Saint Elizabeths Hospital
DOJ Compliance Office Report (September 1, 2009)

V. Integrated Treatment Planning

Summary of Progress

1. The Hospital continued to refine it interdisciplinary recovery\planning training to better reflect an individual focused, recovery oriented approach to treatment. Four of seventeen wards completed IRP training, and the remaining 13 are all in training. The IRP training program was modified, and now includes eight modules, with a combination of didactic, observational, and coaching. Specific modules were created around individual engagement and discharge/transition planning. Other modules cover recovery principles, stage of change and an overview of person centered IRP planning. IRP conference observers report notable improvement in Phase I of the IRP Conference, and some improvement in Phase II of the IRP conference.

2. The Hospital revised its IRP forms (the Initial IRP form and the comprehensive and review IRP forms), developed detailed instructions with examples for each form, and implemented all. The IRP form provides for six focus areas of treatment; psychiatric/psychological, physical health, legal/forensic (if applicable), substance abuse (if applicable), and community integration (if applicable). Discharge criteria are included within each focus area as clinically appropriate, and each IRP is expected to include a mix of treatment and skill-building interventions. In addition, the specific interventions chosen by the individual, treatment team and TLC staff are incorporated in the IRP through the newly created TLC Addendum.

3. The IRP manual was revised significantly. It includes all relevant policies (Assessment policy, IRP Policy, Transfer Policy, Medical Records Policy and Seclusion and Restraint Policy for Behavioral Reasons) and forms (each disciplines assessment forms and assessment update forms with their instructions, IRP forms, clinical formulation and clinical formulation update forms, progress note forms, transfer summary forms). It also includes checklists for IRP conferences (all types), tip sheets for stage of change, engagement, developing needs lists and objectives among others. The instructions around IRP planning are far more detailed, and include examples of needs, objectives, and interventions. Other items included in the Manual are a description of each disciplines role in IRP planning, a summary of the recovery model, flow sheets around IRP planning and other useful documents. A laminated copy of each IRP conference checklist was provided to each unit, and the entire manual is on the Hospital intranet.

4. The Hospital revised the template for the therapeutic monthly progress notes which will be used for the treatment mall and other treatment providers and developed instructions for the note. The revised note specifically ties interventions and progress to IRP objectives. An audit tool and instructions were also developed, and audits will begin in September.

5. The Hospital continues to refine its IRP Process Monitoring tool, indicators and operational instructions. (It is undergoing further revision, which is expected to be completed by the site visit.) Audits were held monthly from February, to present, but not yet at a 20% sample. Discipline chiefs will also participate in IRP observation audits, beginning in September. Data from the IRP observations show improvement in both Phases I and II, but with more improvement in Phase I.

6. The Hospital finalized a clinical chart audit tool with instructions, and piloted it in July, 2009. The results are not consistent with the IRP observation results on key indicators, so PID is reworking the tool, instructions and reviewers are likely to require additional training to ensure meaningful data is obtained.

7. Disciplines (other than nursing) have developed a self audit tool and instructions to evaluate the completion of initial assessments and the monthly updates. Psychiatry, Social Work, Psychology and Rehabilitation Services audits their initial assessments, and Nursing and social work audited the monthly updates. Psychiatry will begin auditing the Update in September, 2009, and nursing will begin auditing the Initial assessment in September, 2009. Results of audits were provided to each discipline.

8. A transfer audit tool was developed for inter unit and inter-hospital transfers, and audits were completed.

V. Integrated Treatment Planning.

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

Findings See sub cells.

Compliance Status: See sub cells.

V.A. Interdisciplinary Teams

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

Findings See sub-cells for findings and status.

Compliance Status: See sub cells.

V.A.1

Compliance Status from DOJ Report: Partial

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 continued efforts to implement this requirement; all 17 units of the Hospital either have completed training or are well into training. The IRP training includes eight modules; an overview, person-centered planning and stage of change, recovery principles, engagement, discharge/transition planning, setting of objectives based upon stage of change, a video of a mock IRP Conference, and unit-based coaching. Training includes a didactic portion that serves to introduce concepts and principles, a video of a model IRP conference and then a portion that involves unit-based observation, coaching and record review to evaluate application of the concepts and to provide coaching to strengthen practice. See IRP Training Curricula, Tab # 1; IRP Training data, Tab # 2. To date, four units have completed training and all others are in various stages of the training. Not surprisingly, coaching hours vary from unit to unit based upon how quickly staff learn how to apply principles learned in the classroom and staff changes due to resignations, promotions and reassignments.

The Hospital revised its IRP policy, IRP manual, IRP forms and the clinical formulation and clinical formulation update forms based upon the recommendations from the March 2009 visit. The modifications, especially those to the IRP manual, increase the focus on individualized and integrated treatment that is recovery focused and provide an improved structure for teams implementing the recovery based model. Tab # 3 (IRP Policy); IRP manual (stand alone manual). The revised IRP forms and IRP manual prompt treatment staff to develop more individualized focus areas, objectives and interventions.

Substantial improvements have been made to the IRP Manual, which now includes all discipline assessment forms and instructions, the IRP forms, tip sheets around topics such as establishing the needs list, identifying objectives, how to engage individuals and stage of change. The Manual also includes IRP related audit tools and instructions, revised checklists for each type of IRP conference, and operational instructions, with examples of objectives or interventions, for the clinical formulation/update as well as the IRP itself. IRP manual. Overall, the Manual provides more detail, contains all current documents and provides tips and examples that should facilitate recovery planning. Each clinical administrator has a hard copy of the manual, and it is available on the intranet.

The Hospital's Performance Improvement Department (PID) modified its IRP process tool and instructions based upon the auditors experience with the tool, as well as DOJ recommendations. Auditors continue to observe IRP conferences; available data will be reported in the related sub cells. IRP Process Monitoring Tool/Instructions, Tab # 8 , Tab # 9 (Results of IRP process monitoring). (Please note that additional modifications are being made to the IRP process monitoring tool and instructions based upon feedback from the reviewers. The revised tool and instructions should be available during the September, 2009 site visit.) Through Spring, 2009, PID continued monitoring only those units which had completed some

significant IRP training, but by July, 2009, all units had enough training that they were included in the reviews.

The Hospital completed a clinical chart audit monitoring tool with instructions, and the tool was piloted in July, 2009. Clinical Chart audit tool, Tab # 10; Clinical chart audit results, Tab # 11. Reviews were conducted by the clinical administrators during July, 2009. Results suggest that the tool and instructions may need to be revised and additional training provided to the auditors. The tool is quite long, and staff who conducted the audits may well have over-rated some indicators. This is being reviewed by Performance Improvement Department and the Office of the Chief of Staff to determine what modifications may be needed in the tool itself, tool instructions, or methodology.

The revised IRP process monitoring tool assesses individualized planning through two primary indicators, numbers 7 and 8. Overall there has been notable improvement in individualized planning as staff apply the skills learned in training, although performance remains stronger in Phase I of the IRP conference than in Phase II of the IRP conference. The IRP process reviews found that 92% of IRP conferences in June, 2009 the team discussed the individual's strengths, actively engaged the individual around discharge planning in in 85% of cases, but did not score as high in areas such as discussing with the individual his or her life goal (77%), reviewing with the individual progress on each focus area (77%), and providing the individual with options of interventions in only 69% of cases. IRP Process Monitoring Results, tab # 9. Other criteria related to individualized planning ranged from 50% to 69% percent. Tab # 9 (Indicator 9). Ratings around individualized planning in the clinical chart audits were high, including a 92% rating in scoring whether the objectives reflect the individual's level of functioning. Tab # 11. As suggested by the results of the IRP observations, overall performance on this requirement is improved, but more improvement is needed to ensure consistency across units.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as in V.A.2 to V.A.5.* — *Civil; Forensic; Clinical Administrators*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.A.2 to V.A.5.	7/1/2009	Clinical chart audit tool, Tab # 10; Clinical chart audit results, Tab # 11	BG; Clinical Administrators

2 *Same as in V.B, V.C, V.D and V.E.* — *Forensic;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in V.B., V.C, V.D and V.E.	9/14/2009	IRP training data, Tab # 2 ; IRP Process Monitoring Tool, Tab # 8 ; IRP Process monitoring results, Tab #9	BG

Status: Psychiatrists are included in IRP training and being observed through IRP process monitoring. - Updated as of 6/25/2009

V.A.2

Compliance Status from DOJ Report: Partial

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

Findings

The Hospital continues to be successful in recruiting psychiatrists in particular, but has suffered some staff losses in psychology. Four psychiatrists began work in July, 2009, and there are an adequate number of psychiatrists. However, caseload ratios are not yet met across the Hospital, in part due to the way the psychiatrists have been deployed and also because there are several doctors on extended medical leave. Data as of July 29, 2009 show on 10 of 17 units (including three of five admission units), caseload ratios are met. On three units, the caseload exceeds the standard by one individual and on another unit, the caseload ratio is exceeding standards by two. One JHP admissions unit exceeds caseload ratios by 3 respectively; on another unit, the psychiatrist is on medical leave, and a psychiatrist has been assigned to cover that unit - between that unit and his own unit, he is responsible for 43 patients. List of Psychiatrists by Ward and Certification status, tab # 37.

Although there is no specific requirement in the Agreement regarding caseloads for psychologists, there currently are 13 psychologists not including clinical administrators who are also psychologists, and two supervisors (one vacant). Each ward is supported by a psychologist. List of

Psychologists, Tab # 39, Civil and Forensic ward assignments, Tab # 43. Further a ward psychologist for RMB 3 has been hired but he is not expected to handle Positive Behavior Support (PBS) issues on other units, as that will be the responsibility of the PBS team leader and team, once recruitment is completed. Positive Behavior Support Team position descriptions, Tab # 40, PBS Vacancy Announcements, Tab # 41. Selection for one additional psychologist was made and that individual should begin work by September 15, 2009.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Continue with current efforts to hire requisite number of psychiatrists and psychologists.* — *Forensic;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify critical must fill vacancies and calculate cost to determine budget availability	6/15/2009	List of vacancies approved to be filled, Tab # 42	Canavan, Baron
	Status: List has been prepared and is under review by leadership - Updated as of 6/18/2009			
2	Once approved, announce position vacancies and create selection certificates for positions on critical positions list.	8/7/2009	List of ward based staff for civil and forensic, Tab # 43; Vacancy announcements for PBS team leader and behavior technician positions, Tab # 41	Seymour
	Status: Four psychiatrists were hired and began work in July, 2008. One psychologist will begin in mid September, and recruitment continues for the PBS team leader position. Director of Psychology position is also under recruitment and interviews are scheduled for the week of August 31, 2009.. - Updated as of 6/25/2009			
3	Upon receipt of selection certificates, interview candidates and make selections	8/24/2009		Arons, Gontang
	Status: Dr. Gontang asked to review applicants for recommendation for offering position. - Updated as of 6/29/2009			

2 *The psychologist leading the PBS team must not have the additional duties of being a unit/treatment team psychologist.* — *Med; COO; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish PBS team to serve as consultants to entire hospital to include psychologis PBS team leader, two behavioral specialists.	7/15/2009	Position Descriptions for PBS team members, Tab #40	Arons, Gouse, Gallo, Seymour
	Complete *Status: Further meeting was held by Dr. Arons with COO, requesting permission to proceed with establishing team. Chief of Staff to assure PD's and position announcements are issued. Follow up meeting to be held on Thursday June 25th to keep process moving. - Updated as of 6/24/2009*			
2	Ensure PBS team leader and PBS specialist positions are on critical vacany list submitted to CA.	7/31/2009	Position Descriptions for PBS team members, Tab # 40	Sseymour
	Complete *Status: Positions descriptions were established and vacancy announcements issued. The PBS Technician certificate was issued 8/12. Selection certificate for supervisory position to be issued week of 8/17. - Updated as of 8/13/2009*			
3	See action steps to prior recommendation around filling vacanies.			
	Complete *Status: See above - Updated as of 8/13/2009*			
4	Reassign duties of psychologist on RMB 3 to focus solely on RMB 3 patients.	7/31/2009		Gontang
	Complete			

V.A.2.a — ***Compliance Status from DOJ Report: Partial***

assume primary responsibility for the individual's treatment;

Findings As has been described in prior reports, the treatment team leader is the psychiatrist on units were the clinical administrator is not a psychologist; on

units where the clinical administrator is a psychologist, either he or she or the psychiatrist is the team leader. The roles of each member of the treatment team are described in the IRP manual. IRP Manual at Tab # 1. The manual is available on the Hospital intranet, as well as in hard copy on each unit.

