled, there will be 19 psychologists on staff.

Contracts have been entered to provide training to psychology staff around behavioral plans and behavior management. See Tab # 24 (Contract for Dan Arnhiem), # 9 (Angela Adkins contract). Training only began in July, 2008.

Compliance Status: Some progress is being made toward the December, 2008 compliance date.

Recommendations	Responsible Party
1 Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards.	***AF; BG; Sam Feinberg***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify consultant with experience in developing and implementing positive behavior support plans/behavioral guidelines.	8/15/2008	Contract with Dan Arnheim Tab # 24	Dr. Patterson to arrange with Dr. Arnheim.

Status: Behavioral consultant is training psychology staff in the development of positive behavior support plans. He will also provide an overview of behavior plans and positive reinforcement to nursing staff on the behavior management unit (RMB 3).

Recommendations	Responsible Party
2 It does not seem possible that the hospital would be able to achieve this part of the agreement and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists.	***AF; AS; PJC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 HR will provide bi-weekly the on board strength for psychologists (separations vs. hires including projected hires) for FY 2008.	7/7/2008	HR report of staffing Tab # 91	James Gallo
2 Upon receipt of applications, interview and select as appropriate to fill three vacant positions within the next 60 days.	9/1/2008		Rose Patterson

Status: A report showing the status of each vacancy is produced weekly and provided to the Executive Staff. It also includes new hires and separations and each report can be sorted by occupation and date. A comprehensive HR database is in the final stages of development and will have the capability of producing targeted reports focusing on specific occupations.
The hospital made one selection for a staff psychologist and expects to fill the other vacancies before the end of the fiscal year.

VIII.B.2

Findings

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.

Approximately one hundred and fifty patients currently attend the treatment mall programs. See Tab # 58 (Description of Mall programs). The Mall referral form has been modified to capture information about the patient's stage of change, but further changes are expected in the referral form. Tab # 56 (Treatment mall referral form). The treatment mall administrator position is in recruitment. See Tab # 97.

In addition, assessment forms for various disciplines have been modified to include a recommendation of the type of therapy from which a patient may benefit based upon their diagnosis, symptoms status, functional level, and discharge setting. See Tab # 38 (Initial Psychiatric Assessment); Tab # 34 (Initial Social work Assessment), Tab # 35 (Rehabilitation Services Assessment), Tab # 23 (Initial Psychology Assessment), Tab # 36 (Initial nursing Assessment).

The Hospital has not yet evaluated in a systemic manner the type and number of groups to be offered in the treatment mall or elsewhere in the Hospital. Its efforts in this regard have been hampered by the lack of an automated information system where key data can be ascertained. Similarly, the Hospital has not yet developed a system for assigning group leaders based upon credentials or skills. It has not yet developed a mall program that is "manual based" with curricula for the various interventions. Information from the Patient data base and AVATAR will assist in an on-going analysis of the clinical profile of the inpatient population and can provide a basis for evaluation of treatment service needs but it is not yet being used in this manner. Tab # 55 (Clinical Profile of Inpatient Population)

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations	***Responsible Party***
1 *Assure that the initial assessments of all disciplines include an assessment of the types of group interventions from which the individual would most clearly benefit based on diagnosis, symptoms status, functional level and discharge setting.*	***CVC; BG;***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise Assessment policy and discipline assessment forms to capture recommendations about group therapies ***Complete***	6/30/2008	Assessment Policy Tab # 39; Discipline assessment forms: Tab # 35 (Psychiatric assessment form); Tab # 34 (Social work assessment form); Tab # 23 (Psychology Assessment form; Tab # 36 (Nursing Assessment form); Tab # 35 (Rehab Services assessment form)	Beth Gouse
2	Hire Treatment Mall Administrator. *Status: Interviews are being scheduled.*	9/15/2008		CVC
3	Reassess patients attending treatment mall using treatment mall referral form that is based on multidisciplinary assessment of patients' functional level-based on this assessment determine the type and number of groups that are required in treatment mall programs *Status: This will follow once initial psychological assessments are routinely done. Data will be used to assist in determining each patient's appropriate level/groups.*	6/11/2008	Treatment Mall referral form Tab # 56	

2 *Determine, based on the hospital's current census, the type and number of the various groups that must be offered in each of the treatment malls.* — ***CVC; JH; PID; assisted by PID***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Using data from clinical profile initially and later AVATAR, PID to assist civil and forensic services based on the monthly trend analysis and the mgmt report from AVATAR in determining group therapy needs.	10/31/2008		PID, CVC, JH

3 *Develop a process for assigning individual clinicians as group leaders for those therapeutic modalities for which they are adequately trained.* ***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create a training program for nursing staff that will foster development of basic group treatment skills.			Medical Director, Clo-Vidoni-Clark, Joe Henneberry
	Status: A group treatment training program for nursing staff will begin in October 2008.			
2	For group therapies that require special expertise (e.g., sex offender groups, trauma groups), ensure groups will be led or co-led by a licensed and where indicated, credentialed professional.	10/31/2008		Medical Director
	Status: Credentialing process for psychologists is in the process of being revised and is expected to resume by October 31, 2008.			
3	To ensure staff understand group interventions develop two-tier curriculum on group therapy for group providers. 1) Basic didactic course to start 9-08 2) Advanced course that awards certification & ability to supervise other group providers. Provide staffing data to group trainers on number of staff by discipline who are providing group interventions in treatment mall.	8/29/2008		Medical Director
4	Begin basic group therapy didactic course	9/30/2008		Medical Director
5	Design group supervision process	10/31/2008		Medical Director
6	Develop example group curriculum outline that will be used as model by group providers in developing individualized group curriculum	11/28/2008		Medical Director

4 *Develop group treatment offerings that are manual-based. Empirically validated and part of a curriculum development process.* ***CVC;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise the Behavior Management Program in the Treatment Mall:	6/27/2008	Descriptions of each Treatment Mall Program attached Tab # 58	CVC
	Complete *Status: The token economy program was modified to include a point system has been implemented based on behavior during group.*			
2	Hire a program administrator for the Treatment Mall	8/29/2008	PD of treatment mall administrator Tab # 97	CVC
	Status: Interviews are being scheduled			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Develop manual and curricula for all mall groups	1/30/2009		CVC
	Status: Consultant Angela Adkins will work with treatment mall staff.			
4	Rehab services will develop manuals for groups offered, with information on treatment methodology and will be available on each unit.	1/30/2009		

5 Develop an auditing process to assure that clinicians are appropriately trained in all therapeutic modalities they are providing and that there is adequate fidelity to the curriculum and the manual for the group. ***CVC; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII B 2 recommendation 3 and 4.			
2	Develop auditing tools that will address the curriculum of each group and that clinicians are keeping to curriculum.	2/27/2009		CVC
3	Rehab services will audit 5 records per month to assess quality of progress notes and track results	10/1/2008		OMS;; Rehab services
4	Discipline chiefs will attend at least two groups led by the discipline per month to assess competency of leaders and provide individual feedback. Schedule shall ensure each group leader is assessed at least once per quarter.	11/24/2008		Discipline chiefs.
	Status: Tools will need to be developed in advance.			

6 Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity.. ***Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify auditors and train once tools developed.	3/31/2009		CVC

7 Periodically, conduct a needs assessment based on current census to determine necessary changes to the mall curriculum. ***CVC; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Use information from AVATAR and patient data base to get patient profile.	12/31/2008	Clinical Profile of Inpatients, Tab # 55	OMS
	Complete *Status: Ongoing. Patient database will be supplanted by AVATAR.*			
2	Treatment mall administrator and PID work to develop protocol for needs assessment using available data.	3/31/2009		CVC; PID
3	Conduct needs assessment and report on same.	6/30/2009		CVC; PID

VIII.B.3

By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial

Findings

See findings for cell VIII.B.2.

The Hospital created and implemented a community reentry program that focuses on preparing the patient for

rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.

discharge. The program includes group therapies, role-play, field practicum, and hands- on experience. See Tab # 72 (Description of Community Reentry Group Protocol). To date, two cohorts have completed the program. The first cohort included 12 patients. Six completed the program, 3 were discharged prior to completing the program, two withdrew due to medical issues, and 1 attended sporadically as he obtained a job in the Work Adjustment Program. Data on the second cohort is not yet available.

Other programs include the Hospital's Work Adjustment Treatment program where patients are provide job opportunities and given work skills in a supportive environment, as well as several day programs in the community A small cadre of patients (about 20-25) attend the McClendon Center, Green Door, Anchor Mental Health and other community based programs as a transition to community living.

Additional services are needed to ensure patients are properly prepared for community placements.

The loss of up 5 rehabilitation specialists positions with the abolishment of positions in March may hamper compliance with this requirement.

Compliance Status: Some progress is being made toward the December, 2008 compliance date.

Recommendations				***Responsible Party***
1 *See the Recommendations from Cell VIII.B.2.*				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 See the Recommendations from Cell VIII.B.2.				
2 *Additionally, demonstrate that the development of group treatment curriculum is based on the discharge needs of individuals.*				***CVC;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Create database that tracks barriers to discharge. ***Complete***	5/21/2008	Discharge Database screen shots Tab # 61	OMS	
2 Provide periodic reports that track barriers. *Status: On-going*	7/11/2008	Discharge Database barrier list Tab # 70	CVC	
3 Work with Authority to obtain data on post discharge patient progress and needs and modify treatment mall groups as needed. *Status: Data will be provided as available.*	4/1/2009		CVC; Authority	

VIII.B.4

By 18 months from the Effective Date hereof, SEH shall ensure that:

Findings

See sub cells for specific findings.

Compliance Status: See sub cells.

VIII.B.4.a

Findings

behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;

See findings for cell VIII.B.1.c.

Compliance Status: See sub cells.

Recommendations	***Responsible Party***
1 *See cell VIII.B1.c.*	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See cell VIII.B1.c.			

VIII.B.4.b

programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;

Findings

The Hospital modified its former "Dually Diagnosis" program, and it is now called the Co-Occurring Disorders program. The program now incorporates stage of change principles. See Tab # 58 (Description of Co-occurring Disorders program). The program has two tracks that reflect the patient's stage of change, and the group work curriculum depending on the patient's stage of change. The referral form now specifically asks for the treatment team to evaluate the patient's stage of change. See Tab # 56 (Referral Form) The program serves 24 patients, far below the capacity needed given the number of patients with substance abuse diagnoses. As reflected in the summary of clinical profile of patient population, 188 of 420 inpatients (45%) are diagnosed with substance abuse disorders. Tab # 55 (Clinical Profile of Inpatients).

There continues to be a need for additional services for this population. The absence of an information system that will provide up-to-date and accurate data is hampering the ability to assess need of the amount and type of services needed, but implementation of Phase II of AVATAR early next year should address this issue.

The Director of Co-occurring Disorders resigned in July, 2008.

Compliance Status: No progress toward the December, 2008 compliance date.

Recommendations	***Responsible Party***
1 *Develop and implement a process that assures that all individuals with substance abuse diagnoses are being referred to appropriate substance abuse groups and treatments.*	***CVC; JH; AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise assessment policy to ensure substance abuse is assessed upon admission and at appropriate intervals thereafter. ***Complete***	7/16/2008	Assessment policy Tab # 39; Tab # 38 (Initial Psychiatric Assessment)	Taylor; CEO
2	Revise treatment mall referral form to capture substance abuse information for consideration in assigning groups. ***Complete***	7/1/2008	Treatment Mall Referral Form Tab # 56	CVC

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3 Use information from AVATAR and patient data base to track diagnosis and treatment interventions; Develop report that can link diagnosis with treatment interventions.	3/2/2009	Screen shots of patient database Tab # 61; Clinical Profile of Inpatient Population, Tab # 55	COO; Medical Director

Status: Patient database has been created but provides limited capacity. Will need expanded reports through AVATAR system.

VIII.B.4.c

where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;

Findings

No action has been taken to address this requirement, other than a cognitive impairment screen to be completed on all new admissions.

Compliance Status: No progress is being made toward the December, 2008 compliance date.

Recommendations	*Responsible Party*
1 Undertake a systematic analysis of the care needs and community placement supports and services required for all individuals with cognitive impairments, and where appropriate develop community living plans for these individuals that optimize community tenure.	***Authority, Barbara Bazron***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct inventory of housing and supports.			Authority
2 See action steps in Section VII F			

VIII.B.4.d

programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;

Findings

Prior level of practice continues to be implemented.

Compliance Status: Substantial

Recommendations	*Responsible Party*
1 Continue current policy and procedure.	

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

Status: Current practice continues

VIII.B.4.e

psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;

Findings

See V.A.2.a and c. Documentation continues to be inadequate on this requirement. Staff do not routinely or comprehensively document the patient's response to particular treatment interventions, so it is not clear from chart reviews which interventions are effective and which are not. Entries into the charts are often generic e.g. "patient is responding to treatment"; "patient continues to be a management problem". Treatment plan reviews often continue the same intervention without clear consideration of the effectiveness of the intervention. In several charts reviewed, the exact intervention ("monitor mental status, prescribe and adjust medications as needed") was carried

for three consecutive treatment plans (and was identical for two patients on the unit).

However, changes to policies and forms were made that are expected to improve this reporting. The Assessment Policy establishes standards for each disciplines' assessments, and the Treatment Planning Policy now requires the clinical administrators to review each month the patient's progress toward goals. See Tabs # 39 (Assessment Policy) and # 1(Treatment Plan Policy). Training on treatment planning is also expected to improve practice in this area.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations — ***Responsible Party***

1 See Recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See Recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e.			
	Status: See related status			

VIII.B.4.f

clinically relevant information remains readily accessible; and

Findings

A progress note template was developed that ties progress to specific short term goals. See Tab # 5 (Progress Note Template). The template was introduced in early July, 2008, and will be revised as needed.

Compliance Status: Minimal progress is being made toward the December, 2008 compliance date.

Recommendations — ***Responsible Party***

1 Develop a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about necessary changes if treatment when treatment has been successful and there is a need to implement the next step in treatment or when treatment is unsuccessful and further assessment. — ***BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop progress note template	6/30/2008	Progress note template # 5	Chief of staff
Complete	*Status: Template is in use. Template is being reviewed by consultant. Comments will be incorporated.*			

VIII.B.4.g

staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavi

Findings

No progress has been made yet, but the recent hiring of two consultants to provide technical assistance to psychology department and designated ward staff (RMB3) is expected to improve development and implementation of behavioral programs. See Tab # 9 (Angela Adkins Contract) and Tab # 24 (Dan Arnheim contract). The Hospital will work with the consultant on development of a tool to monitor progress, but that is not expected for several months.

Compliance Status: No progress is being made toward the December, 2008 compliance date.

Recommendations — ***Responsible Party***

1 *Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans.* — ***CVC; JH; AF; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Contract with consultant(s) to provide technical assistance to units in implementing PBS plans, and to train staff ***Complete***	6/30/2008	Contract with Dan Arnheim, Ph.D., Tab # 24; Contract with Angela Adkins Tab # 9	COO
2	Training for Psychology staff to begin by the end of July and continue for at least 6 months. *Status: Training has started.*	7/30/2008	Contract with Dan Arnheim, Ph.D. Tab # 24: Contract with Angela Adkins Tab # 9	R Patterson
3	Consultant(s) to provide intensive training to the treatment team on RMB 3, a designated behavioral treatment unit beginning by the end of July.	7/31/2008		R Patterson

2 *Train auditors to acceptable levels of reliability.* — ***AF; Rose Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Behavioral programs will be coordinated by the ward psychologist in concert with the CCST; the later will randomly audit on-going behavioral treatment plans for effectiveness and fidelity to the PBS model. *Status: Planning stages.*	1/30/2009		

3 *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* — ***AF; Rose Patterson***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	CCST to work with Dr. Arnheim. *Status: Planning stages.*	12/31/2008		

VIII.C. Pharmacy Services

By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.

Findings

See sub-cells for findings.

Compliance Status: See sub cells.