Treatment planning training is completed on four units, and is underway on the other 13 units. IRP training data, Tab # 2. Each discipline has participated in the didactic training around the new IRP process and is observed and coached by the trainers as well. The IRP training includes eight modules; an overview, person-centered planning and stage of change, recovery principles, engagement, discharge/transition planning, setting of objectives based upon stage of change, a video of a mock IRP Conference, and on unit coaching. IRP Training outline, tab # 1. In summary, 94% of clinical administrators , 87.2% of nursing staff, 88.6% of psychiatrists, 75% of psychology staff, 86.7% of rehabilitation staff, and 100% of social work staff have attended the IRP overview. IRP training data, tab # 2.

In addition, revised checklists that are designed to support facilitation of the IRP comprehensive and review conferences were completed. IRP Manual at Tab # 11. The revised checklists include boxes which the facilitator can use to ensure all aspects are covered during the conference. The Hospital also provided a laminated copy of the conference checklists, for ease of use.

The Compliance Office has observed at least two IRP conferences on 10 of 17 units and notes significant progress on all units. Progress is especially noted in the Phase I clinical presentations, which generally include a robust discussion of the individual's present status and needs; progress also has been made in Phase II of the IRP conferences, but not at the same pace as in Phase I (two units were as effective in Phase II as in Phase I). Training on engagement of individuals was held the end of August and should improve performance in Phase II as well, though the audit results reported below precede this training. It should be noted that in Phase I, despite the overall progress, many units may miss one or two elements, (i.e., fail to settle on questions to ask the individual) but the revised and redesigned checklists should improve that practice. In most IRPs observed, assessment was not occurring.

The Hospital modified its IRP Process Monitoring Observation tool and instructions to reflect indicators and capture data on this requirement. IRP Process Monitoring Tool/Instructions, Tab # 8. (The Hospital is not yet observing a 20% sample of each type of IRP conferences, but plans are in place to expand the sample in order to reach the 20% threshold over the next few months). The data from recent IRP observations show that for the period of February, 2009 through June, 2009, in 85% (February), 89% (March), 62% (April), 81% (May) and by June, in 100% of IRP observations, a person was identified to be responsible for facilitating the meeting. Results of IRP Observation Tab # 9. The clinical administrator by position description is responsible for scheduling and coordination the meeting.

Data from the reviews show that the facilitator encouraged participation from all disciplines in 84% of IRPs observed in February, 2009, 94% of IRPs observed in March, 2009, 69% of IRPs observed in April, 2009, in 83% of cases observed in May, 2009, and in 85% of cases observed in June, 2009; presentation of present status occurred only in 53% of cases in February, 2009, but has increased to as high as 77% of IRPs observed in April, 2009, and was at 69% in June, 2009 IRPs observed. Conferences are still not interdisciplinary in nature (37% in February, 2009, 50% in March, 2009, 54% in April, 2009 and 54% in May, 2009, but only 38% in June, 2009). As previously noted, the IRP checklists were recently revised and made more user friendly. Use of the checklists however, is not yet the practice across all units, which likely accounts for the fact that in many IRPs, one or two topics (i.e., risk factors, stage of change) are overlooked. Data show the use of the checklists ranged from 50% in March, 2009, fell to 46% and 42% in April and May, but rose to 77% in June, 2009. Now that the checklists have been revised to include boxes that can be checked it is expected that use of the tool will continue to increase as it is more user friendly. This should improve compliance with other specific requirements in the Agreement.

It is noteworthy that IRPs continue to run long. The Hospital considered revising the target time frames for IRPs to extend the times per DOJ recommendation, but elected to continue with the present time frames, believing that as staff complete training and with the revised IRP Manual, the original projected time frames are reasonable goals and will be able to be met. This may be revisited upon conclusion of the training.

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

DOJ Recommendations (Report 3)		*Responsible Party*
1 *Develop and fully implement a training program in interdisciplinary recovery planning that emphasizes the*	***- High Priority***	*CNE; COS; Trg; Clinical Administrators*

role of the team leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement IRP training on all units.	9/30/2009	Training data around IRP process, Tab # 2; IRP Training Outline, Tab # 1	Gouse; Snyder
	Complete *Status: Training completed on 5 units and is underway on remaining 12 units. - Updated as of 7/17/2009*			
2	Revise IRP manual based on most recent DOJ recommendations	7/10/2009	IRP manual	Gouse
	Complete *Status: Focus areas, operational instructions, examples of objectives, interventions and needs lists have been finalized. Other documents in manual have been modified and new documents have been finalized for manual. - Updated as of 7/17/2009*			
3	Train clinical administrators on new documents for manual.	7/23/2009	Training data for IRP, Tab #	Gouse; Snyder
	Complete			

2 *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of interdisciplinary recovery planning, and add additional training modules as necessary to achieve this goal.* ***- High Priority*** *COS; Trg; Discipline Chiefs*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct IRP overview training with all clinical staff	8/1/2009	Training data, Tab # 2	Gouse; Snyder
	Status: IRP overview training completed by XXX percent of the clinical staff - Updated as of 7/20/2009			
2	Review expectations with discipline chiefs regarding how staff are expected to participate in recovery planning meetings	7/15/2009		Gouse
	Complete			

3 *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference.* ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise checklists for comprehensive IRP and review IRP.	6/24/2009	IRP Manual	Gouse
	Complete *Status: Checklists were revised during meeting with PID and consultants. Disseminated to Clinical Administrators on 7.9.09. - Updated as of 7/17/2009*			

V.A.2.b

Compliance Status from DOJ Report: Noncompliance

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

Findings

In most case, the individual is attending the treatment plan conference, but the degree of participation varies widely. The revised IRP process monitoring tool tracks both the participation of family members and community members and the individual. IRP process monitoring tool, tab # 8. Data show that the individual attended 95% of IRP conferences in February, 83% (March), 92% (April), 100% (May) and 92% (June), and that family attended 10% of conferences in February, 17% (March), 15% (April), 0% (May) and 8% (June); the percentages of family who were invited are significantly higher than the percentages of families who attend. Community workers attended 25% in February, 28% (March), 15% (April), 33% (May) and 23% (June). IRP Process Monitoring results, Tab # 9. Further, data suggest that the treatment teams engaged the person in discussing objectives and interventions (February, 82%; March, 87%, April, 82%, May, 83% and June, 85%) but did not do as well in providing the individual with options around interventions although recent data suggest improvement in this area as well (February, 47%, March, 40%, April, 36%, May, 50%, and June, 69%). IRP Process monitoring results, Tab # 9.

A training focused on engaging the individual and families was held in late August, 2009, so the data provided above does not reflect that training. See IRP training outline, tab # 1; IRP training data, tab # 2, for specifics around that training. In addition, the trainers focus on individual

engagement during their on-unit observations and coaching.

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

DOJ Recommendations (Report 3)	*Responsible Party*
1 *Develop and (or if developed) implement training in effective ways to engage individuals and their families in the treatment planning conference.*	*Civil;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide IRP training around engagement of individuals to psychiatrists, nurse managers and clinical administrators.	9/1/2009	IRP Manual; IRP Ttraining outlines, Tab # 1; Training data, Tab # 2	BG; Snyder
Status: Training scheduled for August 24, 2009 - Updated as of 7/26/2009			

2 *Provide a roll out plan for when this training will begin and by what date completion is anticipated.* ***- High Priority*** *COS; Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action step and status V.A.2.a			BG
Status: Expected to be completed by September 30, 2009. - Updated as of 6/24/2009			

V.A.2.c

Compliance Status from DOJ Report: Partial

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 Hospital made revisions to the IRP, Assessment and Medical records policy to ensure that they are consistent and meet DOJ required timelines for completion of Assessments. IRP Policy, Tab # 3; Assessment policy, Tab # 12; Medical Records Policy, Tab # 13. Each discipline is required to complete an assessment or assessment update at least two days prior to the IRP conference.

Data from IRP observations and related records review suggest that, in most cases, assessment updates using the correct forms are not being completed the two days before the IRP conference. IRP Process Monitoring results, Tab # 9. Observers reported that while in many cases, a note was completed prior to the IRP conference, per the Audit Instructions, it was not credited if it was not completed on the appropriate form or if it was completed less than two days before the IPR conference. Therefore the data reflect completion of an update two days prior to the IRP conference using the correct form; there were many cases where a detailed update was in the record but was not completed on the correct form. The initial psychiatric and nursing assessments are generally being completed timely - - the IRP process monitoring audits suggest that nursing, and psychiatry are completing their initial assessments in a timely manner, and that psychology is improving its timely completions. This data is borne out by the discipline audits that are discussed in more detail in Section VI.

All disciplines are now completing regular monthly audits of assessments, though psychiatry is just beginning auditing the psychiatric update note. Social work audit results show than the social work initial assessment was completed timely 67% of cases in April, 82% of cases in May, and in only 46% of cases in June and in 27% of cases in July, 2009. The issue around the timeliness seems to be a result of how the days are counted - - under the Hospital policy, the day of admission is counted as day one for purposes of counting due dates for admission assessments. A review of the social work assessments suggest many are completed on the sixth day after admission, when the day of admission is counted as day one. Audit results of the social work monthly update show that it was completed timely 100% of cases in May, June and July, 2009. Each discipline is also monitoring the quality of the assessment or update, and areas where improvement is needed are being identified by each discipline.

Revisions were made to the therapeutic monthly note and instructions were developed, and an audit tool with instructions to monitor the quality of the note was developed, but has not yet been implemented (implementation expected in September, 2009 to review August, 2009 notes). Therapeutic monthly note/instructions, tab # 44; Therapeutic monthly note audit tool/instructions, tab # 45. The modification to the note is designed to link more closely the objective of the IRP to the specific intervention. Further, the TLCs have developed the TLC Addendum, that will be incorporated into the IRP. TLC addendum, tab # 46. This document which is directly linked to the IRP, is completed by the TLC and provided to the Clinical Administrator for the individual.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop and implement an auditing tool that monitors for all aspects of the progress note template.* — ***- High Priority*** *COS; Coleman; Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify therapeutic progress note form to improve linkage with IRP ***Complete***	6/22/2009	Modified Therapeutic Progress Note form and operational instructions ,Tab # 44	BG
2 Write audit tool and operational instructions. ***Complete***	8/12/2009	Monthly progress note audit tool and instructions, Tab # 45	BG
3 Implement audit	9/1/2009		Coleman, Robinson
4 Develop and implement TLC addendum form that links interventions to IRP and can be made part of IRP	8/31/2009 (Ongoing)	TLC Addendum,Tab # 46	Vidoni-Clark

2 *Train all auditors to acceptable levels of reliability.* — *COS; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify auditors for therapeutic progress note.	7/24/2009		BG
Status: Auditors will be discipline chiefs and performance improvement department staff - Updated as of 7/17/2009			
2 Train auditors on tool.	8/15/2009	Therapeutic note audit tool and audit instructions, Tab # 45	BG
3 Implement audit	9/1/2009	Audit results (will not be available by time of visit)	

3 *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* — *COS; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Write operational instructions for therapeutic progress note. ***Complete***	7/10/2009	Therapeutic monthly note and instructions, Tab # 44	Gouse
2 Write operational instructions for auditing tool. ***Complete***	7/10/2009	Therapeutic monthly note audit tool and audit instructions, Tab # 45	Gouse

4 *Ensure that one of the monitored elements includes the alignment of the progress note with the IRP.* — ***- High Priority*** *COS; Coleman, Robinson*

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

V.A.2.d — ***Compliance Status from DOJ Report: Partial***

require that the treatment team functions in an interdisciplinary fashion;

Findings IRP trainers continue to work with teams around operating in an interdisciplinary as opposed to multi-disciplinary fashion. Four teams have completed training, while the remaining thirteen are still in training. See IRP training outline tab # 1 for content of training, and IRP Training data, tab # 2 for training data.

The quality of IRP conferences continue to improve, with little assessment occurring, and stronger clinical presentations occurring in Phase I. Despite this progress, some teams continue to struggle with Phase II, particularly in dealing with a extremely psychotic individual or if Phase II opens without a focused question. Training provided on engaging individuals, as well as new tip sheets in the IRP manual, are expected to support teams during Phase II. A complete outline of the IRP training is attached in Tab # 1 . The training program, as reflected in the IRP manual, clarifies the conceptual framework for IRP planning, noting that the focus is on recovery planning that is geared toward supporting the individual in reaching a life goal. See also findings, V.A.2.a.

In addition, the Hospital revised the IRP checklists to support facilitation of the IRP conference. IRP Manual at Tab # 11. The revised checklists include boxes which the facilitator can use to ensure all aspects are covered during the conference. The checklists are different for the Comprehensive IRP conferences and the IRP review conferences and are more user friendly.

It is noteworthy that IRPs continue to run long. The Hospital considered revising the target time frames for IRPs to extend the times per DOJ recommendation, but elected to continue with the present time frames, believing that as staff complete training and with the revised IRP manual, the original projected time frames are reasonable goals and will be able to be met. This may be revisited upon conclusion of the training.

The Hospital also piloted its clinical chart audits to assess the quality of the IRP itself as well as the clinical formulation. See Clinical chart audit tool/instructions, tab # 10 ; Clinical chart audit results, tab # 11. The early data from the pilot suggest that the audit process may need to be revised or modification be made to the tool or instructions. Results seem to indicate further training may also be needed for reviewers.

Finally, the Hospital is now presenting data reflecting performance on specific indicators relating to the IRP process from month to month, so trends and progress (or lack of progress) can be readily identified.

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

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Develop and fully implement a training program in person-centered treatment planning that emphasizes the role of the team leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences.*	***- High Priority***	*COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement IRP training on all units	9/30/2009	IRP Training data, Tab # 2 ; IRP training outline tab # 1	Gouse

Status: Training completed on 5 units and is underway on remaining 13 units. - Updated as of 7/17/2009

2 *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal.*	***- High Priority***	*COS; Trg;*

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

3 *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference.*	***- High Priority***	*Forensic; Clinical Administrators*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise IRP conference checklists for comprehensive and review IRPs.	7/1/2009	IRP Manual (stand alone manual)	BG

Complete *Status: Checklists were revised during meeting with PID and consultants. Disseminate to Clinical Administrators on 7.9.09. - Updated as of 7/17/2009*

4 *Separate process auditing of the IRP conference from content auditing of the IRP in the medical record.* ***- High Priority*** *PID; COS; Kim*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue audits of IRP process	3/1/2009 (Ongoing)	IRP process monitoring audit tool and instructions, Tab # 8; IRP Process audit results, Tab # 9	Hartley
Complete *Status: Ongoing. Audits using prior tool were conducted and data is available. Audit tool has been modified slightly based upon DOJ report # 3. - Updated as of 6/18/2009*			
2 Finalize clinical chart audit tool and instructions	6/15/2009	Clinical chart audit tool and instructions,Tab # 10	Gouse
Complete *Status: Audit tool and instuctions drafted, will be tested week of June 15, 2009 and modified by June 30, 2009. - Updated as of 6/18/2009*			
3 Train auditors (clinical administrators and discipline chiefs) and begin Audits	6/15/2009		Gouse
Status: Training held on June 11, 2009 - Updated as of 6/18/2009			
4 Begin clinical chart audits, one chart per ward.	8/3/2009		Gouse
5 Develop clinical chart audit DB for audit data entry results	8/3/2009		Kim
Complete			
6 Analyze audit results and share findings	9/18/2009		Kim

5 *Audit a sample of all conferences and charts on a monthly basis and present resulting data aggregated by month for the next 6 months. Continue to audit monthly thereafter.* *PID; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise IRP observation audit tool and instructions.	7/1/2009	IRP observation audit tool and instructions, Tab # 8	Gouse
Complete			
2 Audit sample of conferences	7/1/2009	Audit results, Tab # 9	Gouse
Status: Audits are underway on comprehensive and review IRP conferences. Sample is taken on all IRP's for each month. - Updated as of 7/17/2009			
3 Analyze and share findings with each unit leaders on a monthly basis	8/14/2009		Arena; Kim

V.A.2.e ***Compliance Status from DOJ Report: Partial***

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

Findings

Minimal progress has been made on integrating psychiatric and behavioral modalities. Due to government wide spending pressures and budget cuts, the Hospital was not able to extend its contract with the PBS consultant, although it expects that it will be able to enter into such a contract after the new fiscal year begins (October 1, 2009). Thus, no additional staff have been trained nor has the program been extended. For the same reason, hiring of the PBS team was delayed, although the Hospital recently was authorized to recruit for a PBS team leader and two PBS technicians on July, 31, 2009, but recruitment is underway. While the Hospital has not been able to provide additional training, several psychologists attended training around PBS planning at Georgetown and information was provided to those psychologists who could not attend.

Despite any significant additional training or staff, some progress has occurred. Several PBS plans have been completed or will be completed by the site visit, ward based psychologists are identifying individuals in need of behavioral guidelines or plans and referrals have been made; psychologists continue to provide the technical advice around behavioral issues. Minor modifications were made to the PBS policy. Further, the psychiatric update (now implemented) includes a specific prompt around behavior and psychodynamic issues that affect the individual's progress, which is designed to ensure integration of behavior interventions and psychiatric treatment. Psychiatric Update/Instructions, tab # 17.

However, the Psychology Department has several vacancies, which is affecting attendance at IRP conferences as well as timely completion of the IPA. (One psychologist was recently hired, and a second is expected to start by September 15, 2009.) Psychologists attendance at IRP conferences ranged from a low of 44% in March, 2009 to a high of 67% in May, 2009. It was at 54% in June, 2009. Filling these vacancies is critical if attendance is to improve.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Implement the draft behavioral interventions policy and templates.* — ***- High Priority*** *Civil; Forensic; Med; COO; CAO*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify funding to expand contract for PBS training	7/31/2009		Cavanan, Baron
Status: No training has occurred since March due to absence of contract and additional funding for training. More training needed for nursing, psychology and psychiatric staff. Hospital expects to identify funding in FY 2010 for continued consultation List has been prepared and is under review by leadership - Updated as of 6/18/2009 - Updated as of 8/13/2009			
2 Create PDs for PBS team	7/15/2009	PDs of PBS team leader and PBS specialists/technicians, Tab #40.	Seymour
Complete			
3 Enter into new contract, consistent with DC procurement rules, for PBS training	8/28/2009		Valliere, Moye
Status: See status in action step 1 - Updated as of 7/26/2009			
4 Begin implementing policy through PBS referrals and plan development			JH; CVC; Gontang

2 *Ensure consistent training of direct care providers on the principles and practice of PBS.* — ***- High Priority*** *COS; Trg;*

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

3 *Ensure attendance and participation by psychologists in IRP reviews.* — ***- High Priority***

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Acting Director of Psychology to clearly convey to psychologists the need to attend and participate in all IRP reviews on their units. Psychiatrists will be reminded not to hold IRP reviews without psychologist present and to notify Director of Medical Affairs if psychologist is absent.	6/15/2009		Arons; Gontang
2 Monitor attendance of psychologists through IRP process audit data	8/12/2009	IRP process monitoring auditing results, Tab #	PID; Gontang
Complete			

4 *Ensure documentation, in the psychiatric progress notes, of proper integration of psychiatric and behavioral treatment modalities.* — ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Topic will be discussed at every psychiatrists' staff meeting, held monthly.	9/1/2009		Arons
Status: Not yet begun. - Updated as of 6/24/2009			

2	Finalize format for psychiatric update and develop instructions	7/31/2009	Psychiatric Update form and instructions Tab # 17	Arons
	Complete			
3	Begin audits of psychiatric updates.	9/30/2009		Arons
3	Develop audit tool and operational instructions for psychiatric update	8/14/2009	Psychiatric update audit tool and instructions, Tab # 18	Arons
	Complete			

V.A.2.f

Compliance Status from DOJ Report: Partial

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

Findings The Clinical Administrator is the individual charged with scheduling the IRP conferences, drafting the IRP and scheduling and coordinating all progress reviews as needed. Each unit now has a dedicated clinical administrator. List of ward staff, tab # 43.

IRP process audits reflect that the IRP generally is scheduled consistent with Hospital policy. For example, IRP reviews were scheduled every 60 days in 91% of cases in March, 2009, 75% of cases in April, 2009, 82% of cases in May, and in 44% of cases in June, 2009. The decline in June will be reviewed to determine if there was a particular factor that affected scheduling during June.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Revise audit tool and train auditors.* — *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure IRP process auditing tool includes assessment of this requirement	8/7/2009	IRP process audit tool and instructions, Tab # 8	Arena
	Complete			
2	Implement audit and provide results	8/14/2009 (Ongoing)	IRP process monitoring results,Tab # 9	Arena; Kim
	Status: Ongoing - Updated as of 7/26/2009			

2 *Audit monthly and present trended data.* — *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See V.A.2.f actions steps, recommendation #1	6/25/2009		PID

V.A.3

Compliance Status from DOJ Report: Partial

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

Findings See V.A.2.a.