VIII.C.1

pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and

Findings

The Hospital recently filled all 8 pharmacist positions, and beginning in July, 2008, will conduct monthly reviews of each patient's medication regimen. See Tab # 86 (Pharmacy chart review form). The Hospital also completed a set of Medication guidelines, and created a Medication Intervention tracking forms that tracks communication with physicians and outcomes. Tab # 98 (Medication Intervention Tracking form). In addition, Pharmacy will also be doing drug audits on the following classes of drugs: parlodel, seroquel, lorazepam, valproic acid and clozapine. Tab # 99 (Drug audit Forms)

These changes were implemented just prior to the writing of this report, so data of the audits is not yet available.

Compliance Status: Progress has been made toward the June, 2010 compliance date.

Recommendations	*Responsible Party*
1 *Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments.*	***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a monitoring system for pharmacists to provide medication management.	7/22/2008	Medication Guidelines Tab # 54	Harrison/Zerislassie
	Complete *Status: Guidelines - completed / Mediware WORx - file build 90% complete*			
2	Develop a monitoring system for pharmacists to review each patient's medication monthly and make recommendations	7/22/2008	Pharmacy Medication Review Form Tab # 86	Harrison/Zerislassie
	Complete *Status: Pharmacy Medication Review Form - completed / Mediware WORx - file build 90% complete*			
3	Track results of review to identify trends or other issues.	9/17/2008		Harrison/ OMS

Recommendations	*Responsible Party*
2 *Develop tracking and follow-up mechanisms to address situations when the physician has not addressed the pharmacist's concerns.*	***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a tracking system to document medication interventions by pharmacists	7/22/2008	Medication Intervention Tracking Form Tab # 86	Harrison/Zerislassie
	Status: Tracking Form - completed / Mediware WORx - file build 90% complete			
2	PID to provide technical assistance to pharmacy for implementing tracking form and data collection	9/12/2008	Drug alert report, Tab # 88	PID & Pharmacy
	Complete *Status: Ongoing*			

3 Share data with senior staff and Medical staff Executive Committee. — CEO

Status: Ongoing

3 *Develop and implement self-monitoring mechanisms to assess compliance with the requirements in VIII.C.1 and VIII.C.2.* — ***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a peer review system to monitor compliance.	7/22/2008	Monthly review of Pharmacy Medication Review Forms Tab # 100	Harrison/Zerislassie
Status: Peer review procedure in development/ Mediware WORx - file build 90 % complete			
2 See also action steps in related sections.			
3 Provide reports to P & T committee.	8/29/2008		
Status: will be ongoing			

VIII.C.2

physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.

Findings

Same as above.

Compliance Status: Progress has been made toward the June, 2010 compliance date.

VIII.D. Nursing and Unit-Based Services

By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.

Findings

See sub-cells for findings

Compliance Status: See sub cells.

VIII.D.1

Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;

Findings

The Hospital has taken several foundational steps to improve nursing competencies in mental health diagnoses, related symptoms, effect of medications, and related documentation but it has not yet translated into improved nursing practice. The Hospital is actively recruiting for a Director of Nursing that will oversee nurse education provided both at the unit/division level and hospital wide as well as nurse competencies. See Tab # 102. (PD for DON). This will ensure consistency between training by the Office of Training Services and that provided in the individual programs.

Second, an additional nurse recruiter was hired and started July 7, 2008. Her immediate focus will be on training nursing staff around mental health symptoms and meaning of behavior.

Third, DMH issued scopes of work for consultant trainers to train nursing staff on recognizing signs and symptoms of physical illness and other training relating to seclusion and restraint. See Tab # 103 (Scope of work for seclusion and restraint training); Tab # 104 (Scope of work for training on physical illness and symptoms). That training is expected to occur by September 30, 2008.

Despite these foundational steps, nursing practice is not meeting this requirement. Nursing staff often still see

patient behavior as "willful" or controllable, and they are not meeting best practice standards around recognizing symptoms of mental illness or implementing therapeutic interventions. Interventions by some nursing staff can at times aggravate a situation rather than diffuse it and there are times when the tone and language used by nursing staff are not therapeutic.

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

	Recommendations	Responsible Party
1	*Clearly differentiate the purpose and content of nursing staff orientation that occurs in the Education and Staff Development Office and that which occurs within the Nursing Department.*	***CVC; JH; AS; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Hire a Director of Nursing and an additional Nurse Educator.	9/30/2008		COO
	Complete *Status: Nurse educator began 7/7/08. DON is being recruited.*			
2	Nurse Educator to develop curriculum and clarify training responsibilities in writing.	8/15/2008		CVC
3	Nurse educator to coordinate training with Psychology Training Director	9/18/2008		Medical Director, CVC
4	Begin training of nursing staff.	9/30/2008		

	Recommendations	Responsible Party
2	*Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning.*	***CVC; JH; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.D.1 recommendation 1.	8/1/2008		COO; Chief of Staff
2	Provide competency-based training and track attendance and results of competency assessments.	9/30/2008		CVC; Training

	Recommendations	Responsible Party
3	*Develop/revise nursing competency policies and procedures to assure: clear time lines and accountability for determining individual staff orientation and annual competencies; that nursing staff members are only assigned/perform duties after achieving/maintaining competency.*	***CVC; JH; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Hire Executive Director for Nursing	9/30/2008		CEO
	Status: Interviews are on-going.			
2	DON to work with Associate DONs to revise nursing policies around competency and procedures that satisfy this recommendation.	12/31/2008		CVC; JH

4 Report compliance and noncompliance in the aggregate to evaluate effectiveness of processes to assure competency. ***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.1 recommendation 4.			

5 Augment CPI with content that is consistent with St. E's policies/philosophy and the desired culture change. Consider incorporating content that supports trauma informed services. ***CVC; JH; AF; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training Director to work with internal hospital trauma-informed care expert to revise NCVI curriculum	9/1/2008		Medical Director
2 Expand number of staff trained directly in CVI through attendance at training in Nov.	7/31/2008		Training Director; JH; CVC
Status: Civil and Forensic are identifying staff to participate in training			
3 Revise curriculum as appropriate.	9/10/2008		Training Director

VIII.D.2

Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;

Findings

See VIII.D.1.

The Hospital recently discontinued the use of nursing diagnoses and revised its nursing assessment form and its form for chart monitoring. Tab # 36 (Nursing Assessment form); Tab # 44 (Nursing Chart Monitoring form). Through this chart monitoring form nursing staff will monitor, among other things, linkages of nursing interventions to IRP goals. The nursing stations on RMB 3, 4, 5 and 6 were reconfigured to provide privacy for nursing documentation and other activities. Further, all nursing stations now have computers to facilitate data entry.

The Hospital also is monitoring nursing staff attendance and participation in IRPs as well as the timeliness of assessments through the IRP process monitoring tool. Nursing staff attended 81% of treatment plan conferences hospital wide but presented a summary of nursing assessment in only 44% of treatment plan conferences observed. Tab # 7 (IRP Process Observation Analysis)

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

Recommendations ***Responsible Party***

1 Discontinue the use of Nursing Diagnoses and utilize IRP with problem numbers to formulate plans and document interventions and progress toward goals. ***CVC; JH; PID; PID (Policy)***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise NSP 300-Documentation of Nursing Process	7/3/2008	Tab # 45 (NSP 300)	CVC/JH/DJ/DK
Complete *Status: Discontinued use of nursing diagnosis*			
2 Revise form for chart monitoring of nursing process	7/15/2008	Revised nursing Chart monitoring form Tab # 44	CVC/JH/DK/DJ
Complete			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Implement Nursing Process Monitoring System. *Status: Implementation pending*	8/29/2008		CVC/JH/DK/DJ
4	Monthly reports of results.	9/30/2008		CVC/JH/DK/DJ
5	Develop revised initial treatment plan form. **Complete**	7/17/2008	Revised Initial treatment plan form Tab # 3	Beth Gouse

2 Develop standardized areas of assessment/goal focus for all disciplines to utilize. Pending this common framework, nursing assessments and contributions to the IRP must immediately address the following minimum priority areas: psychiatric/mental health concerns, medical/health and wellness concerns, dangerousness to self or others. ***CVC;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps in VIII D 2 recommendation 1.	7/31/2008		
2	Revise all discipline assessment forms to ensure they are consistent in addressing goals. **Complete**	7/31/2008	Tab # 38 (Initial Psychiatric Assessment); Tab # 34 (Initial Social Work Assessment); Tab # 23 (Initial Psychological Assessment); Tab # 36 (Initial Nursing Assessment); Tab # 35 (Initial Rehab assessment)	Beth Gouse

3 Explore physical/environmental changes that would afford nursing staff a private area to work, and also allow them to provide active treatment/be fully "with" individuals when not doing paperwork. ***CVC; JH; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Reconfigure nursing stations as appropriate. **Complete** *Status: Reconfigured stations on RMB 3, 4, 5 and 6.*	7/31/2008		Gilbert Taylor
2	Complete construction of the prototype if the modified nursing station on ward 3. **Complete**	3/31/2008		Gilbert Taylor Samuel Feinberg
3	Award the contract to modify nursing stations on wards RMB 4, 5 and 6. **Complete** *Status: Construction completed.*	7/15/2008		Samuel Feinberg

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
4	Identify funding to modify nursing stations on wards 1,2,7, and 8.	8/1/2008		COO

VIII.D.3

Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;

Findings

The Hospital revised its nursing Physical Observation Form and Physical Observation Policy to establish standards for monitoring of physical signs and symptoms; training of staff on the new forms is expected to occur by the end of July. See Tab # 105 (Forms/Policy Physical Observations). In addition, the Hospital is seeking to supplement training through a contract to focus on training nurses on identification of physical symptoms. See Tab # 104 (Scope of Work for Nurse Trainer on physical symptoms). The Hospital is developing procedures to address nursing interaction with physicians concerning physical issues and will complete training of nursing in the procedures by August, 2008. Compliance will be monitored by nursing supervisors.

The Hospital also completed a template for a change of shift report, which is expected to be implemented in early August. See Tab # 81 (Change of shift report).

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

Recommendations — ***Responsible Party***

1 *Develop a real-time monitor of documentation related to physical status so that improvements are immediate.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise SEH 506 Physical Observation Form and Physical Observation Policy NCP-600.24 ***Complete***	6/30/2008	SEH Form 506, Tab # 105	CVC
2	Submit revised form to Medical Records Committee for approval *Status: Will be submitted*	7/31/2008		CVC
3	Train nursing staff on revised policy and use of form.	8/27/2008		CVC
4	Implement revised form	8/28/2008		CVC
5	Nurse Managers will initiate monthly monitoring	9/1/2008		CVC

2 *Develop a template for change of shift report that contains prompts so that important information is reported that relates to the IRP as well as physical/medical status.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise change of shift report form to include prompts and GNA-100.3 Change of shift policy ***Complete***	7/1/2008	Change of Shift template Tab # 81	CVC; JH
2	Train nursing staff on revised form & policy.	7/31/2008		CVC; JH
3	Implement revised form & process.	8/1/2008		CVC;JH
4	Nurse Managers will observe & evaluate unit shift report process on a routine basis	8/15/2008		CVC; JH

Recommendations	Responsible Party
3 *Develop/revise policies to specify expectations relative to RN to MD interface as it relates to medical and behavioral emergencies, transfers to and from other treatment settings, and changes in physical condition. The expectations should include timeframes for reporting to the MD and timeframes for the MD response based on the severity of the issue/individual's need.*	***CVC; JH; AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Physician Notification Policy & Log to include timeframes ***Complete***	7/1/2008	Physician Notification Log, Tab # 106	CVC/JH/DJ/DK
2 Train nursing staff on revised policy & log.	7/30/2008		CVC/JH/DJ/DK
3 Implement revised log & process.	8/1/2008		CVC/JH/DJ/DK
4 Nurse Managers will initiate monitoring of process.	8/15/2008		CVC/JH/DJ/DK
5 Ensure that timeframes for MD assessment upon return from a medical facility are clarified. *Status: Assessment policy revised to include specific timeframes.*	8/29/2008	Assessment policy Tab # 39	Medical Director

VIII.D.4

Ensure that nursing staff document properly and monitor accurately the administration of medications;

Findings

The nurse educator is working to establish additional training around documentation of patient response to medication administration. Administration of medication is now recorded electronically through EMAR.

The Hospital is clarifying its policies around reporting medication variances and errors by creating a single policy. While awaiting full AVATAR implementation, the Hospital is tracking medication variances and reporting some trend data, although the capacity is somewhat limited as all data is manually based at this point. Tab # 8 (Trend Analysis). The Hospital plans to develop reports through AVATAR that will provide more current data and will permit additional analysis. In addition, as previously noted, a campaign to increase the reporting of medication variances and ADRs is underway. Pharmacy and Therapeutics Committee continue to review incidents each month.

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

Recommendations	***Responsible Party***
1 *Develop/revise policies that describe medication variances, a subcategory of which would be medication errors.*	***AF; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Pharmacy SOP Policy 1.22 Medication Errors and 1.23 Alerting Orders ***Complete*** *Status: Policies are being revised.*	6/27/2008	Pharmacy SOP 1.22 and 1.23 Tab # 107	Harrison/Zerislassie

Recommendations	Responsible Party
2 *Designate one form for medication variance reporting.*	***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Create single form for reporting medication variance.	8/22/2008		Harrison

3 Review/revise processes used to analyze, identify trends, take actions for improvement, and monitor the effectiveness of actions taken to reduce medication variances. ***AF; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop reports from AVATAR system that track medication variances. *Status: Report developers to meet with Pharmacy and P & T Committee to discuss reports and priorities.*	9/30/2008		COO; Pharmacy
2 Provide data to P & T committee for analysis.	10/31/2008		Pharmacy
3 Develop recommendations and implement as appropriate.	11/28/2008		Medical Director

4 Require that nursing staff monitor individuals' response to the first dose of a medication and that they document the response on the MAR. ***CVC; JH; AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Pharmacy and Therapeutics Committee to develop guidelines relating to definition of first dose of medication.	9/26/2008		Medical Director
2 Revise Nursing Medication Policy and MAR to correspond to guidelines.	10/31/2008		CVC/JH/DJ/DK

VIII.D.5

Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;

Findings

The Hospital's Office of Monitoring Systems is working with the Office of Training to develop a nurse training data base that will include training data and track who has passed competency standards. A decision will be needed as to whether the unit based or division based training will be recorded in the data base as well. It is expected that a database will be completed by the end of August, although that date may be affected if a Director of Nursing is hired. Presently an Excel data base is used by Office of Training which tracks dates of training, but does not track competency assessments. Recently, Office of Training and the Civil and Forensic Directors developed a protocol whereby OTS will notify the directors of upcoming key training expiration dates. See Tab # 108 (Memorandum from Lewis Mayo).

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

Recommendations ***Responsible Party***

1 Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications. ***CVC; JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop training data base that reflects results of competency based training	8/29/2008		PID
2 Enter/maintain data as appropriate.	9/30/2008		Training
3 Produce reports and analyze results.	10/31/2008		OMS

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
4	Develop system to inform Civil and Forensic Services if staff fails training or training expires	7/18/2008	Mayo Memorandum summarizing new process re notification Tab # 108	Training

2** Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.* — ***CVC; JH;

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Training to notify Directors of Civil and Forensic Services when employee does not successfully complete competency based training. ***Complete***	7/3/2008	Mayo Memorandum, Tab #	Training
2	DON and Discipline Directors to complete procedures that limit practice.	10/31/2008		JH, CVC, DON

3** Develop competency measures for medication teaching and for staff interactions that would support an understanding of individuals' potential side effects and/or barriers to adherence. Models associated with stages of change would be useful to accomplish the latter.* — ***CVC; JH; AF; AS;

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

VIII.D.6

Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors;

Findings

See VIII.D.4

Compliance Status: See VIII.D.4

Recommendations	*Responsible Party*
***1** See VIII.D.4*	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.D.4			

VIII.D.7

Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;

Findings

The Hospital has not modified the medication administration policy at this time, but it is expected to be finalized by the end of September, 2008. Currently, the Hospital is using the IRP process monitoring tool to monitor if side effects are discussed with patients at any time, but data has not been analyzed as of yet.

It should be noted that the treatment teams have not yet been trained on this aspect of the treatment plan conference, although the template and tool were provided that reflects this will be assessed.