Compliance Status: Progress has been made.

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as V.A.2.a. — *COS;*

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

1 Same as V.A.2.a

V.A.4

Compliance Status from DOJ Report: Partial

consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and

Findings The Hospital IRP specifies the core members of the treatment team. IRP Policy, tab # 3. All units now have a psychiatrist, social worker, nurse, psychologist and clinical administrator assigned, although some staff cover more than one unit due to vacancies. Ward assignments, Civil and Forensic Services, tab # 43.

IRP process monitoring from the period March, 2009 to June, 2009, shows the following attendance data at IRPs:

March, 2009 - Psychiatrists, 100%, Clinical admin, 100%, RNs, 83%, PNA/FPTs, 6% social worker, 94% and psychologists, 44%
April, 2009 - Psychiatrists, 100%, Clinical admin, 92%, RNs, 100%, PNA/FPTs, 54%, social worker, 85%, and psychologists, 54%;
May, 2009 - Psychiatrists, 92%, Clinical admin, 100%, RNs, 100%, PNA/FPTs, 50%, social worker, 75%, and psychologists, 67%
June, 2009 - Psychiatrists, 92%, Clinical admin, 92%, RNs, 77%, PNA/FPTs, 38%, social worker, 92%, and psychologists, 54%

IRP Process results, tab # 9.

Data as of July 29, 2009 show on 10 of 17 units (including three of five admission units), caseload ratios are met. On three units, the caseload exceeds the standard by one individual and on another unit, the caseload ratio is exceeding standards by two. One JHP admissions unit exceeds caseload ratios by 3 respectively; on another unit, the psychiatrist is on medical leave, and a psychiatrist has been assigned to cover that unit - between that unit and his own unit, he is responsible for 43 patients. List of Psychiatrists by Ward and Certification status, tab # 37.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

Provide data on the hospital's current progress toward achieving stable core team membership. — ***- High Priority*** *Civil; Forensic; PID; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Monitor Attendance through IRP process monitoring tool and provide data	6/1/2009	IRP process monitoring tool/instructions, Tab # 8; IRP process audit results, Tab #9.	PID
	Complete *Status: Tool modified to include attendance by discipline, and data is being provided - Updated as of 6/19/2009*			
2	Develop system to ensure participation from tx mall in IRP conferences	7/10/2009		CVC, BG, JH
	Status: Meeting held on 7/9/2009 with clinical administrators and tx mall staff to discuss collaboration. - Updated as of 7/17/2009			
3	Monitor vacancies in direct care positions and obtain permission to fill if required.	(Ongoing)		Seymour
	Status: Ongoing - Updated as of 8/13/2009			

V.A.5

Compliance Status from DOJ Report: Partial

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

Findings Timeliness of IRP conference is monitored through IRP observations. Due to changes in the tool and instructions, the Hospital is now tracking this in two ways, first, is it scheduled timely, and second, is it held at the time scheduled. IRPs are scheduled timely in 100% of cases in March, 2009, 76% of cases in April, 2009, in 95% of cases in May, 2009 and in 69% of cases in June, 2009. If the IRP is held on the right day but late - i.e., on the date scheduled, but is delayed from original time separate tracking is done. This is likely some of the reasons the compliance percentages on the holding of the IRP conference have fallen from 94% in March (this when this was not tracked) to just 50% in June, 2009. IRP Process Monitoring Results,

tab # 9. Other reasons IRPs are not held timely include court schedules for psychiatrist or individual, clinic appointments or individual was involved in another activity (scheduled recreational trip).

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

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Audit each type of treatment plan monthly.*			*PID; COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Use IRP process and clinical chart audit processes to evaluate timeliness of IRPs.	(Ongoing)	IRP Process audit results, Tab # 9 ; Clinical chart audit results, Tab # 11	PID, BG
Status: IRP process audits and clinical chart audits each review timeliness of IRPS. Data is available and provided to staff - Updated as of 7/26/2009			
2 Develop methodology for sampling each type of IRP	9/30/2009		PID
2 *Present as trended data.*			*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See action steps to V.A.5, recommendation #1	8/14/2009		PID

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.

DOJ Recommendations (Report 3)			***Responsible Party***
N/A			
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 N/A			

V.B.1

Compliance Status from DOJ Report: Partial

where possible, individuals have input into their treatment plans;

Findings The Hospital is making progress in engaging individuals in the IRP process, though additional improvement in implementing Phase II of the IRP conference is needed on a number of units. Specifically, Phase I of the IRP conference, on most units, most of the time, includes a well-focused clinical presentation of the case, in which the team discusses issues around mental status, risk, stage of change, progress or lack thereof, and interventions. However, Phase II of the conference on a number of units can lose focus, and there is often only general discussions of interventions and issues and at times, little discussion of objectives. Further, not all units discuss the diagnosis with the individual even though it is clinically appropriate to do so. Finally, only some units were using the checklists.

Several initiatives were undertaken to improve individual engagement. First, the IRP manual was substantially revised to provide specific guidance around the IRP conference. The manual now includes specific information about recovery planning, including engaging individuals in their planning. IRP Manual at Tab #3. It also includes a "tip sheet" of strategies in engaging the individual. IRP Manual at Tab # 5. In addition, the checklist form was revised to include check boxes, in which the facilitator can actually checkoff that a specific issue or topic was covered. IRP Manual at tab # 11. Second, in August, additional training was provided to staff around engaging individuals and transition/discharge planning. IRP Training outlines, Tab # 1. IRP observation data is from a period preceding the training, so its impact is not yet clear.

Third, IRP observers are providing immediate feedback to teams being observed, and also send the scoring sheets to the team. Generally, observers are attending IRPs on only a few wards, so that teams and observers are able to form mentoring relationships. Finally, each individual in care, before attending the TLC, participates in a week-long orientation that includes a focus on the individual's role in IRP planning. A new Wellness and Recovery Guide is given to all individuals in care, and the Consumer Affairs office (4 individuals) meet with individuals shortly after their admission to review their rights and role in the IRP process. Wellness and Recovery Guide, tab # 47.

In most cases, the individual is attending the IRP conference, but the degree and meaningfulness of participation still varies. Data from March through June reflect the individual's attendance at 83% in March, 92% in April, 100% in May, and 92% in June, 2009. The IRP Observation rates 12 factors in evaluating whether the individual has meaningful input into the IRP. Of the 12 factors, in June, 2009, 4 were rated above 80%, 7 were rated between 50 and 79% and only one was rated below fifty percent. In contrast, in March, 2009, only three factors were rated over 80%, four were rated between 50% and 80%, and five were rated below 50%. IRP Process Observation Results, tab # 9. Despite this progress, there needs to be more involvement of the individual in choosing objectives and interventions.

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

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Ensure that the IRP Manual includes appropriate and clear expectations and operational guidance regarding the process and outcomes of engagement of individuals during IRP meetings.* ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise flow sheet that describes roles and responsibilities of team members	5/28/2009	IRP Manual	Gouse
	Complete *Status: Complete - Updated as of 6/18/2009*			
2	Review with clinical administrators and revise as needed	6/18/2009		Gouse
	Complete *Status: Complete - Updated as of 6/18/2009*			
3	Revise IRP process observation tool to incorporate DOJ recommendations as appropriate	6/25/2009	IRP Process Monitoring Tool and instructions, Tab # 8	Gouse
	Complete *Status: Meeting held on 6.24.09 to discuss IRP process observation tool and recommendations needed to be incorporated. - Updated as of 7/17/2009*			
4	Incorporate additional examples and revise checklist for use by clinical administrators based upon audit results and feedback	7/10/2009	IRP Manual	Gouse
	Complete *Status: Meeting held on 6.24.09 to go over revised checklists. - Updated as of 7/17/2009*			

2 *Ensure that each IRP team has a dedicated mentor and that mentors provide feedback to the teams and to facility management regarding the IRP process.* ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Assign IRP observations on quarterly rotations to ensure mentoring relationship and consistent feedback	7/31/2009 (Ongoing)		BG; PID
2	Ensure IRP process observers provide feedback after each observation	(Ongoing)		PID
	Status: Meeting held on August 6, 2009 with IRP process auditors to discuss and agree upon feedback mechanism for teams. - Updated as of 7/26/2009			

3 *Ensure that the revised IRP Process Observation Monitoring Form includes operational instructions to assess if the team has made clinically appropriate revisions in the case formulation, objectives and/or interventions in response to the individual's expressed cultural preference/needs.* ***- High Priority*** *PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop clinical chart audit tool and Instructions	6/8/2009	Clinical chart audit tool and instructions, Tab # 10	Gouse
	Complete *Status: Audit tool and instructions drafted, will be tested weeek of June 15, 2009 and modified by June 30, 2009 - Updated as of 6/18/2009*			
2	Train clinical administrators in audit tools (IRP Process and clinical chart audit tool)	6/15/2009		Gouse
	Complete *Status: Training on tool held on June 11, 2009 - Updated as of 6/18/2009*			
3	Begin clinical chart audits and continue IRP process audits	6/15/2009 (Ongoing)	Clinical chart audit tool and instructions, Tab # 10; IRP process audit tool and instructions, Tab # 8	Gouse; PID
	Status: Audit tool and instructions drafted, will be tested week of June 15, 2009 and modified by June 30, 2009. - Updated as of 6/18/2009			
4	Report and analyze results, using to improve performance	7/30/2009 (Ongoing)	IRP process audit results, tab # : Clinical chart audit tool resutls, Tab #	Gouse, PID
	Status: Begin 7/30/2009 and on-going - Updated as of 6/18/2009			

4 *Develop and implement a training module focused on Engagement of Individuals to ensure that the individuals provide substantive input in the formulation, review and revisions of treatment objectives and interventions. The module should include lesson plans, process outcomes and post-tests.* ***- High Priority*** *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop examples of needs, objectives and interventions for IRP manual	7/15/2009	IRP manual	Gouse
	Complete			
2	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions	9/30/2009 (Ongoing)		Gouse
	Status: Ongoing - Updated as of 6/18/2009			
3	Revise engagement tipsheet for manual.	7/1/2009	IRP manual	Gouse
	Complete			
4	Train psychiatrists, clinical administrators and nurse managers on engagement of individuals versus assessment	8/26/2009	Training data, Tab # 2; Training outline,Tab # 1	Gouse
	Status: Training scheduled for August 25, 2009 - Updated as of 7/26/2009			

5 *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* ***- High Priority*** *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Make summary outline of training modules and training process.	8/14/2009	IRP Training outline, Tab # 1	Gouse

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Maintain training data by module and teams		Training data, Tab # 2	BG; Snyder

7 *Monitor this requirement using process observation data based on at least a 20% sample during the review period.* *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conintue IRP process monitoring		IRP Process audit results,Tab # 9	PID

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Publish audit results		IRP process audit results, Tab # 9 ; Clinical chart audit results, Tab # 11	PID
1 Continue IRP process monitoring and begin Clinical chart audits.		IRP process monitoring tool and instructions tab # ; Clinical chart audit tool and instructions, Tab #	PID

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.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for compliance findings.