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

Recommendations				***Responsible Party***
1 *Revise Medication Administration policy to include expectations for medication education, queries regarding side effects and response to medications, and ways to understand and explore barriers to adherence*				***CVC; JH; PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Incorporate DOJ recommendations into Medication Administration policy draft.	9/15/2008	Medication Administration policy, Tab # 84	J Taylor	
Status: Revising Medication Administration Policy draft				
2 Track through IRP process monitoring that patients are regularly informed about side effects of medication	6/30/2008	IRP process form Tab # 6; IRP Process Observation results Tab # 7	QID	
Complete				
3 Revise Nursing Medication Procedures	9/8/2008		CVC	
2 *See VIII.D.5, Recommendation 3.*				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 See VIII.D.5, Recommendation 3.				

VIII.D.8

Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;

Findings

See findings for VIII.D.2

Compliance Status: See findings for VIII.D.2

Recommendations				***Responsible Party***
1 *See VIII.D.2.*				
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 See VIII.D.2.				

VIII.D.9

Ensure that each individual's treatment plan identifies:

Findings

Please see sub cells for findings.

Compliance Status: See sub cells for findings.

VIII.D.9.a

the diagnoses, treatments, and interventions that nursing and other staff are to implement;

Findings

A review of charts suggests that completion of nursing assessments continues to be an issue (many sections are not filled out at all), although the new nursing assessment form (Tab # 36) and elimination of nursing diagnoses as DOJ recommended should improve that aspect of care. Further, the development on an integrated initial treatment

plan with nursing, medical and psychiatric in one form is expected to improve performance around this requirement. See Tab # 3 (Initial Treatment Plan form). Data is not yet available on compliance and implementation is set for early August. A monitoring tool has not yet been developed, so data is not likely to be available by September, 2008.

A revised choking assessment is completed and upon completion of staff training, implementation anticipated in August, 2008. See Tab # 110. Choking assessments have been completed on all forensic patients.

IRP observers are evaluating nursing attendance and participation in treatment plans. Nurses attended 81% of IRP conferences. See Tab # 7 (IRP Process Monitoring Analysis).

The quality of nursing interventions will be subject to the clinical audits, but those have not begun.

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

Recommendations — ***Responsible Party***

1 Discontinue Nursing Diagnoses — ***CVC; JH; PID; PID (Policy)***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Discontinue nursing diagnoses.	7/11/2008	Nursing assessment form, Tab # 36	CVC/JH/DJ/DK

Complete *Status: Nursing diagnosis discontinued.*

2 Develop one Initial Treatment Planning document that both the MD and RN use to direct initial treatment and nursing care. — ***AF; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop single initial treatment plan instrument that integrates psychiatric, nursing and GMO plans	7/11/2008	Initial treatment plan instrument Tab # 3	Chief of Staff

Complete

3 Eliminate/do not transcribe orders for which there are no policies or protocols. — ***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Not Identified			Medical Director; CVC; JH

4 Establish and implement a training program to teach nursing staff about diagnoses, the underlying issues associated with behaviors, and generally accepted nursing interventions. — ***CVC; JH; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Recruit and hire DON and nurse educator.	9/30/2008		CEO

Status: Nurse educator began on 7/7/08. DON in active recruitment.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Nurse educator in conjunction with the Director of Training of Psychology Department to provide nursing staff training on diagnosis and behavior underlying symptoms. *Status: Nurse educator hired.*	12/31/2008		Training

5 Develop triggers for and a comprehensive dysphagia assessment. ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft choking/swallowing assessment. ***Complete***	6/9/2008	Nursing assessment document attached, Tab # 110	CVC; JH
2	Pilot for one week. ***Complete***	6/10/2008		CVC;JH
3	Revise assessment & submit to Chief of staff. ***Complete***	6/23/2008	Final draft of choking assessment, Tab # 110	CVC;JH
4	Develop choking assessment guidelines ***Complete***	7/3/2008	Guidelines, Tab # 111	CVC/JH/DJ/DK
5	Train Nursing staff *Status: Forensic training scheduled July 9, 10, 14, 2008*	8/29/2008	Training Materials, Sign in sheets, Tab # 112	CVC/JH/DJ/DK
6	Implement choking/swallowing assessment *Status: Forensic implemented assessment and identified patients*	8/5/2008		CVC/JH/DJ/DK

VIII.D.9.b

the related symptoms and target variables to be monitored by nursing and other unit staff; and

Findings

Change of shift template was developed. Tab # 81 (Change of shift template). Training and implementation is expected by August, 2008. Monitoring of the implementation of the new protocol has not yet begun.

Nursing documentation is not yet tied to the IRP, but that is expected to improve as the nursing diagnoses are eliminated.

Recruitment for DON is underway and he/she is expected to lead the needed change in practice required by the Agreement.

No other information is available.

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

Recommendations — ***Responsible Party***

1 Revise nursing flow sheets to prompt observations/documentation that will contribute to an understanding of the individual, especially as it relates to psychiatric mental health issues, medical/health and wellness issues, and issues of potential dangerousness to self or others. — ***CVC; JH; AS (Med Records)***

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

2 Develop template for change of shift report. Consider ways to use the data on this template as a basis for progress notes in order to minimize duplicative documentation. — ***CVC; JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop change of shift template. ***Complete***	6/30/2008	Change of shift template Tab # 81	CVC; JH; ADON
2 Train staff and nurse managers to observe change of shift reports.	7/31/2008		CVC/JH/DJ/DK

3 Review/evaluate/revise nursing documentation requirements to eliminate duplication in record entries, and to determine the degree to which the current "BIRP" model facilitates documenting to IRP. — ***CVC; JH;***

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

VIII.D.9.c

the frequency by which staff need to monitor such symptoms.

Findings

See VIII.D.9.a. To date, IRPs still do not specify the frequency of nursing observations or monitoring on a consistent basis, although data is not available since nursing peer review and clinical chart audits have not begun. The training on treatment planning will include some component of nursing discipline specific training.

Nursing staff who supervise patients in dining areas will be provided training by nurse educator on identifying triggers for choking, but no date is yet set for the training. Forensic services completed choking assessments on each patient and identified those who are at risk. Civil is completing the assessment by end of August.

Posters depicting the Heimlich maneuver are now posted in eating areas. Tab # 113 (Memorandum describing placement of posters).

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

Recommendations — ***Responsible Party***

1 Fully integrate goals and interventions that involve nursing staff into IRP. — ***AS; BG;***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train nursing staff on treatment planning to ensure they understand how to identify appropriate nursing goals and interventions.	12/31/2008	PO for development of Treatment planning training, Tab # 10.	
	Status: Trainer for treatment planning identified and meeting held July 25th to set up training plan			
2	Develop monitoring tool or amend clinical audit tool to address this requirement. Obtain TA from consultant as needed to refine tool	9/17/2008		CVC;JH
	Status: Not yet begun			
3	Complete staff training and use clinical audit tool/peer review to evaluate whether nursing interventions are appropriate to goals set forth in IRP, with technical assistance from consultant	10/31/2008		CVC;JH

2 *Develop clear expectations for monitoring individuals at risk for choking during meal times.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	The Civil/Forensic Directors to work with nurse management to identify the triggers for dysphasia and frontline nursing staff will be educated by nurse consultant and monitored by the respective unit nurse manager.	7/31/2008		CVC,JH,DJ,DK
	Status: On-going.			
2	Distribute Heimlich maneuver posters in all areas where patients may be eating.	6/30/2008	Memorandum Describing Placement of Posters Tab # 113	CVC,JH,DJ,DK
	Status: Since February 2007 all JHP Day Rooms and Dining Rooms have posters.			
3	Identify patients at risk for choking	7/31/2008	Patient list available in office of Forensic ADON for JHP	CVC,JH,DJ,DK
	Status: Forensic Services has identified 5 patients who are at risk.			
4	At all meals, nursing staff are assigned to sit at table with high risk patients and monitor for choking.	7/31/2008	Nursing Reference Manual NCP 600.25 Effective 6/08, Tab # 111	CVC,JH,DJ,DK
	Status: Ongoing since March 1, 2008 in JHP			

3 Assure that there are posters depicting the Heimlich maneuver in all eating areas. ***AS;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain and deploy posters noting Heimlich maneuver in all dining rooms, dayrooms, treatment mall areas and lobbies where patients may eat.	6/30/2008	Choking Poster Distribution List tab # 113	Amelia Peterson

Status: Posters were affixed to the wall in each day room area and on each patient nourishment refrigerator in the nurse's station in RMB on 7/7/08. Additionally, a First Aid for Choking poster was hung in the day rooms of RMB wards 1 and 2 since these wards eat every meal on the ward daily. Both the First Aid for Choking poster and the Heimlich maneuver poster were also taped to the wall beside the vending machines in the lobby of RMB

VIII.D.10

Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:

Findings

See sub-cells for findings

Compliance Status: See sub cells.

VIII.D.10.a

actively collect data with regard to infections and communicable diseases;

Findings

There has been no progress in the Infection control program. Work continues on revising the Manual, which is expected to be completed by mid August, but it is not yet complete. Some data on a small number of conditions (MRSA, Hepatitis B and C and HIV/Aids) is included in the Trend Analysis (See Tab # 8), but no action has otherwise been taken on the specific recommendations set out in the baseline report.

The Hospital completed another Environmental Survey (Tab # 83) which shows improvement over the prior survey and the results were shared with Senior staff as well as published to the Infection Control Committee, the Risk Management and Safety Committee of Medical Staff Executive Committee and the Performance Improvement Committee, as well as the public. It also hired a Safety Officer to focus on environmental issues, which frees up the Risk Manager to focus on direct patient care issues.

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

Recommendations — ***Responsible Party***

1 The Medical Director should pursue his current plan to review the Infection Control Program. Consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload. ***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise infection control policy manual	8/15/2008		AF

Status: Not yet complete.

2 Immediately develop a clear TB screening program based on CDC guidelines, including those related to risk level. ***AF;***

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

3 Identify categories of data to be collected with initial focus on those data that relate to risks for this population. — ***AF; PID; AF with PID***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Expand current reporting system by adding other key indicators.	9/30/2008		AF, Infection Control Coordinator
2	After data is collected, OMS and Infection Control to begin trending and analysis	11/20/2008		Medical Director, OMS

4 Develop monitoring instruments and define intervals for the ICC on site monitoring of specific areas in the hospital. — ***JH; AF; PID; with PID***

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

5 Develop policies and procedures to identify cluster outbreaks. — ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action step to VIII.D.10 recommendation #1			

6 Develop policies and procedures for food borne illness, flu, and norovirus. — ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action step to VIII.D.10 recommendation #1			

7 Promote unit staff ownership for the unit environment. The Nursing Unit Manager should provide oversight for unit staff to complete the ES on a weekly basis, assuring inter-rater reliability, and a user- friendly way to document actions taken on deficiencies. — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Nursing procedure QIR-206 Environmental Monitoring Developed, Environmental Survey completed on monthly basis, nursing deficits corrected		Nursing Procedure QIR 206, Tab # 114	CVC/JH/DJ/DK

8 A mechanism should be established for regular senior level review of ES findings to assure resolution since in most instances multiple departments will need to be involved. — ***CVC; JH; PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Share results of Environmental survey to all senior staff.	5/1/2008	Environmental survey, Tab # 83	PID
	Complete *Status: Sent to all senior staff.*			
2	Develop a Corrective Action Plan which immediately address red and yellow zone issues identified in the Environmental Assessment	6/16/2008	Environmental Survey Corrective Action Plan, Tab # 115	Gilbert Taylor, Donna Moran, Robert Winfrey
	Complete *Status: A corrective action plan to address red and yellow zone issues identified in the quarterly Environmental Self Assessment issued in March 2008 was developed by the Directors of Facilities & Environment and Materials Management & Logistics*			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Environmental Survey forwarded to Administrative Officer for correction by facility & maintenance departments **Complete**	7/31/2008		COO
4	Red and yellow zone issues identified in the Environmental Survey are to be corrected by 7/15/2008.	7/15/2008		Donna Moran, Gilbert Taylor, Robert Winfrey

VIII.D.10.b

assess these data for trends;

Findings

No progress to report. See VIII.D.10.a

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

Recommendations — ***Responsible Party***

1 *Identify priorities for data collection and analysis* — ***AF; PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Review the current data and finalize the data collection with the Medial Director	9/30/2008		PID, AF, Infection Control

2 *The Infection Control Coordinator should provide preliminary written analysis.* — ***AF;***

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

3 *Infection Control Committee should review data/data analysis no less than quarterly.* — ***AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Data will be provided to infection control committee, who will identify other data to track **Complete** *Status: Some data is in trend analysis, but additional data will be available once Phase II of Avatar is implemented, which is set for Winter, 2008*	9/26/2008	Trend Analysis (April/May) Tab # 8	Medical Director

4 *Aggregate data from the ES should be reviewed and analyzed by the Infection Control Coordinator on a monthly basis and reported to the Medical Director and the Assistant Directors of Nursing.* — ***AF; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide results of ES to Environment and Risk Management Committee as well as Infection Control Committee. **Complete**	6/30/2008		PID

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Develop a tool to identify assess potential safety hazards including suicide risks, infection control risks and other occupational safety hazards.	7/31/2008		As; AF, Robert Winfrey

Status: The Hospital Safety Officer will develop or modify an existing tool to be used in monthly Safety Inspections of all occupied areas which will assess potential safety hazards including suicide risks, infection control risks and other occupational safety hazards.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Conduct monthly inspections of all occupied areas.	8/7/2008	Hospital Safety Inspection and Reporting Schedule, Tab # 116	Robert Winfrey

Status: Monthly inspections will begin on 8/7/2008.

VIII.D.10.c

initiate inquiries regarding problematic trends;

Findings

No progress to report. See VIII.D.10.a.

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

	Recommendations	*Responsible Party*
1	*The Infection Control Committee should determine areas for further "drill down" based on trends in data.*	***AF;***

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

	Recommendations	*Responsible Party*
2	*The Medical Director and Assistant Directors of Nursing should review the ES findings on a monthly basis.*	***CVC; JH; AF; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Safety officer will submit environmental survey findings each month to COO, Medical Director, ADON, and Civil and Forensic Directors	8/7/2008	Hospital Safety Inspection and Reporting Schedule: August to December 2008. Tab # 116	Safety Officer

Status: Monthly Safety Inspections will begin 8/7/2008 and findings will be submitted on a monthly basis to the COO, Medical Director, ADON and Civil and Forensic Directors beginning September 1, 2008.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Med Director, ADON and Civil and Forensic Directors and their respective Administrative Officers will implement corrective actions as needed, supported by COO.			

Status: Ongoing.

VIII.D.10.d

identify necessary corrective action;

Findings

No progress to report other than the creation on the position of Safety Officer. See VIII.D.10.a The Environmental Survey report included recommendations, and the Safety Officer is monitoring implementation but there is no

systemic method to monitor the recommendations.

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

Recommendations — ***Responsible Party***

1 *Document corrective actions in an attachment to aggregate data/reports, specifying names and due dates.* — ***CVC; JH; AF; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 OMS will work with Safety Officer to develop database to track environment survey results and corrective actions.	9/24/2008		Safety Officer; OMS
2 Safety officer to ensure findings included in database and produce reports monthly	10/31/2008		Safety Officer
3 Safety officer to track implementation of recommendations and report monthly to Risk Management Committee.	10/31/2008		Safety officer

2 *The Medical Director and Assistant Directors of Nursing should initiate actions on ES findings and document the action taken.* — ***CVC; JH; AF;***

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

VIII.D.10.e

monitor to ensure that appropriate remedies are achieved;

Findings

No progress to report. See VIII.D.10.a

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

Recommendations — ***Responsible Party***

1 *Develop a policy/procedure/process to monitor effectiveness of actions taken to resolve findings relative to infection and communicable diseases.* — ***AF;***

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

2 *Develop an instrument to monitor that the process was followed.* — ***AF; PID; PID with AF***

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

VIII.D.10.f

integrate this information into SEH's quality assurance review; and

Findings

No progress to report. See VIII.D.10.a

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

Recommendations — ***Responsible Party***

1 *See VIII.D.10.a through VIII.D.10.d*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.D.10.a through VIII.D.10.d.			

VIII.D.10.g

ensure that nursing staff implement the infection control program.

Findings

See VIII.D.10.a. Nursing amended policy of wearing gloves in dining room that limit it to specific circumstances warranted by infection control practices. See Tab # 117 (QIR 203). Nursing will be conducting regular environmental surveys of units. (See Tab # 114) No other progress to report.

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

Recommendations	Responsible Party
1 Develop policies/procedures that clearly define precautions, the steps to implement each type, and to document implementation of precautions. Consider developing a flow sheet to streamline this documentation.	*CVC; JH; AF;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop Infection Control Manual.	8/29/2008		AF

Recommendations	Responsible Party
2 Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions.	*CVC; JH; PID;*

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

Recommendations	Responsible Party
3 Evaluate the routine need for gloves in the dining room as it is not individualized and does not contribute to a recovery informed environment.	*CVC; JH; AF;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discontinue nursing practice of use of gloves in dining room except in specific circumstances	7/1/2008	QIR 203 Infection Control program Tab # 117	CVC; JH
Complete *Status: Policy amended to limit use for specific circumstances*			

VIII.D.11

Ensure sufficient nursing staff to provide nursing care and services.

Findings

The Hospital is recruiting for a Director of Nursing who will lead nurse education and nursing policy. The Hospital revised its nursing staffing standards, See Tab # 118, and is continuing to recruit nurses. Eleven nurse manager positions were filled, and there has been a substantial improvement in the number of on board nursing staff. Specifically, the Hospital has had a net gain of 11 nurse managers, 13 RNs, 3 LPNs, 11 PNAs, and 16 FPTs. In forensic services, each unit, each shift has an RN on duty, but civil services has not yet been able to meet this standard.

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

Recommendations	Responsible Party
1 Develop a comprehensive SEH Plan for Nursing Services that includes the components described in findings (above).	*CVC; JH;*

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Recruitment of Nursing Staff-Revise GNA-100.4 Staffing Standards	7/1/2008	Copy of revised staffing standards Tab # 118	CVC/JH
2	Continue to recruit nurses.	6/30/2008	Staffing reports Tab # 11	COO
	Status: The Hospital filled eleven vacant nurse manager positions during the fiscal year and is currently screening applications for three more vacancies and is in the early stages of the recruitment process for the DON position. Other nursing hires include 13 RNs, 3 LPNs, 11 PNAs and 13 FPTs.			
3	Hire DON	8/29/2008		CEO
	Status: Interviews underway.			
4	DON to review all nursing services and procedures and modify as appropriate.	2/12/2009		

2 *Prioritize filling Nursing Unit Manager positions, the Forensic Nurse Consultant position, and an assistant position to the ADONs in both services.* ***CVC; JH; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Fill vacant Nurse Manager, Forensic Nurse Consultant and Assistant to the ADON positions.	7/31/2008		James Gallo
	Complete *Status: The Hospital is in the final stages of filling these positions. EOD dates for all nurse manager incumbents are staggered throughout the eight week period beginning 6/23/2008.*			
2	Produce regular HR reports that track recruitment activities	7/31/2008		James Gallo
	Status: Ongoing			

3 *Ensure at least one RN on duty on every unit 24/7.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Fill vacant RN positions	9/30/2008	Staffing report # 11	HR
	Status: Forensic has RN on duty on all shifts 24/7. Civil services is not yet meeting this standard.			
2	Pilot scheduling software to assist in scheduling nurse coverage	9/30/2008		COO; CVC; JH

4 *Clarify the nursing organizational structure at the most senior levels, especially the roles of the "DON" and "ADON".* ***CVC; JH; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise the new Chief Nursing Executive position description to clarity the roles of the DON and the ADON	4/30/2008	Copies of Position Descriptions for DON and ADONs, Tab # 102	Human Resources
	Complete			

IX. Documentation

Summary of Progress

See Sections V, VII, VIII, and X for progress summary.

IX. Documentation.

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

Findings

See sections V, VI, VII, VIII and X concerning documentation issues.

Compliance Status: See related compliance findings.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications

Summary of Progress

1. The Hospital revised its Seclusion and Restraint and Involuntary Administration of Medication Policies. It also created a separate policy involving use of protective measures. See Tab #s 48 (Seclusion and Restraint Policy), # 119 (Use of Protective Measures and Devices) and # 84 (Involuntary Administration of Medication). The revised policies reflect recommendations from the Baseline Report.

2. The Hospital developed a new tracking system for monitoring seclusion and restraint episodes that has improved the accuracy of data, but which is not wholly accurate. Implementation of AVATAR and modification to the UI policy that requires completion of a UI when seclusion or restraint is used is expected to achieve highly accurate data. The improved data collection system implemented in February 2008 likely accounts for some of the increased seclusion and restraint hours reflected in the Trend Analyses.

3. The Hospital still lacks the capacity to track incidents of emergency involuntary administration of medication.

4. Trauma informed care training occurred on two wards, but has not yet been expanded to other units. There has not been other training for nursing staff around alternatives to seclusion or restraint.

5. The compliance office reviewed a small sample of cases involving use of seclusion or restraint. Of the cases reviewed, there were physician assessments in all cases and the orders included a maximum duration, but there were few cases in which there was documentation of alternatives tried before use of restraints or seclusion. These results suggest that there has been little progress since the baseline review in key areas such as use of alternatives to seclusion/restraint and documentation.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications.

By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.

Findings

See sub cells for findings.

Compliance Status: See sub cells for findings.

X.A.

By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:

Findings

See sub-cells for status.

Two new policies - seclusion and restraint for behavioral reasons and use of medical/protective devices, were finalized. Tabs # 48 and # 119. A seclusion and restraint monitoring tool was drafted and piloted, but is also under review by the Hospital consultant. See Tab # 120. (Seclusion and restraint monitoring tool).

Seclusion and restraint data in the Trend Analysis shows a marked increase since February, but that some of that increase is as likely attributable to a better reporting system introduced in February, 2008 as it is to a substantial increase in use. Both seclusion and restraint increased in May and restraint was higher than at any point in the prior twelve months. However, data also shows that 77% of all restraint episodes involved 2 patients and 79% of the restraint hours involved these same patients. Tab # 8 Trend Analysis (April/May).

A small study of use of seclusion or restraint was done by the compliance office. Highlights of the data from the review sample shows that in all cases sampled, the physicians' orders included maximum duration and that a

physician assessed the patient within the required time frames. However, the review also showed that in 64% of the cases reviewed, there was no documentation of alternatives to use of seclusion and restraint, that there is no documentation that patients are informed regularly of the behavior that is needed for release, and that the treatment team debriefings are not occurring as required. See Tab # 49 (Seclusion/Restraint analysis)

Compliance Status: Partial

X.A.1

the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.

Findings

The seclusion and restraint policy was modified to incorporate all DOJ recommendations. See Tab # 48 (Seclusion and restraint for behavioral reasons). Key changes include development of a separate policy for use of medical restraint, protective devices and techniques for medical reasons, as opposed to behavioral reasons, and prohibiting use of prone restraint. Tab # 119 (Medical and Protective Device Policy). A decision was made not to include operational steps in the policy, but instead to have Nursing develop operational directions. The Policy also provides additional guidance on alternatives to seclusion or restraint.

Compliance Status: Partial

Recommendations	Responsible Party
1 Consider developing a separate policy for medical and protective restraints that would also include voluntary mechanical supports and/or positioning devices since these are governed by different standards (see CMS interpretive guidelines).	***CVC; JH; AF; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a separate policy for medical and protective restraints using CMS standards.	6/15/2008	Medical or Protective Devices and Techniques Policy Tab # 119	J Taylor
Complete *Status: Policies have been drafted and approved by Executive staff.*			

Recommendations	Responsible Party
2 Provide step-by-step operational direction in this policy, or charge the Nursing Department to develop the operational direction to assure consistent implementation of the umbrella policy.	***CVC; JH;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Nursing department shall incorporate operational guidelines into nursing procedures	8/29/2008		CVC; JH; ADON
Complete *Status: Policy only just finalized. Guidelines will now be developed*			

X.A.2

training in the management of the individual crisis cycle and the use of restrictive procedures; and

Findings

See VIII.D.1.5. In addition, reviewing the NVCI training will be an early focus for the new nurse educator.

Compliance Status: Partial

Recommendations	Responsible Party
1 Augment CPI with a module that incorporates some of the content from the training on Trauma Informed Services.	***AF; Trg;***

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

1 See action steps in VIII.D.1 recommendation 5.

X.A.3

the use of side rails on beds, including a plan:

Findings

A new policy was developed that governs the use of side rails as well as other protective interventions. See Tab # 119 (Medical and Protective Devices Policy).

Only two wards, RMB 1 and 2, use side rails and currently 4 patients on RMB 1 use some form on side rails, and 2 on RMB 2 use side rails. One patient is expected to discontinue use of side rails soon. Nursing staff also is updating the nursing policy on use of side rails and nursing interventions, and a new tool to monitor use.

Compliance Status: Substantial

Recommendations — ***Responsible Party***

1 See XA.1 above

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

2 Develop a tool and process to monitor side rail use. — ***CVC; JH; PID; with PID***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Update nursing policy and develop revised tool.	7/31/2008	Policy and tool attached Tab # 119	CVC; JH; ADPN
Complete *Status: Revised policy and nursing monitoring form developed*			
2 Train nursing staff on revised policy.	8/29/2008		
Status: training has not yet begun			

X.A.3.a

to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and

Findings

Requirements for alternative, less intrusive interventions prior to use of seclusion or restraint, and time limits for use, are included in the revised policy. Tab # 119 (Medical and Protective Devices Policy). Policy has been finalized, but implementation will begin as soon as medical and nursing staff have been trained.

Compliance Status: Partial

Recommendations — ***Responsible Party***

1 See XA.1 and 2 above

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XA.1 and 2 above.			

X.A.3.b

to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the

Findings

The revised policy includes a requirement to include use of side rails into a patient's treatment plan. See Tab # 119 (Medical and Protective Devices Policy). The treatment plans for the majority of patients using side rails reflect their use, and the staff undertake efforts to minimize use and/or to work with patient so side rails can be discontinued.

Compliance Status: Substantial

medical symptoms.

Recommendations — ***Responsible Party***

1 See XA.1 and 2 above

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XA.1 and 2 above.			

X.B.

By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:

Findings

See sub-cells for status

Compliance Status: See sub cells.

X.B.1

are used after a hierarchy of less restrictive measures has been considered and documented;

Findings

The final policy on Seclusion and Restraints for Behavioral Reasons includes additional examples of alternatives to use of seclusion and restraint. However, a sample of medical records reviewed by the compliance office do not consistently reflect that alternatives were tried. The most common alternative is "redirection", and in many cases, the patient's Advanced Instruction for Treatment Preferences was either not completed or not used (i.e.. PM, GS, AB did not have completed Advanced Instruction). There were two incidents in which medication in advance of restraint or seclusion (as opposed to at the time of seclusion/restraint) was tried but both cases ended up with a restraint episode.

The Treatment Plan Conference Protocol now includes a reminder for staff to ensure the Advanced Instruction is completed and reviewed at each treatment plan. See Tab # 17 (Treatment Plan Conference Protocol).

See also VIII.D.1 recommendation 5 relating to amending NVCI training.

The compliance office reviewed all UI forms for the period of February through April, 2008. It found that while in many cases, an assault on staff led to a seclusion or restraint episode, there were six incidents in which seclusion or restraint did not occur following an assault on staff. The incidents which did not lead to seclusion or restraint involved 5 patients and 5 different wards/locations.

Compliance Status: Partial

Recommendations	***Responsible Party***
1 Augment CPI with a module that emphasizes alternatives to restrictive measures. Consider incorporating some of the content from the training on Trauma Informed Services.	***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in section VIII.D.1 recommendation 5.			

2 Determine whether or not individuals are routinely restrained following staff assault. **CVC; JH;**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review UI reports for three month period to identify incidents of patient on staff assault.	4/30/2008		Compliance officer

Complete *Status: Compliance office conducted a review of UI reports for the three month period of February to April, 2008 to determine if all incidents of patient on staff assault resulted in seclusion or restraint. Review showed that there were six incidents of patient on staff assault in which seclusion or restraint was not utilized.*

X.B.2

are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

Findings

DC Students working at the Hospital for the summer devised a plan to collect games, reading materials and other supplies for each unit. The drive will last for 3 to 4 weeks, and conclude in August, 2008.

Other than increasing the number of nursing staff and nurse managers and hiring another nurse educator to develop curricula and retrain staff on mental health symptoms and behaviors, there is no progress to report on this requirement. In a review of a small sample of seclusion/restraint episodes (12 incidents involving 6 patients), there was one incident involving a patient with multiple incidents of s/r in which staff stated the patient "Showed no remorse for his actions" suggesting staff believed he could control his actions or should be punished for his actions. Significant training on behaviors and mental illness and alternatives to seclusion or restraint is needed.

Compliance Status: Noncompliance

Recommendations	***Responsible Party***
1 Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning.	***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.D.1 recommendation 1.			
2 Develop special training curricula to retrain nursing staff on mental health diagnosis, symptoms and role of behavior in treatment.	9/30/2008		Nurse educator
Status: Nurse educator hired, but training not yet begun.			
3 Begin training for all nursing staff, and complete by January 31, 2009.	10/31/2008		Nurse Educator

2 Train all nursing staff on how to initiate conversations and activities to improve the individuals' quality of life. ***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.D.1 Recommendation 1 and 5			
2 Develop curricula and begin training staff	8/29/2008		Nurse educator
3 Expand trauma informed care training to all units over the next 9-12 months.	7/31/2009		Medical director

3 *Provide games, reading material, and other supplies to each unit that staff can use to involve individuals in leisure activities.* ***CVC; JH; Candyce Hughes***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a plan for the Mayor's High School Intern group at Saint Elizabeths Hospital to organize and implement a drive to collect leisure supplies	6/20/2008		Candyce Hughes
	Status: In Process - The plan has been developed by the students, but requires some feedback prior to implementation. The tentative date for setting up collection points is 7/14/2008. Target date for distribution of donated items to the wards is 8/4/2008.			
2	Civil and Forensic Administrative officers to collaborate with Clinical Administrators and Nurse Managers around collection and distribution	8/29/2008		JH; CVC
	Status: Once plan finalized, it will be presented to Civil and Forensic managers			

4 *Consider ways to identify and utilize nursing staff, especially PTs, to act as unit level leaders for culture change.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue implementation of Trauma informed care on RMB 6. Plans to introduce to RMB 3 as mentored by RMB 6 staff.	8/1/2008		CVC; JH
2	Continue to implement patient focused treatment planning on RMB 1/2. Plans to introduce treatment planning training to other RMB units by the RMB 1/2 Clinical Administrator as mentor and consultants as trainers.	8/29/2008		CVC; JH
3	Civil And Forensic Directors to consult with respective Associate Directors of Nursing regarding utilizing nursing staff as unit level leaders for cultural change.	7/25/2008		CVC; JH
4	Revise Dress code Policy-GNA 100.6	6/30/2008	Dress code policy # 121	
	Complete *Status: Policy completed*			
5	Train Nursing staff on policy	7/31/2008		
6	Train all units hospital wide in trauma informed care within 9-12 months.	7/31/2009		Medical Director

X.B.3

are not used as part of a behavioral intervention; and

Findings

The Director of Psychology has reminded her staff that seclusion and restraint should not be used as part of a behavioral plan. This will also be addressed with psychologists in training with the consultant hired to provide training on behavioral support plans. See Tab # 24 (Contract with Consultant) ; Tab # 92 (Memorandum From Director of Psychology)

Trauma informed care is to be expanded to RMB 3, but no date has been set for training to begin.

Compliance Status: Partial.