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

V.B.2.a

Compliance Status from DOJ Report: Partial

initial assessments are completed within 24 hours of admission;

Findings The Hospital's Assessment and Medical Records policies were updated and the timeframes required by the Agreement (as modified by Agreement of the parties, [Comprehensive IRPs to be completed in 7 calendar days]) is incorporated. Assessment policy, tab # 12; Medical Records policy, tab # 13.

The revised initial assessment forms were implemented over the summer for all disciplines, including psychiatry, social work, rehabilitation services, psychology, and nursing. Social work initial assessment/instructions, Tab # 31 ; Rehabilitation Services Initial Assessment/guidelines, Tab # 23 ; Initial Psychological Assessment, part A and B)/instructions Tab # 19 ; Comprehensive Initial Psychiatric Assessment, tab # 14 ; Comprehensive Initial Nursing Assessment Form/instructions, tab # 26. Psychiatric update form/instructions, social work update and nursing update/instructions were developed and introduced in August or early September, 2009. Psychiatric update/instructions, Tab # 17 ; Nursing Update/instructions, tab #

28 ; Social work Update, tab # 34. Audits by the disciplines are also underway for the initial assessments, and will be undertaken for the updates as they are implemented. Tab #s 16 (CIPA Audit results), #21 (IPA Audit Results), #25 (Rehabilitation Services audit results); #30 (Nursing Update audit results). In the CIPA audit, not all reviewed CIPAs were rated on timeliness, but of those which were rated, 15 of 17 were timely completed. The audits of the IPA found that 88% were completed timely; 50% of the Rehabilitation Services assessments were completed timely, and 53% of social work initial assessments were completed timely. The low percentage for social work is likely due to a misunderstanding of whether the initial day of admission counts as day one.

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

DOJ Recommendations (Report 3)	*Responsible Party*
1 *Same as in VI.A.1.*	*Med;*

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

2 *Same as in VI.2.b, Recommendation 5.*	*Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.2.b, recommendation 5.	6/1/2009		
Status: Same - Updated as of 6/25/2009			

V.B.2.b

Compliance Status from DOJ Report: Partial

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

Findings The Hospital is implementing the requirement for completion of initial IRPs within 24 hours and completion of the comprehensive plan within 7 calendar days of admission or transfer. This will be monitored through AVATAR once the IRP module is active, but for now is monitored through the IRP observation tool. To date however, the sample size to measure compliance has not been sufficient, in part because a large number of IRPs being observed are reviews, and the individual's involved have long stays at the hospital, so measuring compliance for initial IRPs and Comprehensive IRPS does not reflect current practice. PID is developing a methodology to ensure review of an adequate number of each type of IRPs.

Despite these limitations, some data is available. For initial IRPs, data from March through June, 2009 show compliance ranging from 0% in March, 2009 to 67% in May, 2009. For comprehensive IRPs, the range is 67% in June, 2009, and 100% in other months; for comprehensive IRPs within 7 days of transfer, the compliance data shows a range of 33% (June) to 50% (March through May). IRP Process results, Tab # 9.

The new initial IRP form integrates the nursing, psychiatric and general medical officer treatment interventions into a single document and is being implemented. Initial IRP form, tab # 4. The IRP manual was revised and is on the intranet.

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

DOJ Recommendations (Report 3)	*Responsible Party*
1 *Ensure consistent implementation of a timeframe of seven calendar days for completion of the comprehensive IRP and consistency between the IRP Process Monitoring Form and the revised Policy #602.2-04 regarding all timeframes for implementation of the IRPs.*	***- High Priority*** *PID; Jana Taylor*

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

1	Review policy and Modify policy or IRP instructions and form (if necessary) to ensure consistency between policy and IRP Tool	7/31/2009	IRP Policy (revised),Tab # 3; IRP process monitoring tool/instructions, Tab # 8	PID
	Complete			

2 *Monitor the timeliness of the initial and comprehensive IRP based on at least a 20% samples during this review period.* ***- High Priority*** *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue audits of IRP	3/1/2009	IRP Process audit results, Tab # 8	PID
	Status: Audits using prior tool were conducted and data is available - Updated as of 6/18/2009			
2	Revise audit tool to reflect comments in May 24, 2009 DOJ report and modify instructions	6/30/2009	IRP Process audit form and instructions,Tab # 8	PID
	Complete			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Analyze IRP audit data and publish results	(Ongoing)	IRP audit results,Tab # 9	PID
	Status: Ongoing - Updated as of 7/26/2009			

4 *Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.* *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue audits of IRP process	3/1/2009	IRP process audit results, Tab # 9	Hartley
	Complete *Status: Audits using prior tool were conducted and data is available. - Updated as of 6/18/2009*			
2	Revise audit tool to reflect comments in May 24, 2009 DOJ report and modify instructions	6/30/2009	IRP process audit tool and instructions,Tab # 8	Hartley
	Complete *Status: Tool and instrcuctions revised - Updated as of 6/18/2009*			

V.B.2.c

Compliance Status from DOJ Report: Partial

treatment plan updates are performed consistent with treatment plan meetings.

Findings See findings V.B.2.b.

The IRP process monitoring tool tracks the timeliness of the IRPs as well as whether they are held as scheduled. See V.A.5 for data.

The Clinical administrator is charged, through the position description, with ensuring IRP meetings are scheduled and held in accordance with Hospital policies.

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

DOJ Recommendations (Report 3)	***Responsible Party***
1 *Ensure monitoring instructions regarding the identification by the IRP team of some one to be responsible*	*PID;*

for scheduling the IRP meetings in accordance with the required timeframes.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue audits of IRP process **Complete**	3/1/2009	IRP process audit results,Tab # 9	Hartley
2	Revise audit tool **Complete**	6/30/2009	IRP process tool and instructions, Tab # 8.	Hartley

2 *Monitor this requirement using the process observation tool based on at least a 20% sample during the next review period.* — *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct audit on 20% sample of IRP conferences *Status: Ongoing - Updated as of 7/26/2009*	7/31/2009 (Ongoing)	IRP audit results, Tab # 9	PID

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure report includes specified data	8/13/2009	IRP audit results,Tab # 9	PID

V.B.3

Compliance Status from DOJ Report: Partial

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

Findings The Hospital's IRP form includes a "consent for treatment." IIRP Form, tab # 4. The psychiatrist will obtain informed consent to medications, but the team continues to work with the individual on obtaining informed consent on other interventions. In addition, the Office of Consumer Affairs recently undertook two efforts. First, it began conducting satisfaction surveys with discharged individuals, which includes a question concerning medication side effects. According to the most recent survey of 212 individuals in care, 59% on individuals in care agreed that the doctor discussed with them why the medication was prescribed, 11% were neutral and 29% disagreed. Fifty five percent agreed they were given information about medication side effects, 13% were neutral and 32% disagreed. Consumer Satisfaction Survey Results, tab # 50.

In part, based upon the results of the survey, the Office of Consumer Affairs also developed a Medication Information Manual that provides detailed written information that will be given to individuals who are taking the relevant medication. Medication Information Manual, tab # 49. The Consumer Affairs Office is working with Nursing staff and Medical staff to determine the most effective way of providing that information, which may include 1:1 meetings with each individual to review their rights, roles etc. A decision on implementation will be made by September, with implementation immediately following. The intent of this is not to replace the physician - individual discussion around side effects and consent which will continue, but to provide a method for the individual to get additional information and work with an advocate if desired.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.* — ***- High Priority*** *PID; COS;*

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

1	Develop audit tool and operational instructions	7/1/2009	Clinical chart audit tool and instructions,Tab # 10	Gouse
	Status: Piloted clinical chart audit occurred in June. Data will be collected for the month of July. - Updated as of 7/17/2009			
2	Conduct audits, initial by auditing 1 record per unit, then expanding.	8/28/2009 (Ongoing)	Clinical chart audit results,Tab # 11	Gouse

2 *Provide a sample of information regarding the content of informed consent for specific medication classes.* ***- High Priority*** *Civil; COS; OAG*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure curriculum in medication classes in treatment mall includes information about informed consent	6/1/2009	Curriculum from TLC medication groups will be available during the survey	CVC
2	Develop medication information for consumers and plan for informing consumers.		Wellness and Recovery Guide,Tab # 47; Medication information manual, Tab # 49	Gouse

3 *Monitor this requirement using clinical chart audit based on at least a 20% sample during the review period.* *Med; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include audit of informed consent in consumer satisfaction survey	8/28/2009	Consumer satisfaction survey and results, Tab # 50	Gouse; Kahaly
2	Assess whether informed consent was given through audits of comprehensive initial psychiatric assessment and psychiatric update	8/31/2009	CIPA audit tool/instructions, Tab # 15	Arons
	Status: Instructions for audit tool address informed consent - Updated as of 7/26/2009			

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

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

V.B.4

Compliance Status from DOJ Report: Noncompliance

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.

DOJ Recommendations (Report 3) ***Responsible Party***

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

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

2 *Same as in V.D.4 and V.D.5.* *COS;*

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

V.B.5

Compliance Status from DOJ Report: Same as in XIIE2

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

Findings Use of seclusion and restraint continues to decline as reflected in the PRISM data both by percentage of individuals secluded or restrained as well as restraint or seclusion hours. PRISM Report, Tab # 53. The Hospital policy titled "Seclusion and Restraint for Behavioral Reasons" requires the Medical Director to review incidents of use of seclusion or restraint that are: 1) for more than 12 hours; 2) more than twice in a 24 hour period; and 3) 3 or more times in a thirty day period. Restraint or Seclusion for Behavioral Reasons policy, tab # 51.

The Hospital recently developed and implemented a system to track compliance with this (and other) high risk indicators. The Medical Director and Risk Manager met and established a single, coordinated, comprehensive approach that will meet clinical quality improvement as well as provide documentation. In mid-August, designated PID staff began regular tracking, among other things of Restraint/Seclusion, with trigger being 2 or more episodes in a 24 hour period, 3 or more in a 30 day period, episodes over 2 consecutive days, and any episode over 12 hours. Under the protocol, staff will notify the Medical Director of Civil or Forensic Services of any incidents that meet this threshold; staff will then collect the results of the Medical Director review and maintain documentation of the results of the Medical Director review. Tab # 56.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as in XII.E.2.* — *PID;*

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

2 *Provide documentation of the purpose and results of the Medical Director's review of the use of seclusion and/or restraint during the reporting period.* — *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop process on the review by Medical Director of use of restraint or seclusion consistent with triggers outlined in policy.	7/31/2009	Tracking report, Tab # 56	Arons, PID

Status: Meeting held 7/21/2009 to define process. Risk Management office will track through UI process and will notify Med Director (Civil or Forensic) for review. Results to be reported to Risk Management office for tracking. - Updated as of 6/25/2009

V.B.6

Compliance Status from DOJ Report: Partial

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

Findings The Compliance Officer's Status Report in July, 31, 2008 remains accurate, in that Forensic Services implemented its policy of ensuring all post-trial cases are presented to the Forensic Review Board at least once per year. It also modified the template for FRB reports to include at the beginning of each report a list of risk factors leading to initial hospitalization and current risk factors, as well as ensuring these are addressed in the body of the report and in the conclusion. Template for Review Board report, tab # 57. In addition, it implemented a system to document and track the implementation of FRB recommendations. Responses to FRB Recommendations, tab # 58.