Recommendations	Responsible Party
1 Use positive behavior support team/psychologist to assist treatment team to develop alternative interventions.	*CVC; JH; AF;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Enter into contract with consultant to provide training to psychology staff and targeted ward staff on Behavioral support strategies. *Complete*	6/30/2008	Dan Arnheim contract Tab # 24;Angela Adkins contract Tab # 9	Chief of staff
2 Expand trauma informed care to RMB 3 and by July 31, 2009 to all units in Hospital.	8/29/2008		Medical Director; JH; CVC
3 Psychology staff to mentor staff on positive behavior support	7/31/2008		

Recommendations	Responsible Party
2 Establish date by which the use of seclusion or restraint as part of a behavioral intervention will be prohibited.	*EXEC*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Chief Psychologist has clarified that behavioral plans will never include seclusion or restraint as a behavioral intervention. *Complete*	6/30/2008	Memo to Psychology Staff. Tab # 92	Rose Patterson
2 Provide training to RMB 3 on PSB plans and their implementation. *Status: Contract has been signed and training to begin by July 31, 2008*	7/21/2008	Arnheim contract, Tab # 24; Adkins contract Tab # 9	Rose Patterson
3 Chief Psychologist is monitoring and approving all behavioral plans being proposed by staff to ascertain that seclusion and restraint is not mentioned as a behavioral intervention and for quality assurance. *Status: Ongoing*			Dr. Patterson

X.B.4

are terminated as soon as the individual is no longer an imminent danger to self or others.

Findings

The seclusion and restraint policy was revised to provide that nursing staff should terminate seclusion/restraint when the patient is no longer an imminent dangerous to self or other. See Tab # 48 (Seclusion/Restraint for Behavioral Reasons Policy). Training has not yet begun and the policy therefore is not yet implemented. In the small sample reviewed by the compliance office there were two incidents when it was not clear when the intervention ended, although the record suggested the patient was out by at least the time the order expired. Further, in the sample cases reviewed, there were no clear incidents found where seclusion/restraint terminated before the order expired, but there were no incidents noted where the s/r exceeded the time in the order without renewal. There was one case in which the notes suggested the patient was calm and restraints could have been

terminated, but in that case, the patient remained in restraint for the full period. Tab # 49(Seclusion/restraint data report)

Compliance Status: Partial.

Recommendations	Responsible Party
1 Develop a tool and implement a monitoring process to identify and resolve incidences where the individual remains in seclusion or restraint when no longer an imminent danger to self or others. This tool/process should also identify any indicators of "routine" restrictions following seclusion or restraint.	***CVC; JH; AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize S/R policy and draft monitoring tool **Complete** *Status: Tool drafted and policy completed*	7/15/2008	Seclusion/Restraint Policy # 48 Monitoring Tool Tab # 120	PID; CEO
2	Modify S/R monitoring tool and obtain technical assistance from consultant *Status: Tool provided to consultant for feedback*	8/29/2008	Draft S/R monitoring tool Tab # 120 ; Results of Monitoring, Tab # 49	PID
3	Train staff, begin monitoring and report on same.	9/12/2008		PID
4	Revise tool as needed.	11/3/2008		PID

Recommendations	Responsible Party
2 Revise documentation forms to prompt a discussion with the individual and document the individual's ideas about what would most help him/her to successfully re-integrate into the treatment milieu.	***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise policy to require staff to have discussion and related forms **Complete**	7/16/2008	S/R Policy and related forms Tab # 48	Policy Director
2	Include this requirement in monitoring tool. *Status: Tool not yet modified.*	8/18/2008		compliance officer

X.C.

By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:

Findings

See sub cells

Compliance Status: See sub cells.

X.C.1

Findings

the specific behaviors requiring the procedure;

The Hospital has announced a solicitation for a training that focuses on use of seclusion and restraint, alternatives to seclusion and restraint, and nursing documentation around seclusion or restraint consistent with Hospital policy, the Agreement with the Department of Justice and the ensuing report, and with best practices. That contract has not yet been awarded, but is expected to be done so soon. Tab # 123 (Statement of work for nursing training on seclusion and restraint)

In the small sample of cases reviewed by the compliance officer, documentation about the behavior leading to restraint or seclusion varied from staff to staff. In some cases, the behavior was described in detail either in a nursing note or by doctor note (patient threw chair or television) but in others, it was more generally described (i.e. agitated). Tab # 49 (Seclusion and restraint data report)

A seclusion and restraint monitoring tool was drafted and piloted, but is also under review by the Hospital consultant. See Tab # 120. (Seclusion and restraint monitoring tool). Highlights of the data from the review sample shows that in all cases sampled, the physicians' orders included maximum duration and that a physician assessed the patient within the required time frames. The consultant is expected to make recommendations that will improve the monitoring process and factors being monitored.

Compliance Status: Partial.

Recommendations	***Responsible Party***
1 *Develop a tool and implement a monitoring process to identify and evaluate trends in standards adherence.*	***PID;***

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

X.C.2

the maximum duration of the order;

Findings

There was a pilot review of seclusion/restraint information using a draft tool. In all cases reviewed, the physician's order included a maximum duration. Tab # 49 (Seclusion/restraint audit data analysis)

Compliance Status: Substantial.

Recommendations	***Responsible Party***
1 *Continue current practice.*	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice. *Status: Current practice continues.*			

X.C.3

behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;

Findings

In the sample cases reviewed by the compliance office, criteria for release generally included statements such as "when not at high risk of violence"; "when calm and appropriate".

Policy was revised to provide that nursing staff should contact physician when individual behaviors may be different from release criteria but do indicate patient is ready for release. Tab # 48 (Seclusion and restraint policy)

Compliance Status: Noncompliance.

Recommendations — ***Responsible Party***

1 *In order "jump start" a change in their thinking about criteria for release, provide RNs and MDs with a 'cheat sheet" of examples of how to write behavioral criteria for release.* — ***AF; BG; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop curriculum and train RN's and MD's on newly revised seclusion and restraint policy which includes a revised order form.	8/31/2008	Seclusion and Restraint Policy Tab # 48	Medical Director, Chief Nurse
	Status: This order form cues staff to consider behavioral criteria for release.			
2	Develop list of examples of how to write behavioral criteria for release	10/15/2008		Medical Director
	Status: No action yet taken.			

2 *Make an addition to the policy that directs the RN to contact the physician to review individual behaviors that may be different from the release criteria but that do, in fact, indicate readiness for release.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include in revised S/R policy that RN must contact physician to review patient behaviors that indicate readiness for release	6/15/2008	S/R policy, Tab # 48	J Taylor
	Complete *Status: Inserted required statement into policy*			

X.C.4

ensure that the individual's physician be promptly consulted regarding the restrictive intervention;

Findings

The sample survey by the Compliance Office reveals this was done in all cases. See Tab # 49 (Seclusion/restraint audit data analysis)

Compliance Status: Substantial.

Recommendations — ***Responsible Party***

1 *Continue current practice.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice.			
Status: Current practice continues.			

X.C.5

ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;

Findings

The sample survey by the Compliance Office could find no documentation in any of the medical records reviewed that patients in seclusion or restraint were informed of the behavioral criteria for release. Tab # 49 (Restraint/seclusion audit data). However, the revised Policy includes this requirement, and it will be included in the nursing monitoring tool. Tab # 124 (Seclusion/restraint nurse monitoring tool)

Compliance Status: Partial.

Recommendations — ***Responsible Party***

1 *Act on trends identified through monitoring to resolve discrepancies.* — ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify tracking of S/R (nursing monitoring forms) to ensure nursing staff re-inform patients of criteria for release and document same.	7/17/2008	Modified nursing tracking log Tab # 125	CVC;JH
	Complete *Status: Nursing log modified*			
2	Track this in S/R monitoring form	7/16/2008	S/R Monitoring form, Tab # 124	
	Complete *Status: S/R monitoring tool modified and under review by consultant*			
3	Track data and respond as trends identified.	7/16/2008		Compliance office

X.C.6

ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;

Findings

This still is not being consistently met. In the sample, it appeared that debriefings occurred in about half the cases, although in some cases, it was outside the one business day time frame. One unit in particular, (RMB7/3) is the most consistent in documenting debriefing. Tab # 49 (Restraint/seclusion audit data)

Compliance Status: Partial

Recommendations	Responsible Party
1 Act on trends identified through monitoring to understand and resolve barriers.	***CVC; JH; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure S/R monitoring tool checks for compliance	6/5/2008	S/R monitoring tool Tab # 120	PID
	Complete *Status: Tool includes this requirement; tool is being reviewed by consultant*			
2	Begin monitoring this aspect and report on same, by unit.	8/29/2008		CVC; JH
	Status: Tool being reviewed. Tool was piloted and included this requirement			
3	Use data to identify problem areas, issues and modify practice through training, policy clarification or other appropriate intervention.	9/30/2008		PID
4	Develop capacity in AVATAR to monitor S/R usage, data entry and post S/R interventions.	2/27/2009		COO

X.C.7

comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and

Findings

In all incidents reviewed in the sample, a physician assessed the individual and completed an order. Tab # 49 (Restraint/seclusion audit data)

Compliance Status: Substantial

Recommendations	Responsible Party
1 Continue current practice.	

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

Continue current practice

Status: Continue current practice

X.C.8

ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.

Findings

In general, patients in seclusion or restraint are supervised by a 1:1 staff member. However, there remains no system in place to monitor whether the person has completed competency based training. Recently, the Office of Training Services and the Directors of Civil and Forensic Services established a protocol to monitor when training is expiring, but it does not yet address if an individual staff achieves basic competencies. Tab # 108 (Mayo Memorandum). The development of a data base to capture information about completion of training has begun but is not yet completed.

Compliance Status: Partial.

Recommendations	Responsible Party
1 Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications.	***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training Director to work with Civil and Forensic Directors on monitoring training hours and courses for staff, to include notification of managers when employee's training is to lapse or when competency not achieved	6/27/2008	Mayo memorandum summarizing meeting Tab # 108	Training Director, CVC; JH
Complete *Status: Meeting held and procedure agreed upon*			
2 See also V.B.1 recommendation 4			

Recommendations	Responsible Party
2 Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.	***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Discuss process with Civil and Forensic Directors to ensure notice is sent when competence is not achieved or training expires	6/18/2008	Memorandum from Lewis Mayo, Tab # 108	Training director
Complete *Status: See also X.C.1 recommendation 1*			

Recommendations	Responsible Party
3 Develop basic core competencies for all clinical disciplines consistent with their potential involvement in seclusion and restraint as well as less restrictive interventions.	***CVC; JH; AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Director of Nursing to develop standards for core competencies related to use of seclusion and restraint.	9/15/2008	PDs, Tab # 102	CEO
Status: Positions are posted and interviewing is in process			
2 Hire Training Director to develop and implement training module.	9/30/2008		CEO

X.D.

Findings

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.

In February, 2008, a new system was put in place to improve accuracy of seclusion/restraint data. Under that system, seclusion and restraint data is collected each shift by the nursing supervisor's office. This system has substantially improved the data collection, but there remain some discrepancies. The compliance office reviewed all UI reports for the three month period of February, 2008 through April, 2008 (note, policy at the time only required a UI when the episode was not consistent with s/r policy, but UIs were filed in many cases nonetheless). We compared those reports against the Civil Services daily nursing log of seclusion and restraint episodes. The review established that there were 16 UIs indicating use of seclusion or restraints for which there was no annotation on the log. Please note that we did not review JHP records as its usage of restraint was significantly lower, but we were not able to locate any UI report reflecting use of restraints or seclusion at JHP, although were are aware of some usage. In addition, the compliance office looked at the charts of 6 patients with 12 incidents of seclusion to compare the data (hours, date and time) with that in the nursing log. Under this review, the office found two incidents of restraint that were not recorded in the chart (later incidents the same day for two patients were recorded, but the earlier incidents were not) and in some cases, there was no clear documentation of when the seclusion or restraint ended, so it was difficult to tell if the hours were accurately reported. The new system has improved data accuracy, which has translated to what appears to be a significant increase in the use of seclusion or restraint in the trend analysis, but which is more likely due to better reporting and tracking. Until AVATAR is fully implemented it is unlikely that the data will be wholly accurate.

Compliance Status: Partial.

Recommendations				***Responsible Party***
1 *Explore and resolve barriers to accurate reporting.*				***CVC; JH; PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 See action steps to X.C.5 recommendation #1 and X.C.6				
2 Implement automated data tracking through AVATAR beginning with Phase 2	1/30/2009		COO	
2 *Evaluate potential ways to embed reporting requirements within other documentation requirements.*				***CVC; JH; PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Provide technical assistance to program managers on how to avoid duplicative reporting requirements.	8/20/2008		PID; CVC; JH	

X.E.

By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or res

Findings

The Hospital policy meets this requirement. See Tab # 48 (Seclusion/restraint for behavioral reasons). Implementation is not consistent, based upon a small sample case review. Tab # 49 (Restraint/seclusion audit data).

Compliance Status: Partial.

Recommendations	***Responsible Party***
1 *Explore and resolve barriers to adhering to this standard.*	***CVC; JH; PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize monitoring form for S/R with input from consultant	8/15/2008	Draft S/R Monitoring Tool, Tab # 120	PID; Chief of Staff
	Status: Tool is in draft. Under review by consultant, but it is being used at this point			
2	Monitor compliance with policy and report results.	10/1/2008	Results for S/R Monitoring Tab # 49	PID
3	Identify issues and implement corrective actions.	12/1/2008		JH; CVC

X.F.

By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:

Findings

See sub cells for findings

Compliance Status: See sub cells for findings.

X.F.1

such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;

Findings

The Hospital revised its Involuntary Administration of Medication policy as well as created a new a Seclusion and Restraint for Behavioral Reasons policy to improve clarity around this requirement. DC has a very restrictive law on involuntary medication that is not wholly consistent with CMS regulations but is more protective of the patient's rights. Consequently, there may be differences in the Hospital's policy compared with CMS regulations.

The Hospital is not capturing any data on use of PRN, STAT or emergency involuntary medication at this time. It is anticipated that with AVATAR there will be capacity to identify those cases, and thereafter review and monitor how the medication was used and what response, if any the treatment team took to address the underlying issues. No tools have been developed to review use of emergency involuntary medication at this time.

Compliance Status: Noncompliance.

	Recommendations	Responsible Party
1	*Develop policies that define pharmacologic restraint consistent with CMS definitions, that establish clear standards for use, and that also describe the use of prn and stat medication. Clearly differentiate the requirements and indications for each of these three categories.*	***CVC; JH; AF; PID; BG; Matt***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Incorporate CMS-defined definitions into Restraint/ Seclusion and Involuntary Medication policies to the extend consistent with DC law.	6/15/2008	Restraint/Seclusion Policy Tab # 48 Involuntary Medication policy Tab # 84	J Taylor
	Complete *Status: Incorporated CMS-defined definitions into policies. Please note DC has a specific law which differs in part from CMS definition, so policies reflect both*			

2 Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide. — ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Create crystal reports through AVATAR that will track use and time frames for use of emergency involuntary medication, prn medication and stat medications by developing Crystal reports *Status: In process of hiring Crystal report writers*	10/31/2008		COO
2 Reports to be reviewed and monitored by discipline chiefs	11/28/2008		Medical Director; CVC; JH
3 Once developed, ensure capacity to run reports at least monthly to identify trends and provide data to Exec staff and P & T Committee	12/17/2008		

3 Explore alternatives to gathering data that do not involve nursing staff filling out reports, in addition to regular documentation. Paper technologies, such as NCR copies of orders, pharmacy records, as well as electronic technologies should be explored. — ***AS; Avatar ?***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Successfully implement Phases One and Two for the Avatar application. *Status: The ability to update progress notes in the Avatar application is a part of Phase II of the implementation- tentatively scheduled to go live at Winter 2008.*	2/27/2009		Eric Strassman, Sharmaine Allen, Mark Larkins

X.F.2

a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and

Findings

No progress has been made. Data or other information on meeting this requirement is not available. No tool has been developed to collect this data. However, anecdotally, in appears that when involuntary emergency medication is administered as part of a restraint or seclusion episode, there is a physician assessment of the patient as part of the seclusion/restraint episode; information shows that the physicians are seeing patients if seclusion or restraint is ordered.

Compliance Status: Noncompliance.

Recommendations	*Responsible Party*
1 See X.F.1	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See X.F.1			

X.F.3

Findings

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.

No progress has been made. Data or other information on meeting this requirement is not available. No tool is available to collect this data.

Compliance Status: Noncompliance.

Recommendations	***Responsible Party***
1 *See X.F.1.*	
1 *Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide.*	***CVC; JH; PID; AS;***

Recommendation 1 (See X.F.1.):

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See X.F.1.			

Recommendation 1 (Develop tools and implement processes…):

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Crystal Report that captures emergency involuntary administration of medication so that trigger can be identified.	11/7/2008		COO
2	Provide reports weekly to Medical Director and Civil and Forensic Directors to ensure treatment teams review cases as appropriate and tracks by practitioner, unit and system wide.	12/12/2008		COO
3	Obtain technical assistance from consultant to review tools and data reports.	3/2/2009		

X.G.

By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based

Findings

No information is available.

Compliance Status: Noncompliance

Recommendations	***Responsible Party***
1 *Develop and implement a competency-based training curriculum to jointly train MDs and RNs on these policy requirements since most involve both disciplines and a collaborative effort will support success.*	***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Hire Director of Nursing to develop training on policy requirements. *Status: Position has been posted and interviews are in progress.*	9/15/2008	PD	CEO

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Work with nurse educator on design and implementation of training.	10/31/2008		CVC; JH

2 *Develop aggregate reports on the percent of staff that satisfactorily complete this training.* ***CVC; JH; AF; PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Formulate report on completion of related training.	11/30/2008		Medical Director, Chief Nurse, Training Director

Status: Training module to be developed.

3 *Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.* ***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop procedures to provide remedial training and when indicated, disciplinary actions when competence is not achieved.	11/15/2008		Medical Director, Director of Nursing

Status: Procedure needs to be developed. May require negotiations with labor unions.

XI. Protection from Harm

Summary of Progress

1. The Hospital finalized a policy requiring the "Reporting of Abuse or Neglect". See Tab # 126.

2. The Hospital revised its unusual incident reporting policy and UI form. See Tab # 127, (UI Policy) Tab # 128 (UI form). See also Summary of Progress Section XIV.

3. The Hospital began implementation of criminal background checks for unlicensed direct care staff employed after 2001, the full extent permitted by DC Law. See Tab # 129 (DMH Policy). The law excludes criminal checks of licensed employees, and it does not appear that DC licensing boards routinely complete criminal background checks prior to issuing licenses.

4. The Hospital conducted an environmental survey in March, 2008 that showed improvement compared with the previous survey. Tab # 83 (Environmental Survey)

XI. Protection from Harm.

By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.

Findings

See sub-cells in Sections XII, XIV, VIII.D and VIII.A.2.b.iv.

Compliance Status: See related sections

Recommendations	***Responsible Party***
1 *For discrete recommendations to fulfill the obligations of this Section, please refer to:*	

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

1 *The recommendations listed below in Section XII regarding incident management.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related action steps in section XII			

2 *The recommendations listed in Section XIV regarding environmental conditions.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related actions steps in Section XIV			

3 *The recommendations listed in Section VIII.D regarding nursing services.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See related action steps in Section VIII.D			

4 *Develop and implement a mortality review system that ensures that death reviews are timely, thorough and complete, contain specific recommendations for corrective action, and that such actions are implemented. (See Section VIII.A.2.b.iv. of SA and Report p. 110).* ***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in VIII.A.2.b			
2 Revise policy to provide for a system that includes 1) peer review; 2) investigation by Risk Manager; 3) interdisciplinary review process; 4) and external review	10/15/2008		Medical Director, J Taylor
Status: Revised Policy is in draft form, and is expected to be finalized in fall, 2008			
3 Enter into contract with external reviewer.	12/31/2008		DMH; COO

XII. Incident Management

Summary of Progress

1. The Hospital revised its UI policy to reduce the number of codes, clarify reporting structure and also revised the UI form to capture severity of incident, identity and roles of staff, patient and witnesses, all use of seclusion or restraint, among other changes. See Tab # 127, (Reporting of Unusual Incidents); Tab # 128 (UI Form). The form will be piloted for 30 days on four units, and then will be rolled out to all staff by the end of September. The Risk Manager is leading the training. See Tab # 130 (Training outline for UI policy pilot)

2. The Hospital created a position of Safety Officer to supplement the position of Risk Manager. The Safety officer will focus on environmental issues, and the Risk Manager will focus on patient care issues. See Tab # 131(Safety officer PD); Tab # 132 (Risk Manager PD).

3. The UI database is updated to reflect the new Form. However, until the UI form is implemented across the Hospital, both forms will be used, so some data elements for some UIs may not be available.

4. The Hospital is conducting investigations into all reported allegations of abuse or neglect, suicide or suicide attempts, and elopements of dangerous patients.

5. The Hospital has not yet initiated a campaign to encourage reporting of abuse or neglect, nor has it modified training to ensure accurate information of what constitutes abuse or neglect is provided to staff.

6. The UI data is reported bi-monthly in the trend analysis. With full implementation of the new UI form reporting of additional factors will begin. Back up data is made available to managers. See Tab # 8 (Trend Analysis, April/May)

7. The Hospital recognizes the need to track review of recommendations of the Risk Manager, QI Department and Mortality review committee and is considering options. The Risk Manager is developing a tracking system specific for her investigations, and QID is more aggressively monitoring QIRs.

8. The Hospital has not yet implemented thresholds for injury/event indicators that initiate reviews at both unit level and at supervisory level.

XII. Incident Management.

By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.

Findings

See sub-cells for findings

Compliance Status: See sub cells for findings.

XII.A.

By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall requir

Findings

The Hospital revised its UI policy and UI form, incorporating the recommendations in the Baseline Report. See Tab # 127 (UI Policy); Tab # 128 (UI Form). It also revised and approved a new policy titled "Reporting Patient Abuse and Neglect". See Tab # 126. Training on the new policies has not begun, but with the addition of a second nurse educator, training on the new Reporting Patient Abuse or Neglect policy will be prioritized. Training on the new UI policy is set for August, 2008. Grievances are now reviewed and if they in fact are reports of patient abuse or neglect, they are forwarded to the Risk Manager for review.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				Responsible Party
1 *Review and revise incident management policies.*				***PID;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Discuss with the Mental Health Authority DOJ recommendations to reduce number of UI codes and other related recommendations.	4/30/2008		Acting PID director	
Complete *Status: Agreement reached to reduce number of codes.*				
2 Receive approval from DMH Office of Accountability	5/9/2008		CEO	
Complete				
3 Revise UI policy to incorporate approved changes	6/30/2008	Revised UI policy Tab # 127 ;UI Form Tab # 128	Director, Policy; Risk Manager	
Status: Revised Policy is complete				
4 Train staff from selected units in civil and forensic units on new policy and form, first piloting the form; pilot to last until August 31, 2008	8/29/2008	UI Training outline, Tab # 130	Risk Manager	
Status: Training is being developed				
5 Train all staff on new policy and form	9/30/2008	Training Tab # 130	Risk Manager	
Status: on-going				
2 *Clarify the appropriate use of the grievance system and include the distinction between a grievance and an incident in incident training at orientation and during annual training.*				***PID; Trg;***
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Develop new policy governing allegations of abuse and neglect.	6/30/2008	Reporting Abuse and Neglect, Tab # 126	Director, Policy	
Complete				
2 Obtain approval by Exec staff..	7/17/2008		CEO	
Complete				
3 Train all staff on new policy and incorporate into new employee orientation	9/30/2008		Director, Policy; Risk Manager; Director, Training	
Status: Not yet underway				

XII.A.1

identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;

Findings

The new UI policy and form have substantially simplified the number and reporting of unusual incidents. In addition, the UI policy now requires that all incidents of seclusion or restraint result in the completion of a UI report. Under the new system, the Risk Manager will assign severity codes to each incident, and the number of categories have

been reduced to 17. The new form will be piloted on 4 units (2 in civil and 2 in forensic), beginning in August, after training has occurred. It is expected that the new form will be implemented hospital-wide by the end of September, upon completion of training.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1 Compress the number of incident types to reduce the likelihood of coding errors.				*PID; BG;*
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Revise incident type list and obtain approval of Authority ***Complete***	5/16/2008		Acting Director, PID	
2 Finalize policy with reduced codes ***Complete***	7/15/2008	UI policy, Tab # 127	CEO	
2 Revise the incident policies to require the reporting of all uses of restraint and seclusion.				*PID;*
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Revise seclusion and restraint policy and UI policy to require reporting of all incidents of seclusion and restraint as UI ***Complete***	6/30/2008		Director, Policy	
2 Approve restraint and seclusion policy and UI policy	7/15/2008	UI Policy Tab # 127; Seclusion/restraint policy, Tab # 48	CEO	

XII.A.2

immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;

Findings

The draft policy "Reporting Patient Abuse or Neglect" was modified to include an obligation to report suspected as well as known abuse. See Tab # 126. The UI form has been modified for better tracking and to collect specific data about staff and patients; the UI data base is being revised to capture the data reflected in the new form It is expected that the new form will be used Hospital wide by September, after a pilot is completed to test and refine the form.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations				*Responsible Party*
1 Revise both DMH and SEH policies to require employees to report witnessed, discovered (suspicious injuries) or reported incidents and allegations of abuse and neglect.				*PID; PJC*
Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff	
1 Revise reporting suspected abuse or neglect policy. ***Complete***	6/30/2008	Reporting Patient Abuse and Neglect Policy Tab # 126	Acting director, Policy	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Train staff on new policy using competency based training.	10/31/2008		Training director
	Complete *Status: No action taken. New curriculum will need to be developed.*			

2 *Revise the incident reporting form to include an incident number.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise UI form.	6/30/2008	New UI form, Tab # 128	Director, Monitoring Systems; Risk Manager
	Complete			

3 *Consider revising the "role" designation on the draft incident reporting form and including a severity of injury code.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise UI form.	6/30/2008	UI Form Tab # 128	Director, Monitoring Systems; Risk Manager
	Complete			
2	Obtain approval by Exec staff.	7/15/2008		
	Complete			

4 *Review and correct the July 2006 revision of the Investigation of Patient Abuse and Neglect policy before implementing it.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise reporting patient abuse and neglect policy.	6/30/2008	Reporting abuse and neglect policy Tab # 126	Director, Policy
	Complete			
2	Train staff on new policy.			Training Director

XII.A.3

mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;

Findings

The Hospital policy governing "Reporting Patient Abuse or Neglect" (which controls incidents at the Hospital) specifically requires an employee suspected of abuse and neglect to be reassigned to non-patient areas or to be placed on administrative leave pending the outcome of an investigation. Reporting Abuse and Neglect Policy Tab # 126. It is the routine practice of the Hospital to do so when an allegation of abuse of neglect has been made.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	***Responsible Party***
1 *Revise the policies cited above so that they are consistent and clearly state that the named employee in allegations of abuse and neglect will be reassigned from direct support of individuals or will be placed on administrative leave, pending the conclusion of the*	***PID;***

investigation.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise allegation of patient abuse or neglect policy to address handling of suspect employee abuser. ***Complete***	6/30/2008		Director, Policy
2	Obtain approval by Exec staff. ***Complete***	7/15/2008	Approved policy Tab # 126	CEO
3	Train managers on new policy at Senior staff meeting.	9/15/2008		Director, Policy

XII.A.4

adequate training for all staff on recognizing and reporting incidents;

Findings

No new training has been provided and the training curricula has not been modified. However, new training is expected now that a new policy has been developed.

Compliance Status: No progress is being made toward the June, 2009 compliance date.

Recommendations	Responsible Party
1 Revise and expand training on the prevention and identification of abuse and neglect at both annual and orientation training, making it a discrete training course. Include in the title of the training the terms "abuse" and "neglect".	***CVC; JH; Trg;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize new policy.	7/15/2008	Approved Reporting abuse and neglect policy, Tab # 126	CEO
2	Develop training plan for competency based training on identifying and preventing abuse, with new curricula for current and new employees; begin training by Sept 30, 2008. Training will include component involving patient speakers. *Status: not yet started*	9/30/2008		Training Director
3	Complete training of all staff and include in new employee orientation.	11/17/2008		Training Director

Recommendations	Responsible Party
2 Review and revise if necessary the practices in place when a prospective employee does not pass the competency test.	***CVC; JH;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a system by which the Directors of Civil and Forensic Services are notified of an employee who fails competency based training. See also action steps to V.B.1 recommendation #4 *Status: Memorandum completed, data base under development*	9/30/2008	Mayo memorandum to Forensic and Civil Directors, Tab # 108.	training Director, Director Civil Services and Forensic Services

3 Implement plans to have employees complete annual training around the time of their birthday month, so that training is completed prior to the employee's annual performance review and is considered during the performance review. — ***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a training data base that includes employee's date of birth and well as type and dates of training and results of competency based training.	8/31/2008		Director, Monitoring of Monitoring Systems; Training Director
Status: Preliminary discussions on data base begun			
2 Ensure that employees' performance standards reflect requirements to complete annual training.	9/30/2008		All exec staff
Status: Ongoing			

XII.A.5

notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;

Findings

See XII.A.2. The Policy was revised to specifically require notification of suspected abuse and neglect. It is covered in new employee orientation, but the curricula to incorporate DOJ recommendations has not been revised as of this date.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations	***Responsible Party***
1 Revise policies as discussed above and expand and revise abuse and neglect prevention and identification training at annual and orientation training to ensure that employees understand their obligation to report.	***CVC; JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above sections for action steps.			
2 Hire Training Director.	9/17/2008		CEO, COO
3 Develop curriculum that includes patients in training on abuse and neglect and reporting.	10/31/2008		Training Director

2 Write guidelines to govern actions by instructors when employees fail the competency test at the conclusion of training. — ***CVC; JH; Trg;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hire Training director	9/17/2008		CEO; COO
Status: Position is advertised. Offer was made and rejected. Recruitment continues			
2 Working with Directors of Civil Services and Forensic Services, develop process and provide guidance to instructors on procedures when employee fails competency.	11/3/2008		Training director

XII.A.6

Findings

posting in each unit a brief and easily understood statement of how to report incidents;

Posters continue to be maintained on each unit.

Compliance Status: Substantial

Recommendations	Responsible Party
1 Continue current practice.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Continue current practice.		Environmental Survey results Tab # 83	
Status: Practice continues.			

XII.A.7

procedures for referring incidents, as appropriate, to law enforcement; and

Findings

The UI policy has been revised to reduce the scope of unusual incidents that must be reported to the Police. See Tab # 127 (UI policy).

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	Responsible Party
1 Revise the DMH policy to ensure that those incidents that require police notification are reported in a timely manner and those that do not require reporting are handled appropriately internally.	PID;

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise policy accordingly.	6/30/2008	UI policy Tab # 127	Director, Policy
Complete			

XII.A.8

mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.

Findings

The Hospital policy titled "Reporting Patient Abuse and Neglect" includes a specific statement that a reporter shall be free from retaliation. See Tab # 126. Language in DC regulations governing consumer rights similarly protects patients who may seek to file a grievance.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations	Responsible Party
1 Ensure that in the revisions to the relevant policies specific mention is made of the right for all persons to be free of retaliation or threats of retaliation for reporting an allegation of abuse or neglect in good faith. Include also the statement that staff members found to have engaged in threats or retaliation will be subject to disciplinary action.	PID;

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise policy around reporting suspected abuse or neglect. **Complete**	6/30/2008		Director, Policy
2	Exec staff to approve policy **Complete**	7/15/2008	Reporting patient abuse or neglect, Tab # 126	

XII.B.

By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect.