The Chief, Post-trial Services continues working with clinical administrators so that the Review Board reports appropriately address risk. He also conducted a review of records to evaluate the follow up by treatment teams to Review Board recommendations. His review revealed that during the period of March 1, 2009 to May 31, 2009 in 79% of the cases, the feasible Review Board recommendations were implemented; another 9% were in process, and 12% of feasible recommendations had not been addressed. Summary of Responses to Review Board recommendations tab # 58.

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

DOJ Recommendations (Report 3)	Responsible Party
1 *Continue monitoring of treatment team response to FRB recommendations and presentation of data to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement.*	*Forensic; Morin*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Continue monitoring responses to Review Board recommendations	5/11/2009 (Ongoing)	Responses to Review Board report, Quarterly review report, Tab # 58	Henneberry; Morin

Status: Ongoing, Quarterly review was completed June 30th and feedback was provided to clinical administrators by 7/7/09.. Post Trial Branch Chief reviewed the "Treatment Team Response to Forensic Review Board Recommendations" in 34 clinical records. .Branch Chief has discussed all major findings requiring corrective action with clinical administrators. Next quarterly review will be completed by September 30, 2009. - Updated as of 7/30/2009

2 *Revise Risk Factor section and final section of FRB submissions so that each FRB submission contains a list of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. After each factor, a sentence explaining its relevance to the individual can be added. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk factor should again be listed and updated based on the findings in the body of the report. This section is also the appropriate section to report current scores from actuarial risk assessment instruments.*	*Forensic; Morin*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop written template for risk factor and rationale sections of Forensic Review Board Report	5/4/2009	Written template,Tab # 57	Henneberry; Morin
	Complete *Status: Completed 05/04/09 - Updated as of 6/18/2009*			
2	Present and discuss template with clinical administrators	5/11/2009		Henneberry; Morin
	Complete *Status: Completed 05/11/09 - Updated as of 6/18/2009*			
3	Monitor all reports prepared after presentation to clinical administrators to ensure compliance with template	5/18/2009 (Ongoing)		Henneberry; Morin

Status: Ongoing beginning week of 05/18/09. Dr. Morin reviewed 4 presentations the week of June 15, 2009. Dr Morin reviewed 3 presentations the week of June 22, 2009. Dr. Morin Reviewed 3 presentations the week of June 29th. Dr. Morin reviewed 5 presentations the week of July 6, 2009, 6 presentations the week of July 13 and 3 presentations the week of July 20, 2009. - Updated as of 7/30/2009

V.B.7

Compliance Status from DOJ Report: Partial

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 sections.

DOJ Recommendations (Report 3)	Responsible Party
1 *Same as in V.E.3, V.E.4 and V.E.5.*	*Med; PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Same as in V.E. 3, V.E. 4, and V.E. 5			

Status: IRB Process being monitored with feedback to team to assure compliance with this requirement - Updated as of 6/29/2009

2	Develop audit tool and instructions for psychiatric update that reviews include assessment of need for changes to treatment based upon patient's progress or lack thereof and report results	8/5/2009	Psychiatric update audit tool/instructions,Tab # 18	Arons; PID
	Status: Tool and instructions developed. Audits to begin in August - Updated as of 7/26/2009			
3	Develop chart audit tool/instructions to assess if changes are made to treatment regimen based upon assessments and patient's changing needs **Complete**	7/31/2009	Chart audit tool/instructions, tab #	Gouse
4	Begin clinical chart audits	7/1/2009		Gouse

2 *Same as in VIII.* *Med;*

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

V.B.8

Compliance Status from DOJ Report: Partial

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

Findings The Hospital revised the Transfer policy to incorporate an addendum that describes the mission statements of the units, as well as to modify the documentation requirements for transfer to a medical facility for emergency reasons. Transfer policy, tab # 59.

The Hospital also conducted audits of both intra and inter- hospital transfers. The tool specifically looks to determine if "barriers to discharge", review of risk factors, and plan of care are addressed in the psychiatric note. An audit was conducted each month from March through June, 2009, evaluating both inter-unit and inter-hospital transfers. It should be noted that during this period, a significant number of individuals were transferred among units for administrative reasons, to align individuals with Medicaid certified units. Civil admission units are now RMB 4 and RMB 6.

Results of the transfer audits show a marked decline in compliance with some areas of the Hospital's transfer policy around inter-unit transfers, likely due to the high number of administrative transfers that occurred in April and May, 2009. Presence of a psychiatric transfer note was found in 100% of charts reviewed in March, 2009, but in only 75% in April, 2009, and 33% in May, 2009 charts and 0% in June, 2009. Some other discipline transfer notes were even less likely to be found - - only 39% of social workers completed transfer notes in May, 2009 but was up to 75% in June, 2009; but a nursing transfer note was found in 100% of cases in March, April and June, 2009, and in 72% of cases in May, 2009. Other areas for improvement the quality of the note, including content of psychiatric transfer note, especially around anticipated benefit of transfer, review of risk factors, and recommended plan of care. Performance around inter-hospital transfers was worse. Although only a few cases were reviewed (5 in March, 2 in April, 3 in May and 5 in June, 2009) the vast majority of notes did not meet most of the standards. Transfer audit results, March through June, 2009, Tab # 61.

The Hospital's Performance Improvement Committee identified communication and continuity of care as two initiatives for this year. A draft transfer form was recently developed that is designed to improve documentation around transfer. Tab # 121, 122.

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

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Ensure that the current policy regarding Patient Transfers also addresses the mission of each unit in the hospital.* ***- High Priority*** *PID; Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify each mission statement by specific unit as a policy addenda.	6/30/2009	Transfer policy, Tab # 59.	Jana Taylor

2 *Implement corrective actions to ensure that the transfer assessment meets the requirements of the facility's policy.* *- High Priority* *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement system to track implementation of recommended corrective actions around transfer audit results.	8/28/2009	Transfer audit tool and results, Tabs # 60 and 61	PID
2 Continue to conduct audits of transfers to ensure transfer assessments meet Policy requirements	6/1/2009 (Ongoing)	Transfer audit results, Tab # 61	PID

Status: Ongoing - Updated as of 6/25/2009

3 *Monitor this requirement using the inter-unit transfer assessment tool based on at least a 20% sample during the next review period.* *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify audit tool to incorporate DOJ recommendations	8/20/2009	Audit tool and instructions, Tab # 60	Hartley
2 Conduct monthly audits using revised tool	6/15/2009 (Ongoing)	Transfer audit results,Tab # 61	Hartley

Status: Ongoing - Updated as of 6/18/2009

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Anaylze and publish transfer audit results	(Ongoing)	Transfer audit tool resutls,Tab # 61	PID

Status: ongoing - Updated as of 7/26/2009

V.B.9

Compliance Status from DOJ Report: Partial

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. See also description of monitoring system that sets out the various audits and reviews used to assess quality and timeliness of assessments and other clinical care. Description of monitoring system Tab # 62 See also Audit tools for each discipline, Tab ## 15, 18, 20,24, 27, 29, 32, 35.

Each discipline is auditing the quality and timeliness of their assessments and progress notes. The Clinical chart audit is being piloted, IRP process audits are well underway, as are audits around use of restraint or seclusion, tardive dyskinesia, patient transfers, discharge, medication, among others.

An automated information system which will permit data collection by practitioner across all aspects of care is expected to be rolled out in phases. Implementation of this system however, has been delayed due to technical software issues around the content and approval processes for assessments, etc. At this juncture only some disciplines are completing their assessments in AVATAR, while others are still in AVATAR development. Once implemented, timeliness of IRPs, assessments and progress notes will be tracked through AVATAR.

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

DOJ Recommendations (Report 3) ***Responsible Party***

Ensure adequate completion of items #3-14 outlined in this consultant's summary above. *Civil; Forensic; Med; CNE; PID; COS; Psy;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop audit tools for each discipline initial assessments and udpates, with instructions for each	8/14/2009	Audit too/instructions CIPA,Tab # 15; Psych updateTab # 18; Audit tools/instructions IPA, Tab # 20; Audit tools/instructions SWIA, Tab # 32, SW Update, Tab # 35; Audit tools/instruct Initial Nursing Asmnt,Tab # 27; Nursing Update, Tab # 29	CNE; Rehab; Social Work; Psychiatry, Psychology.
	Status: Audits tools for both types of assessments completed for social work, psychiatry and nursing. Psychology and rehab only complete initial assessments and tools are completed for those. - Updated as of			
2	Implement the above specified audits	8/28/2009	CIPA results, Tab # 16, IPA results, Tab # 21, Rehab results, Tab # 25, Nursing update results, Tab # 30, SWIA/update results, Tab # 33	CNE; Rehab; Social Work; Psychiatry, Psychology.
	Status: Audits ongoing - Updated as of			
3	Analyze and publish audit results	8/14/2009 (Ongoing)		PID
	Status: Ongoing - Updated as of			
4	Continue audits on transfers, medication reviews, discharge, tardive dyskinesia and publish results	6/26/2009 (Ongoing)	Transfer audit results, Tab # ; TD Audit results, Tab # ; Medication Audit results, Tab # , Discharge audit results, Tab #	PID
	Status: Ongoing - Updated as of			

V.C. Case Formulation

By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individu

Findings See individual cells for findings.

Compliance Status: See individual cells for findings.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

V.C.1

Compliance Status from DOJ Report: Partial

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

Findings The Hospital made substantial modifications to its IRP manual which now contains specific instructions, with examples, in completing the clinical

formulation and clinical formulation update as well as the IIRP, the IRP and the IRP update. IRP Manual at Tab # 7 and 8. The instructions provide extensive details about what should be included in and the focus of the clinical formulation/update, as well as how it should be used in IRP planning. Included in the instructions for the IRP development is a focus on improving functional skills and the role of enrichment activities in achieving higher levels of functioning. Further, the IRP manual includes specific instructions that each IRP requires inclusion of enrichment activities reflecting development of enhanced social and functional skills designed to improve quality of life. IRP Manual at Tab # 8, # 3 (noting specifically that the focus areas must address eleven dimensions, including functional skills).

As previously noted, all units have either completed training (four units) or are in the midst of training. The IRP training includes a combination of didactic and observation with coaching, with eight modules around recovery, engagement, discharge/transition planning among other topics, and includes a video of a mock IRP conference as well as hours of observation, record review and coaching. IRP Training summary, tab # 1; IRP training data, tab # 2.

All units are now (beginning in June, 2009) using the clinical formulation and clinical formulation updates, to somewhat varying degrees of effectiveness. The new IRP form is also being used across all units. The Hospital revised its clinical chart audit tool and instructions, and piloted it in late July, 2009. Clinical Chart Audit tool/instructions, tab # 10; Clinical chart audit results, tab # 11. Based upon the results (which appear to overstate progress to some degree), as well as feedback from clinicians using the instrument, additional work on the tool and instructions is being undertaken to ensure a more accurate analysis; additional training of auditors may also be needed.