Findings

The Hospital modified its UI policy to incorporate the recommendations of the DOJ report. It also has created two positions, a Safety Officer and Risk Manager to ensure adequate attention can be paid to patient care and environmental issues within the Hospital. See Tab # 132 (PDs for Risk manager); Tab # 131 (PD for Safety Officer)

Monitoring the implementation of recommendations continues to be an issue, although the recent changes to the UI form and anticipated changes to the database should allow for better tracking of recommendations. Presently, there is no systemic tracking of recommendations or follow up to ensure that recommendations are considered by Executive staff, approved and implemented. The Risk Manager is working to develop a tracking method for recommendations in her investigations.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

	Recommendations	*Responsible Party*
1	*Ensure the review of incident investigations with approval indicated by the signature of an appropriate staff member other than the staff completing the investigation.*	*CVC; JH; AF; PID; BG;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Clarify UI policy and revise form. **Complete**	6/30/2008	UI policy Tab # 127; UI form Tab # 128	Director, Policy; Risk Manager; Director, Monitoring Systems
2	Obtain approval by Exec staff. **Complete**	7/15/2008		CEO

XII.B.1

require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;

Findings

Investigations are completed by either the Hospital Risk Manager, who is assigned to PID, or at times by the Mental Health Authority's Office of Accountability. The Hospital Risk Manager is trained in investigations. However, a new system of presenting recommendations to Executive staff, review by Executive staff, and tracking implementation of approved recommendations is not yet implemented, but is expected by September, 2008.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

	Recommendations	*Responsible Party*
1	*Identify why recommendations are not being reviewed, approved or revised as needed and*	*CVC; JH; AF;*

take measures to correct the problem. Identify persons/offices for monitoring implementation of the corrective measures and reporting back to the appropriate body. — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish a short term work group led by QID Director to assess why recommendations of Risk Manager or other committees are not implemented and to make recommendations on new process for review, approval and tracking.	8/29/2008		Director, QID, Policy Director
	Status: Review has begun but only relating to Mortality Review Committee			
2	Exec staff to approve new process	10/15/2008		CEO
3	QID will implement new process	11/3/2008		QID Director

XII.B.2

require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;

Findings

See findings in XII.B. 1. The Safety Officer is the former Risk Manager, and also has completed investigations training.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Ensure that all staff members who investigate serious incidents have investigation training. — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Training provided as needed to Risk Manager.			Risk Manager
	Complete *Status: New Risk Manager has completed State Farm Insurance training program. Also, Safety Officer (former risk Manager) completed training as provided previously*			

XII.B.3

include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and

Findings

The Hospital is revising its mortality review system, and will address this at that time. The revised process is expected to be completed by September, 2008.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Develop and implement procedures for the review of death reports completed by Risk Management by the appropriate member of the hospital's medical leadership. — ***AF; PID; AF ?***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps related to XII.B.1			

XII.B.4

Findings

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.

See XII.B. The Risk Manager will work with the Risk Management and Safety Committee to establish a format for presenting investigation material to it and to track implementation of recommendations.

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Identify the source of the problem in failing to give timely consideration and approval to recommendations made at the close of a death investigation by the Risk Manager. — ***PID; EXEC***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps related to XII.B.1			

2 Ensure the Risk Management and Safety Committee reviews all serious incident investigations in addition to reports on incidents prepared by the Risk Manager. — ***PID; Medsec***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager and Safety Officer will present information about all investigations to Risk Management and Safety Committee in month following completion of investigation.	7/31/2008		Safety Officer; Risk Manager

3 Identify a method for reviewing the effective implementation of corrective and preventive actions identified by the incident review process. — ***CVC; JH; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to XII.B.1			

XII.C.

By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding

Findings

See XII.B.3

Compliance Status: Minimal progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Revise the review of deaths and the operations of the Mortality Review Committee to meet current practice standards. — ***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Mortality Review Committee will review the policy to assess how deaths are reviewed and make necessary changes to ensure reviews meet appropriate standards *Status: Policy is under review.*	7/31/2008		Director, Medical Affairs, Director, Policy
2 Exec staff will review and modify as needed and submit to DMH Authority	9/30/2008		CEO

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3	Risk Manager will reinstitute sentinel event/root cause analyses for deaths	8/29/2008	Copies of results of sentinel event analyses	Risk Manager

2 Review the role of the Office of Quality Improvement and expectations around response to its reports. — ***PID; BG;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See XII B. 1			

XII.D.

By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigatio

Findings

The UI form has been revised to capture information about patients, staff involved, and witnesses. The form will be tested in a pilot phase on 4 wards for approximately one month, and then will be rolled out for the entire hospital. The data base is being revised for the pilot, but until full implementation, both databases will have to be maintained. Draft training materials on the new UI process are attached at Tab # 130.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Include the names of individuals in the incident management database. — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise UI form and process.	7/15/2008	UI Form Tab # 128	Exec staff; Director of Monitoring Systems; Risk Manager
	Status: Revised UI form and policy have been drafted and scheduled for review by Exec staff			
2	Train staff on new process	9/26/2008	UI Training, Tab # 130	Risk Manager
	Complete			
3	Modify data base	7/31/2008		Director of Monitoring Systems
4	Ensure information can be captured in AVATAR (Phase II) database and reports	3/18/2009		COO

2 Revise the incident management information system when appropriate to reflect the changes made in the incident definitions and codes and on the incident reporting form. — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See XII D 1.			

XII.E.

By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and trending of incidents and results of actions taken.

Findings

See XII.D. See also revised UI form. Tab # 128. The database will permit tracking and trending of each field of the UI form.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Such a system shall:

Recommendations — ***Responsible Party***

1 *Redesign the incident information systems so that the hospital can produce periodic reports on the characteristics of incidents specified in the Settlement Agreement.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See XII D 1.		Trend Analysis (Feb/March) Tab # 21; Trend Analysis (April/May) Tab # 8	Director, Monitoring Systems
	Status: Currently, bi-monthly trend analysis captures some data, which will be revised subsequent to Exec staff approval			
2	Implement automated system through Phase II of AVATAR	12/31/2008		COO
	Status: Staff are working with AVATAR to ensure that it can capture key data to generate reports and capture data			

2 *Identify and correct whatever made the death tracking inaccurate and be sure it did not infect other counts as well.* — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review data around deaths in CY 2007.	6/2/2008		
Complete	*Status: Reviewed data around deaths, clarifying that some reports of death include death of JHP outpatients as well as Hospital inpatients which accounts for discrepancy.*			

XII.E.1

Track trends by at least the following categories:

Findings

See XII.E

Compliance Status: See XII.E

XII.E.1.a

type of incident;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations — ***Responsible Party***

1 *Produce reports on incidents on a more frequent basis—initially on a quarterly basis.* — ***PID;***

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Produce Trend Analysis every two months.	5/31/2008	Trend Analysis (Feb/March) Tab # 21; Trend Analysis (April/May) Tab # 8	Director of Monitoring Systems
	Complete *Status: Trend analysis will become monthly once AVATAR (Phase 1 and 2) are fully functional*			

XII.E.1.b

staff involved and staff present;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations	Responsible Party
1 Consider changing the incident reporting form to identify aggressor, victim, witness and otherwise involved making it possible to report on staff members involved.	***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Obtain approval from DMH and revise form	4/30/2008	Revised UI form Tab # 128	Acting PID Director
	Complete			
2	Obtain Exec staff approval	7/15/2008		CEO
	Complete			

XII.E.1.c

individuals involved and witnesses identified;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations	Responsible Party
1 Consider revising the incident reporting form so that a single reporting form identifies aggressor, victim, witness and persons otherwise involved.	***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Obtain approval from DMH and revise form	4/30/2008	UI Form Tab # 128	Director, Monitoring System
	Complete			
2	Obtain Exec staff approval	7/15/2008		CEO
	Complete			

2	*Once this information is available in an information system, provide reports on individuals and staff members frequently involved in incident so that further inquiry can begin and corrective measures taken as indicated.*	***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Track data and issue reports.	8/29/2008	Trend analysis (April/May) Tab # 8	Director, Monitoring System; Risk Manager
	Status: Current system does not capture this data yet. Training underway for pilot of new form. Information will be captured in Revised UI database, but will not be available until Fall after all staff are trained.			
2	Hire Crystal Report developers to ensure capacity to report once AVATAR is fully functional.	8/29/2008		COO
3	Develop reports to elicit staff and patient data relating to UIs	12/10/2008		COO

XII.E.1.d

location of incident;

Findings

See XII.E.

Compliance Status: See XII.E

	Recommendations	*Responsible Party*
1	*Identify the location of incidents more precisely down to the unit level.*	***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify data base to collect data based upon new form.	7/31/2008		Director, Monitoring Systems
	Status: In process			
2	Modify form	5/30/2008	Copy of UI form Tab # 128	Director, Monitoring systems
	Complete			
3	Produce reports.	9/30/2008	Trend analysis (April/May) Tab # 8	Director, Monitoring Systems, Risk Manager
	Status: See Trend analysis page 36 to end.			

2	*See also the recommendation below.*	

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See also the action steps recommendation below.			

XII.E.1.e

date and time of incident;

Findings

See XII.E

Compliance Status: See XII.E

Recommendations — ***Responsible Party***

1 Provide a report of the high-risk times of day and location to the Risk Management and Safety Committee for review and action. — ***PID;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include information in Trend Analysis. ***Complete***	6/30/2008	Trend Analysis (April/May) Tab # 8	Monitoring Systems Director
2	Report data and discuss at Risk Management Committee every other month.	8/21/2008		Risk manager

XII.E.1.f

cause(s) of incident; and

Findings

See XII.E

Compliance Status: See XII.E.

Recommendations — ***Responsible Party***

1 Invest in the Risk Management and Safety Committee the responsibility to identify and review factors that have been identified in serious incidents and make recommendations for corrective measures. — ***AF; EXEC***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure Risk Manager's PD reflects responsibility. ***Complete***	6/11/2008	Copy of Risk Manager PD Tab # 132	HR; PID
2	Ensure Hospital Bylaws establish this as responsibility of Risk Management Committee ***Complete***		Copy of Bylaws Tab # 135	

XII.E.1.g

actions taken.

Findings

See XII.E

Compliance Status: See XII.E

Recommendations — ***Responsible Party***

1 Identify the source of the problem in the failure to approve or revise recommendations for corrective actions and take action to remedy the problem. — ***CVC; JH; AF;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Create capacity in database for follow up monitoring.	8/29/2008		Director, Monitoring Systems

Status: Database will need to be updated as new UI form is implemented

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
3 Monitor follow up and report same to Exec staff and Risk Management and Safety Committee	8/29/2008		Risk manager
1 Create capacity for follow up on UI form. **Complete** *Status: UI form includes capacity for follow up*	6/30/2008	UI form Tab # 128	

2 *When the incident management database is expanded and improved, collect and report on corrective measures.* — ***PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1, recommendation 1			

XII.E.2

Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.

Findings

The Hospital has not implemented this requirement.

Compliance Status: No progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 *Include both behavioral and medical issues when determining the hospital's quality indicators and triggers that will require a specific clinical response.*	***AF;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Work with consultant to assist with developing Hospital's quality indicators and triggers, that can be tracked given the lack of automated information system. *Status: Consultation initiated June 2008*	11/28/2008		

XII.E.3

Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.

Findings

No progress to report.

Compliance Status: No progress is being made toward the June, 2009 compliance date.

Recommendations	*Responsible Party*
1 *Refine the incident management system so that it identifies the type of incidents in which individuals are involved and run reports that will identify repeat aggressors, repeat victims*	***PID;***

and those individuals demonstrating suicidal gestures or attempts.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise UI form and policy to capture such information. ***Complete***	7/15/2008	Approved UI Policy Tab # 127; UI form Tab # 128	CEO, Director of Monitoring Systems
2	Monitor data and produce relevant reports to Senior staff. *Status: On-going*	8/29/2008		Risk Manager

XIII. Quality Improvement

Summary of Progress

1. The Hospital produces a Trend Analysis bi-monthly to monitor key data and performance indicators. See Tab # 21 (Feb/March) and Tab # 8 (April/May).

2. The Hospital is conducting IRP observations of 20% of scheduled treatment plans and is reporting the results. Specific results are embedded in the related sub-cells of this report.

3. The Hospital is reviewing 20% of closed records to evaluate discharge planning, and is reporting the results. Specific results are embedded in the related sub-cells of this report.

4. The Hospital created a patient data base that allows analysis of patient diagnosis, medications, risk and other key factors.

5. The Hospital completed a special study of patients with three or more medical emergencies in a 6 month period. See Tab # 136 for report.

6. The Hospital completed an Environmental Survey of all patient care areas. See Tab # 83 for report.

7. The Hospital has not identified additional quality indicators since the Baseline Report.

8. The Hospital has not formalized a policy on review of quality improvement recommendations and tracking implementation, but one is expected to be completed by the end of September, 2008.

XIII. Quality Improvement.

By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.

Findings

See sub-cells for findings.

Compliance Status: See sub cells for findings

XIII.A.

Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.

Findings

The Hospital continues to publish its Trend Analysis based upon manual data, but is limited in its ability to increase indicators given the absence of an automated system. The Hospital added monitoring of ADRs and medication variances to the Trend Analysis, and continues to monitor Seclusion and Restraint use, IRPs and mall group cancellations as performance indicators. Data is largely manually collected as there remains no information system, so the reliability of the data is at times questionable and makes trending challenging. Data is analyzed and trended in the bi-monthly Trend Analysis that is submitted to all managers and posted on the internet. The Hospital anticipates adding an additional indicator or two as the new UI form is implemented Hospital wide in September, but until AVATAR is implemented it will be difficult to add additional indicators. The Hospital is continuing reviews of discharge records and is observing about 20% of treatment plans. See Tab # 21 (Feb/March Trend Analysis); Tab # 8 (April/May Trend Analysis).

The Hospital also created a Patient database intended to provide a bridge until AVATAR is implemented. Data around diagnosis, medication, completion of risk assessments etc in being analyzed, but since the system was only available beginning in May, trends are not yet available. See Tab # 61 (Patient data base screen shots). Risk

Assessment data is available in the data base for 215 patients and shows that 175 of the 215 are assessed to be a danger to self, others or property. While these categories are not yet aligned with those in the DOJ Agreement, this is the first time any such data has been available. Tab # 62 (Risk Assessment findings).

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

Recommendations	Responsible Party
1 Continue with plans to identify other quality indicators and include both physical and behavioral triggers.	***CVC; JH; AF; PID; BG;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Receive technical assistance from consultant to identify quality indicators which include both physical and behavioral triggers.	10/31/2008	Angela Adkins Contract Tab # 9	Chief of Staff; QID director
Status: Given lack of comprehensive information system, selected indicators will have to reflect areas in which reliable data is available.			
2 Evaluate capacity of Phase 1 Avatar to be used to assist in collecting data that will assist in identifying triggers	11/20/2008		COO; Chief of Staff
Status: Will need to consider AVATAR capacity in identifying triggers and quality indicators.			
3 Collect data and assess trends and identify issues relating to indicators. Provide reports to Managers	1/30/2009		PID

XIII.B.

Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:

Findings

See XIII.A Data is trended and analyzed through a Trend Analysis, but corrective action plans are not yet developed from this data in any systematic way. Tab # 21 (Feb/March Trend Analysis); Tab # 8 (April/May Trend Analysis). The Hospital recently retained a consultant to assist it with development of quality indicators and triggers.

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

Recommendations	Responsible Party
1 Select additional quality indicators and begin collecting baseline data that includes the identification of individuals who reach an indicator or trigger. For example, identify individuals who have been the victim of an assault that required more than first aid.	***CVC; JH; AF; PID;***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps related to XIII.A			
2 Modify UI process to ensure more specific data is collected to assist in identifying trends.	6/30/2008	UI policy Tab # 127 UI form Tab # 128	PID
Complete			

2 Identify corrective measures for priority quality indicators and measure performance. **CVC; JH; AF; PID;**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps in XIII.A *Status: No action yet taken*			

XIII.B.1

the action steps recommended to remedy and/or prevent the reoccurrence of problems;

Findings

See XIII. B.

Compliance Status: See XIII.B

Recommendations	Responsible Party
1 Select quality indicators and begin collecting baseline data.	**CVC; JH; AF; PID; EXEC**

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

Recommendations	Responsible Party
2 Begin the conversation on the policies and procedures that will govern quality indicators and triggers (those events under each quality indicator which require a specific response by the IRT).	**EXEC**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Work with consultant and educate Senior staff about identifying quality indicators	9/30/2008		
2 Research quality indicators used by CMS, JCAHO and other certifying bodies.	9/30/2008		Director, Policy

XIII.B.2

the anticipated outcome of each step; and

Findings

See XIII. B

Compliance Status: See XIII.B

Recommendations	Responsible Party
1 See above findings and recommendations for XIII.B.1.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above action steps for XIII.B.1.			