IRP observations continue, and reviewers are noting significant progress in the use of the clinical formulation/update during Phase I of the IRP conferences, as well as an improved focus on present status from all disciplines during Phase I. IRP process data shows that Phase I of the IRPs generally include a discussion of risk factors (ranging from a low of 85% in April, 2009 to a high of 100% in June, 2009) as well as discussion of issues around discharge (ranging from 92% in April, 2009 to 100% in March, May and June, 2009). Phase I in most IRPs also include a review of clinical relevant material through updates of present status (range of 75% in June, 2009 to 94% in March, 2009) . Staff are not as effective in discussing stage of change in Phase I, and during Phase II, with the individual present, do not always include specific discussions of objectives and interventions for each focus area. However, data on these aspects are generally trending upward and observers have reported improvement overall. IRP Process results, tab # 9. Training continues to be provided, and observers are providing feedback which teams are incorporating into their practice. For example, one team was observed two days in a row by two different observers, and by the second day, had incorporated the feedback received the prior day, which resulted in a specific discussion on each focus area, objective and interventions with the individual. In another case, strategies used by one team of beginning the conference with statement of diagnosis, focus areas and needs within each focus area made transition to the present status update smooth and easy. Teams seem to be helping each other out by identifying strategies that work in Phase II as well, but again, progress is lagging in effectively engaging the individual. Staff are aware this area needs improvement.

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

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Ensure that the IRP manual adequately addresses the individual's needs in the domains of social skills/functional status.*	***- High Priority***	*COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise flow sheet that describes roles and responsibilities of team members. recommendations as appropriate. ***Complete***	5/28/2009	IRP manual, tab #	Gouse
2	Review with clinical administrators and revise as needed. ***Complete***	6/18/2009		Gouse
3	Revise IRP process observation tool to incorporate DOJ recommendations ***Complete***	6/25/2009	IRP Process monitoring Tool,Tab # 8	Gouse

4	Incorporate additional examples and revise checklist for use by clinical administrators based upon audit results and feedback	7/10/2009	IRP Manual	Gouse
	Complete			

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. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.* — ***- High Priority*** *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Meet with clinical administrators for feedback on new forms.	4/30/2009		Gouse
	Complete			
2	Look at clinical formulation and IRP and revise forms	5/1/2009	Clinical formulation and update forms, Tabs # 6 and 7; IIRP and IRP forms, Tabs #4 and # 5	Gouse
	Complete *Status: Clinical Formulation and IRP forms have been revised - Updated as of 5/1/2009*			
3	Develop examples of needs, objectives and interventions for IRP manual	7/15/1990	IRP manual	Gouse
	Complete			
4	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions.	9/30/2009	Training data, Tab # 2	Gouse
	Status: Training completed on 5 units and is underway on remaining 13 units. - Updated as of 7/17/2009			

3 *Provide summary outline of the disciplines participating in the above training and the training process (didactic, observation, feedback to teams) and content.* — ***- High Priority*** *COS; Trg;*

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

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.* — *COS; Trg;*

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

5 *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* — ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop clinical chart audit tool and instructions		Clinical chart audit tool and instructions,Tab # 10	Gouse
	Complete			
2	Train clinical administrators in audit tools			Gouse
	Complete *Status: Training on tool held on June 11, 2009 - Updated as of 7/17/2009*			
3	Revise audit tool and instructions		Clinical chart audit tool and instructions,Tab # 10	Gouse
	Complete *Status: Audit tool and instructions revised based on feedback from pilot and data will be collected starting in July. - Updated as of 7/17/2009*			

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
4	Begin audits	7/1/2009	Clinical chart audit results,Tab # 11	Gouse

Status: Clinical administrators and discipline chiefs are auditing clinical charts (1 chart per unit initially) - Updated as of 7/17/2009

6 *Monitor this requirement using the clinical chart audit tool based on at least a 20% sample during the review period.* — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Audit 10% of sample	9/1/2009	Clinical chart audit results, Tab # 11	Gouse

Status: Audits have begun for month of July with 10% for Civil and 10% for Forensic. - Updated as of 7/17/2009

2	Expand audits to 20% sample	11/2/2009		Gouse

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Analyze and publish audit results		Clinical chart audit results,Tab # 11	PID

V.C.2

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as above. — *COS;*

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

V.C.3

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as above. — *COS;*

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

V.C.4

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*COS;*

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

V.C.5

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*COS;*

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

V.C.6

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*COS;*

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

V.C.7

Compliance Status from DOJ Report: Partial

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

Findings Same as V.C.1

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

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*COS;*

	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.

DOJ Recommendations (Report 3)			***Responsible Party***
Please see sub-cells for findings and compliance.			
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See sub-cells for action steps.			

V.D.1

Compliance Status from DOJ Report: Partial

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

As previously noted, the IRP manual was substantially revised to provide more clear operational instructions, including providing examples of individualized goals/objectives that are individualized and strengths-based, with improved focus on improving the functional skills of individuals in care. See IRP Manual at Tab # 7 and 8. The manual includes specific tip sheets on how to complete needs list and objectives, (IRP Manual at tab # 8) and more detailed instructions around identifying objectives and interventions that reflect the individual's functional status. The IRP manual, as well as the IRP and clinical formulation forms, ensure staff identify and consider risk factors and levels of dangerousness; this is addressed in the relevant operational instructions. The Manual also guides staff in development of treatment and skill building interventions designed to address needs other than simply symptom reduction; enrichment and improved quality of life are two clear goals of IRP planning. Discharge is to be addressed within each focus area, and the focus area around community integration is used only for individuals for whom discharge poses particular challenges. The Manual provides more tip sheets, and checklists of areas to be covered in the IRP conferences. It is available on each unit, as well as on the intranet. Training continues on 13 units and has been completed on four units. See IRP training outline, tab # 1; IRP training data, tab # 2.

The IRP process observations also continue, and the clinical chart audit tool and instructions were piloted. IRP process observations (tool is undergoing some modification) are assessing whether individualized objectives, based upon the individual's strengths are being addressed during the IRP conference. Data from March through June, 2009 shows that improvement is needed in this aspect, ranging from a low of 50% in April, 2009, to a high of 78% in June, 2009 ("Did the treatment team leader facilitate the process of reviewing and revising objectives for the individual"). Performance also lagged on ensuring there was a corresponding individualized intervention that is linked to the objective, from a low of 36% in April, 2009 to a high of 56% in March, 2009, with June's performance at 50%. The piloted clinical chart audit tool evaluates whether needs are built upon the individual's strengths, as well as whether objectives are based upon needs and reflect the individual's level of functioning. Results of the clinical chart audit pilot on these two indicators showed these were adequate in 92% of cases. Clinical chart audit results, tab # 11.

The IRP observations conducted during the review period also showed some improvement in the discussion in Phase II of the IRP conference around the individual's strengths (low of 75% in April 2009 to high of 92% in June, 2009) and life goals (ranging from 77% to 93%). However, teams scored in the needs improvement zone in other key areas such as asking the individual what he or she wants to change (69% in June, 2009) providing options of interventions for the objectives (69% in June, 2009) and updating the present status with the individual's input (54% in June, 2009). IRP Process Results, tab # 8.

The Hospital fully implemented its redesigned therapeutic learning centers (treatment mall) including opening a treatment mall at JHP in July, 2009. There are now four TLCs, three operating in CT 8 and one at JHP. Minimum security individuals from JHP attend one of the TLCs located on the civil side, and the JHP treatment mall serves maximum and medium security JHP patients. Currently TLC I serves 56 individuals, TLC II serves 52 individuals, TLC III serves 40 individuals and TLC IV (JHP) serves 62 individuals. Copies of the group schedules for the TLC are attached as Tab # 69. Please note that each individual completes a week long orientation as part of the TLC curricula. (The curricula for each TLC is too voluminous for copying but has been completed and will be provided during the onsite review.) Each TLC is multi-disciplinary, with psychiatry, psychology, social work, nursing and rehabilitation services providing services and has programming that includes cognitive remediation interventions (the specific curricula for each group will be provided during site visit). TLC Schedules, tab # 69. Staff were trained in cognitive remediation, including a grand rounds for psychiatry and training for TLC group leaders as well. Tab # 72, 153. Fifty two staff have completed a course in leading groups. TLC-provided interventions are incorporated into the IRP through the "TLC Addendum" which is developed during the individual's orientation with the

TLCs and is then made part of the IRP. TLC addendum, tab # 46, 101.

The Hospital also has developed a number of medical care policies and procedures to address the issues raised in the most recent DOJ report. Each individual is required to have a history and physical within 24 hours of admission, within 1 hour of return from a general medical facility, and as often as otherwise clinically necessary. Assessment policy, Tab # 12. Additionally, the Initial IRP includes a specific focus area around physical health, which is required to be completed by the GMO. Tab # 4. The Hospital also is finalizing a policy around "Medical Response". The policy establishes the standards and procedures for the provision of medical care in emergent, urgent, and non-urgent situations; communication uses the SBAR method of communication. Medical response policy, tab # 70. Finally, the Hospital just finalized a new policy titled "Hand off Communication Guidelines" which establish standards for change of shift communications, nursing to physician communications, physician to physician communications, among others. Handoff Communications Policy, tab # 71. Communications shall be made using the SBAR formulation. Staff will be trained over the upcoming weeks, and implementation will immediately follow. Other relevant policies include the Patient Transfer policy (documentation around inter-unit and inter-hospital transfers) , tab # 59, and Medical records policy (lab results) and role of GMO in treatment planning, IRP Manual at Tab # 1.

See also V.C.1.

Compliance Status: Partial compliance

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Revise the IRP Manual to ensure the following:*	***- High Priority***	*COS;*
a *The outline of foci (goals) includes social skills/functional impairments;*		
b *Issues of dangerousness and impulsivity are adequately addressed in the IRP;*		
c *Operational guidance, including adequate clinical examples, are provided to facilitate the following:*		

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop examples of needs, objectives and interventions for IRP manual ***Complete***	7/15/2009	IRP Manual	Gouse
2	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions *Status: Ongoing - Updated as of 6/18/2009*	9/30/2009 (Ongoing)		
3	Train clinical administrators on new documents for manual	7/23/3009		Gouse

2 *Develop and implement a training module focused on the development of Foci, Objectives and Interventions. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions.*	***- High Priority***	*COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop examples of needs, objectives and interventions for IRP manual ***Complete***	7/15/2009	IRP manual	Gouse

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
2	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions	9/30/2009 (Ongoing)		Gouse
	Status: Ongoing - Updated as of 6/18/2009			

3 *Provide a summary outline of the disciplines participating in the above training and the training process (didactic, observation, feedback to teams) and content.* — *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See V.B.1, recommendation # 5			Gouse

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See v.B.1 recommendation # 6			

5 *Develop a Clinical Chart Monitoring Form to include complete indicators and operational instructions to adequately address this requirement.* — *PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Clinical chart audit tool with instructions	6/30/2009	Clinical chart audit tool/instructions, Tab # 10	BG
	Complete *Status: Tool was piloted for June. - Updated as of 6/19/2009*			
2	Modify tool/instructions based upon results of pilot	7/2/2009		BG
	Complete			
3	Implement clinical chart auditing with 10% sample in July - September, 2009, reaching 20% sample of IRPs completed in a month by October/November, 2009	10/1/2009		BG
4	Provide data on results monthly		Clinical chart audit results, tab #	PID

6 *Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least a 20% sample during the review period.* — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps to Recommendation 5.			