XIII.B.3

the person(s) responsible and the time frame anticipated for each action step.

Findings

See XIII. B

Compliance Status: See XIII.B

Recommendations	Responsible Party
1 See above findings and recommendations for XIII.B.1.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See above action steps for XIII.B.1.			

XIII.C.

Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:

Findings

No progress has been made.

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

Recommendations	Responsible Party
1 Begin the conversation on the policies and procedures that will govern quality indicators and triggers.	*EXEC*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XIII.B.1			
2 Consultant to meet with Exec staff to begin focused discussion on identification of indicators.	9/30/2008		
3 Executive staff and Medical Staff Executive Committee to identify key policy issues	12/28/2007		CEO; Medical Director
4 Research quality indicators used by CMS or other certifying bodies and consider applicability to Hospital	9/30/2008		J Taylor, Exec staff

XIII.C.1

disseminating corrective action plans to all persons responsible for their implementation;

Findings

No progress has been made.

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

Recommendations	Responsible Party
1 See findings and recommendations above for XIII.C.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for XIII.C.			

XIII.C.2

monitoring and documenting the outcomes achieved; and

Findings

No progress has been made.

Compliance Status: No progress toward compliance date of June, 2010.

Recommendations	Responsible Party
1 See findings and recommendations above for XIII.C.	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps for XIII.C.			

XIII.C.3

modifying corrective action plans, as necessary.

Findings

No progress has been made.

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

Recommendations — ***Responsible Party***

1 See findings and recommendations above for XIII.C.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps for XIII.C.			

XIII.D.

Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.

Findings

See XIII.A. and B.

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

Recommendations — ***Responsible Party***

1 Select a limited number of performance goals and take steps to ensure that the entire hospital is aware of these goals and that the administration is counting on each staff member and individual to move the hospital toward achieving them. — ***EXEC***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Medical Staff Exec Committee and Exec staff to identify 4-5 performance goals for remainder of FY 2009. Goals should be in areas for which data is available.	9/26/2008		CEO
2	Data will be collected on goals and will be incorporated into Trend Analysis.	11/20/2008		PID
3	Performance goals and progress will be routinely reported at "All staff" meetings, senior staff meetings and will be posted on internet.	10/31/2008		

XIV. Environmental Conditions

Summary of Progress

1. The Hospital created a new position, Safety Officer, who will conduct monthly reviews of all units, identify deficiencies, make recommendations and monitor their implementation. See Tab # 130. (Safety Officer PD).

2. The Hospital is modifying the environmental checklist to include identification of potential suicide hazards. Tab # 137. (Building checklist)

3. The Hospital completed an environmental survey in March, 2008. See Tab # 83.

4. The Hospital increased its nursing staffing by 11 nurse managers, 13 RNs, 3 LPNs, 11 PNAs, and 16 FPTs, for a total net gain of 54 nursing staff members. Recruitment to fill additional vacancies continues. Tab # 11 (Hiring report.)

5. A Fire Plan has been prepared and submitted to DC Fire Department for approval. Tab # 138 (Draft Fire Plan).

XIV. Environmental Conditions.

By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:

Findings

See sub cells for specific findings.

Compliance Status: See sub cells for compliance update.

XIV.A.

By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.

Findings

The Hospital created a position of Safety Officer charged with assessing the environment of care and patient and employee safety. See Tab # 131 (PD for Safety Officer). The Safety Officer conducts a monthly walk-through of the hospital to look for potential hazards and is refining the environmental checklist. The Infection Control Coordinator also conducts reviews of the wards and patient areas. The Safety Officer is to work with the Risk Manager to revise the current checklist of safety items to guide the walk-through. Finally, nursing has developed a checklist as well to conduct regular environmental checks on the units.

In addition, the Hospital continues to conduct a periodic environmental survey using staff and outsiders as review teams. See Tab # 83 for most recent environmental survey.

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

Recommendations	Responsible Party
1 Identify a list of possible suicide hazards, paying particular attention to bathrooms and bedrooms where most suicides in institutions occur. Prioritize the correction of these hazards, determining timelines and cost.	*AS;*

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Safety officer will conduct monthly walk through of all patient units to identify potential suicide hazards, using instrument he develops.	8/7/2008	Hospital Safety Inspection and Reporting Schedule: August to December 2008. Tab # 116	Bob Winfrey

Status: Monthly Safety Inspections will begin 8/7/2008 and findings will be submitted on a monthly basis to the COO, Medical Director, ADON and Civil and Forensic Directors beginning September 1, 2008

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Continue process of quarterly Environmental survey and report same.	9/30/2008	Hospital Safety Inspection and Reporting Schedule: August to December 2008 Tab # 116	Bob Winfrey

Status: Monthly Safety Inspections will begin 8/7/2008 and findings will be submitted on a monthly basis to the COO, Medical Director, ADON and Civil and Forensic Directors beginning September 1, 2008

2 *Include this list of suicide hazards on the environmental checklist or identify another method for the periodic and systematic review of each of the areas to which individuals have access.* ***PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify the environmental survey checklist to include the identification of areas that may pose a suicide hazard risk.	7/28/2008	Environmental checklist, tab # 139	Bob Winfrey, Jacquelyn Ehrlich

Status: The Hospital Safety Officer will develop or modify an existing tool to be used in monthly Safety Inspections of all occupied areas which will assess potential safety hazards including suicide risks, infection control risks and other occupational safety hazards.

2 See action steps in XIV.A recommendation 1

3 *Alert staff to the presence of suicide hazards on their units.* ***PID; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct a public awareness campaign to sensitize nursing staff of areas that are at risk of posing suicide hazards.	7/15/2008		Bob Winfrey, Risk Manager

Status: Shower areas and curtain rods have been identified as major areas which pose a potential suicide hazard risk. The Hospital Safety Officer met with Civil and Forensic Nursing staff regarding the usage of break away shower curtain rods and safety shower curtains in the patient's bathrooms on 6/11/2008. 50% of patient bathrooms in RMB and the CT complex are equipped with the break-away version of these items. The Forensic Administrative Officer completed the assessment for JHP including a cost estimate for the number of curtains required. A total cost estimate for the Hospital for equipping all patient bathrooms with these items was submitted to the COO by the Hospital Safety Officer.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Share results of Environmental Survey.	8/7/2008	Hospital Safety Inspection and Reporting Schedule: August to December 2008, Tab # 116	Bob Winfrey
	Status: Monthly Safety Inspections will begin 8/7/2008 and findings will be submitted on a monthly basis to the COO, Medical Director, ADON and Civil and Forensic Directors beginning September 1, 2008			
3	See XIV.A. recommendation 1 for additional steps			

XIV.B.

By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.

Findings

DMH no longer requires the Hospital to report incidents of patients found with cigarettes. The Hospital is also developing a policy around searching patients, but it will not be completed until September, 2008. Finally, the Hospital is revising the building checklist to look for and track contraband found during the inspections.

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

	Recommendations	Responsible Party
1	*Enter into conversations with DMH regarding its expectation that the hospital report incidents that involve finding only cigarettes.*	**PID; PJC**

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Discuss with DMH need to notify them of incidents involving cigarettes with no injury	6/30/2008		Risk Manager
	Complete *Status: DMH agrees that it will not need to be notified.*			

	Recommendations	Responsible Party
2	*Revise the building inspection checklist to include evidence of contraband or find an alternate method that would meet the same objective.*	**AS;**

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Security will develop a draft Contraband Form to be used as a guide by security and nursing staff to screen more thoroughly for contraband. The first draft of this form will be submitted to the COO for review by July 15, 2008.	8/1/2008		Savannis Peoples
	Status: The current building inspection checklist is not designed to screen patients and visitors for contraband. This form focuses on environmental and infrastructure issues.			
2	ES form requires reviewers to note if there was evidence of contraband such as cigarettes. ***Complete***	6/30/2008	See Environmental Survey, Tab # 83	

3 Reorganize and revise the draft "Patient Search" policy. **PID;**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Patient Searches Policy.	9/15/2008		J Taylor

Status: Policy currently under revision

XIV.C.

By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a saf

Findings

The Trend Analysis includes data on incidents involving assaults/altercations, elopements and injuries that could be attributable to supervision issues. Tab # 21(Feb/March Trend analysis); Tab # 8 (April/May Trend Analysis).

The Hospital's UI revised policy requires that the Risk Manager conduct investigations into all incidents involving serious injury to patients or staff, elopements of potentially dangerous individuals, deaths, suicides or attempted suicides, and allegations of patient abuse and neglect. As of the writing of this report, the Risk Manager is conducting investigations into these categories of cases, although as previously noted, the number of reports of patient abuse or neglect is lower than one would anticipate.

New nursing staffing standards have been developed, Tab # 118 (Nursing staffing standards). Further, there has been a significant improvement in the on board nursing staff, (gain of 56 nursing staff) which is expected to improve the level of supervision on units.

Compliance Status: Progress is being made toward the June, 2009 compliance date.

Recommendations — ***Responsible Party***

1 Conduct an investigation into all incidents that result in serious injury, looking to make findings on the adequacy of staffing levels, staffing assignments, and neglect in the form of failure to provide adequate supervision. **PID; BG;**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager will conduct investigations into all such incidents and will address factors that led to incident, as reflected in UI policy ***Complete***	7/31/2008	UI policy Tab # 127	Risk Manager
2 Sentinel event policy will be reviewed and updated as necessary.	8/29/2008		Risk manager
3 RM will conduct investigations into all incidents involving serious injury and reports will consider staffing, supervision and assignments.			Risk Manager

Status: Ongoing

2 Conduct investigations into the unauthorized leaves of potentially dangerous individuals and those who are at risk because of their disability to determine the contributing factors, including those related to staffing levels and assignment. **PID;**

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Action steps for XIV.C 1			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Modify UI policy to clarify type of UI that is a major incident. **Complete**	6/11/2008	UI Policy Tab # 127	J Taylor
3	RM to conduct investigations into UIs reporting elopements that involve forensic inpatients or other patients who may be at risk due to disability	7/31/2008		

XIV.D.

By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local a

Findings

The elevators at JHP continue to have repair issues. Facilities is developing a tracking system to determine the nature of repairs and the length of time an elevator may be out of service.

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

Recommendations — ***Responsible Party***

1 *Include in the Facilities and Environment Monthly Status Report the date elevator problems were reported and the date they were fixed. Also include the date of any elevator inspections by local authorities.* — ***AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Begin tracking data regarding the breakdown and subsequent date of repair of elevators in the monthly Trouble Desk report to PID. *Status: Reports are submitted 14 days after the end of the reporting period.*	8/14/2008		Gilbert Taylor Tim Coefield Trouble Desk Analyst
2	Revise the Trouble Desk report to capture the dates on which repairs were completed and the dates of all DCRA and third party inspections.	8/14/2008		Gilbert Taylor
3	Work with Facilities in developing report that includes analysis of environmental issues.	9/8/2008		OMS

2 *Inventory the residential units of individuals using wheel chairs to ensure that whenever possible, these individuals are housed on the first-floor.* — ***CVC; JH; AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	RMB and Civil to assess patient mobility issues. *Status: JHP layout will not permit wheelchair patients all to be on first floor.*	8/7/2008		

XIV.E.

By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.

Findings

The Fire plan has been updated and submitted to DC Fire Department for comment and approval. See Tab # 138 (Fire Plan)

Compliance Status: Partial

Recommendations — ***Responsible Party***

local authorities. **Winfrey**

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Update the existing Fire Prevention and Emergency Life Safety Plan and submit to the COO for review and approval.	7/1/2008	Draft Fire Prevention and Emergency Life Safety Plan Tab # 138	Robert Winfrey, Bridget Peterson, Bernard Phipps
	Status: The plan has been updated and sent to DCFD.			
2	Update all floor plan diagrams for all occupied buildings to highlight all exits, areas to shelter in place, fire alarm pulls, fire extinguishers and areas of rescue.	8/7/2008		Robert Winfrey
	Complete *Status: The floor plans for all occupied buildings were updated to highlight all exits, areas to shelter in place, fire alarm pulls, fire extinguishers and areas of rescue were approved by the Hospital Fire Inspector and submitted for review to the DMH Risk Manager on 7/2/2008. Upon approval by the Risk Manager, the plans will be submitted along with the Fire and Evacuation Plan to the Fire Marshall by July 31, 2008. Signs will be posted in all Shelter in Place locations in all floors beginning 8/7/08 and will be completed by 8/29/2008*			
3	Submit the approved Fire Plan along with Floor Plan Diagrams to the DMH Risk Manager who, upon approval, will submit it to the DC Fire Marshall.	7/31/2008		Robert Winfrey, Bridget Peterson, Bernard Phipps
	Status: The Fire & Evacuation Plan was sent to the Hospital COO for review on 7/1/2008. The floor plans for all occupied buildings were updated to highlight all exits, areas to shelter in place, fire alarm pulls, fire extinguishers and areas of rescue were approved by the Hospital Fire Inspector and submitted for review to the DMH Risk Manager on 7/2/2008. Upon approval by the Risk Manager, the plans will be submitted along with the Fire and Evacuation Plan to the Fire Marshall by 7/31/2008			

XIV.F.

By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.

Findings

The Hospital is increasing its attention to the environment through the new creation of the position of Safety Officer which will allow for more regular reviews of patient areas to supplement the quarterly environmental surveys, as well as through increased monitoring by nursing. Tab # 131 (Safety Officer PD). It conducted and produced an environmental survey report in May, Tab # 83 (Environmental Survey report).

In July, due to issues with the fire hydrants experienced city wide, the Hospital began a fire watch for JHP.

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

Recommendations ***Responsible Party***

1 *Revise the system of staff assigned to particular individuals to clarify the staff member's responsibility. At least weekly, the staff member should be responsible for documenting that he/she has ensured that the individual has personal hygiene items and clothes.*

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

2 *Determine how best to solve the problem of laundering clothes with sufficient frequency that individuals have clean clothes.* ***AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Evaluate the number and condition of washers and dryers on units.	8/29/2008	Washer and Dryer Inspection Report, Tab # 139	JH; CVC; AS; Donna Moran; Gilbert Taylor
	Complete *Status: FED conducted an assessment of all washers and dryer on the units has been completed and reveals that washers and dryers are installed on all patient wards with the exception of JHP 5. There are 4 washers and 4 dryers in the RMB building, 10 washers and 10 dryers in JHP and 6 washers and 4 dryers in CT2 and 3. There are an additional 2 washers and 1 dryer in CT-7. A copy of the Washer/Dryer Inspection report is attached. FED will continue to maintain this equipment as needed.*			
2	If needed, purchase additional washers and dryers or laundry supplies for patient use.			Donna Moran, Gilbert Taylor
	Status: FED conducted an assessment of all washers and dryer on the units has been completed and reveals that washers and dryers are installed on all patient wards with the exception of JHP 5. There are 4 washers and 4 dryers in the RMB building, 10 washers and 10 dryers in JHP and 6 washers and 4 dryers in CT2 and 3. There are an additional 2 washers and 1 dryer in CT-7. A copy of the Washer/Dryer Inspection report is attached. FED will continue to maintain this equipment as needed. Timeframe: Completed Responsible Staff: Gilbert Taylor. Laundry supplies, mainly laundry detergent, are deemed critical supply items, thus Materials Management does not allow the stock to fall below a minimal level. Nursing staff are to use a 1509 Form to request laundry supplies from Materials Management. Minimal stock levels are determined based upon historical use and revised on an annual basis.			
3	Establish procedures to ensure each patient has an assigned nursing staff member to assist with laundering clothes.			CVC; JH
4	Ensure each ward has schedule to provide sufficient time for each patient to launder clothes at least every 5 days.			JH, CVC

3 *Determine whether the lack of clothing (particularly for men) and personal hygiene supplies is a matter of insufficient supply or a distribution problem and take appropriate action.* ***AS;***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Determine issues associated with lack of personal hygiene supplies.	7/25/2008		Clinical Function
2	Clinical staff are responsible for submitting request form 1509 to Materials Management Stock Rooms (RMB & JHP) whenever personal hygiene supplies are needed for patients			Donna Moran; Renee Bivins
	Status: Ongoing			