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps to Recommendation # 5			

8 *Provide an outline of the following:* ***- High Priority*** *Civil; Forensic; Med; Morin*

a *Cognitive remediation interventions that are currently provided and plans to increase these interventions.*

b *Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 TLC 2 & TLC 3 will develop cognitive remediation interventions	7/31/2009 (Ongoing)	Program schedules & group curriculum, Tab # 69	Viidoni-Clark
Status: Cognitive Remediation interventions implemented in TLC 2, TLC 3, & TLC 4. - Updated as of 6/24/2009			
2 Train staff on cognitive remediation and remotivation techniques.	(Ongoing)	Sign-in sheets & training curriculum, Tab # 72	Vidoni-Clark
3 Cognitive remediation interventions provided in RMB 3 program	(Ongoing)	RMB 3 Program Schedule, Tab # 69	Vidoni-Clark
4 Train psychiatric staff around cognitive remediation therapies	(Ongoing)	Cognitive remediation training outlines, Tab # 72	Moyhuddin; Snyder

9 Develop and implement medical care policies and procedures to address the following: **- High Priority** Med; PID; Jana Taylor Sumit Anand

a Requirements for preventive health screening of individuals;

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

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

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

e Proper physician-nurse communications to ensure the following:

f Emergency medical response system, including drill practice;

g Consultation and laboratory testing to ensure the following:

h Requirements regarding transfer of individuals to outside facilities to ensure the following:

i Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician:

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete training on critical nursing practices, including seclusion and restraint, physical assessment, mental health diagnosis and patient engagement	9/1/2009		Hartley
	Status: Training will begin on these items through the training on new nursing procedures. Supplemental training will be developed as needed. - Updated as of			
2	Develop physician practice policies	9/1/2009 (Ongoing)	Medical Response policy,Tab # 70 ; Hand-off communications policy, Tab # 71	Arons
	Status: Medical Response policy and hand off communication polices developed. Training needed prior to implementation - Updated as of 6/19/2009			

V.D.2

Compliance Status from DOJ Report: Noncompliance

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.

The IRP Manual, and revised IRP form, require that objectives address both treatment, skill building, enrichment and rehabilitation needs. IRP Manual; IRP Form, tab # 5. The Hospital piloted a clinical chart audit tool in July 2009, tab # 10, but based upon the results, is reviewing the tool to determine if the tool or instructions (or both) need modification, or if additional training is needed for staff. The data from the clinical chart audits suggests that objectives reflect the individuals level of functioning (92%), stage of change (88%), and reflect clinically appropriate interventions, both skill-building and treatment) in 96% of the cases reviewed. This data shows a level of performance that is not consistent with the IPR observations, and thus suggests work on the tool or with reviewers is needed to get more meaningful data.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as above.			*- High Priority* *PID; COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as above			

V.D.3

Compliance Status from DOJ Report: Noncompliance

write the objectives in behavioral and measurable terms;

Findings Same as V.D.1.

The Hospital revised its IRP manual, which now includes specific tip sheets on writing objectives. Further, four of seventeen teams have completed the IRP training, and the remaining 13 are all actively participating in training. The Hospital piloted a clinical chart audit tool in July 2009, but based upon the results, is reviewing the tool to determine if the tool or instructions need modification, or if additional training is needed for staff. The clinical chart audit pilot attempted to measure if objectives were written in behavioral and measurable terms consistent with the individual's level of functioning -- this was rated as adequate in 92% of cases reviewed.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as above.			*COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as above			

V.D.4

Compliance Status from DOJ Report: Noncompliance

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

Findings Same as V.D.1-3.

The Hospital significantly revised the IRP form so that each objective includes a related intervention which is either treatment or skill building, and it is expected that each intervention has a designated person (not discipline) with clear responsibility for providing the intervention and the timing of the intervention. The IRP form has been utilized since June, 2009. Training is completed for four units, and is ongoing for 13 units. The training includes an emphasis on ensuring interventions are specific and include specific persons who are responsible for providing the intervention. In addition, the Hospital revised its therapeutic monthly note form to tie specific interventions to objectives, and developed guidelines for completion of the note. Therapeutic monthly note/instructions, tab # 44. In addition, an audit tool was developed, with instructions, for auditing the therapeutic monthly notes, with audits set to begin in September, 2009. Tab # 45.

The Clinical chart audit tool was piloted in July, 2009, and included an indicator around ensuring each intervention met the requirements of this subsections. Data showed that interventions reflected the individual's stage of change in 88% of cases, and reflect both treatment and skill-building

interventions in 96% of cases. Tab # 11. However, as previously noted, there is some concern around the results of the pilot, so the tool and training related thereto is being reassessed.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as above.* — *COS;*

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

2 *Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Ensure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box.* — ***- High Priority*** *COS;*

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

3 *Make data available both at the individual level, so that progress toward discharge can be appropriately tracked, and at the aggregate level so that performance improvement can be maintained.* — *PID; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct monthly audits(IRP process and Clinical chart audits) using revised tools	7/1/2009	IRP Process audit results, Tab # 9; Clinical chart audit results,Tab # 11	Hartley; BG
Status: IRP process audits using prior tool were conducted and data is available> Clinical chart audits have begun for July - Updated as of 7/17/2009			
2 Modify audit tool to incorporate DOJ recommendations **Complete**	6/15/2009	IRP process monitoring tool/instructions, Tab # 8; Clinical chart audit tool/instructions,Tab # 10	Hartley
3 PID to continue discharge record audits	6/15/2009 (Ongoing)	Discharge audit results,Tab # 68	Hartley
Status: Ongoing - Updated as of 6/18/2009			
4 Clinical chart audits to be implemented with 10% sample of IRPs by July 31, 2009, expanding to 20% sample by October	7/31/2009	Clinical chart audit results,Tab # 11	BG
Status: Clinical charts audits have begun for July - Updated as of 7/17/2009			

V.D.5

Compliance Status from DOJ Report: Noncompliance

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 does not yet have reliable data around the hours of treatment per week, but may have some data by the time of the site visit. Beginning in August, the four TLCs began using AVATAR to schedule groups and track attendance. Not unexpectedly, there have been some start up issues, but those are being resolved, and it is anticipated that by some time in September or October, ward based activities will be added and tracked through AVATAR. Based upon the TLCs schedules, it is clear that individuals who attend the TLCs are scheduled for 20 hours of treatment each week; additional ward based activities puts the hours scheduled over the 20 hour requirement. However, the Hospital will not know in a data-retrievable way how many individuals are attending the scheduled groups until September, 2009. The clinical chart audit reviewed the number of hours of treatment scheduled in the IRP - 19% had 0 hours scheduled, 19% had 1-9 hours scheduled, 37% had 10-19 hours scheduled and 26%

had twenty or more hours scheduled. The data reflect the period to implementation of the TLC Addendum, which was implemented in late August, 2009, and is now part of the IRP.

While progress has been made in hiring staff, there remain key shortages in rehabilitation services and nursing staff which are impacting the provision of treatment hours; two additional rehabilitation services staff have been selected but are awaiting criminal background clearances, and nursing recruitment continues. Each discipline provides treatment services in each of the TLCs. See tab # 69.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop and implement a system to track active treatment hours scheduled per week.* — ***- High Priority*** *Civil; Forensic; COO; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create Work group to assess capacity of Avatar to track treatment hours and make recommendations to modify system as needed.	7/31/2009		CVC, Seymour
	Complete *Status: Initial Treatment Scheduling & Attendance Documentation meeting held 6/22/09. As a result of meeting, TLC staff reviewed & critiqued AVATAR system. Major agenda item at 6/24/09 AVATAR Steering Committee meeting. Conference call to plan Netsmart WebX demo. Vinitha Cheruku will coordiinate all comments for 6/29/09 demo. Chiefs of Forensic Pre and Post Trial Branch and Rehabilitation Services and Forensic Health Sysems Consultant participated in Netsmart WebX demo on 6/29/09 and in Treatment Scheduling and Group Documentation Planning Meeting for Avatar Setup on 7/1/09. Meeting on-going working toward August launch.*			
	As of August 03, 20009 active treatment hours are now being tracked through Avatar. - Updated as of 8/13/2009			
2	Provide full menu of groups and other interventions (with description, including TLC as well as ward based interventions) in centralized place so staff are aware of offerings	7/31/2009		CVC, JH, BG
	Status: TLC, Unit, Community Group & Activities Form drafted. Distributed for coments 6/24/09. Data collected on interventions offered across hospital - Updated as of 6/24/2009			
3	Create treatment mall for forensic patients to expand access to treatment	7/31/2009	Forensic treatment mall schedule and curricula,Tab #69.	JH
	Status: Forensic treatment mall for Wards 8, 10 and 12 is on track and scheduled to open on July 27th on JHP Ward 11. - Updated as of 7/20/2009			
4	TLC 1 Program Administrator finalizing orientation schedule for JH 3 patients. Orientation to begin 6/29/09.			Vidoni-Clark
5	Began meeting with Clinical Administrators of unit-based programs in RMB to determine adequacy of unit-based programming		TLC and Civil Side program schedules, Tab # 69	Vidoni-Clark
	Status: RMB 3, 4 & 6 program schedules revised. - Updated as of 6/24/2009			
6	Groups, group leaders, & patient rosters being entered into AVATAR in order to build tracking system. Tip-sheets & training for group leaders being developed. Implementation date is 8/03/09.	8/10/2009		Vidoni-Clark
7	Conclude data entry of groups hospital wide (including ward-based) by August 10, 2009	8/10/2009		vidoin-Clark

8	Train staff on Avatar scheduling system	8/7/2009	Seymour, Branic and CVC

Status: As of August 03, 20009 active treatment hours are now being tracked through Avatar. Group leaders have been trained and a step-by-step training guide has been provided on how to post attendance in Avatar. Ongoing training and assistance is available as needed. - Updated as of 8/13/2009

2 *Develop and implement a system to track individuals' attendance of and participation in scheduled active treatment hours.* ***- High Priority*** *Civil; Forensic; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create Work group identified to assess capacity of Avatar to track treatment hours	7/31/2009		Seymour, Vidoni Clark

Complete *Status: Treatment Scheduling & Attendance Documentation meeting held 6/22/09. TLC staff reviewed & critiqued AVATAR system. Major agenda item at 6/24/09 AVATAR Steering Committee Meeting. Conference call to plan Netsmart WebX demo. Vinithu Cheruku will coordiinate all comments for 6/29/2009 demo. Chiefs of Forensic Pre and Post Trial Branch and Rehabilitation Services and Forensic Health Sysems Consultant participated in Netsmart WebX demo on 6/29/09 and in Treatment Scheduling and Group Documentation Planning Meeting for Avatar Setup on 7/1/09.*

As of August 03, 20009 active treatment hours are now being tracked through Avatar. - Updated as of 8/13/2009

2	Work group to develop tracking system for implementation by July 31, 2009	7/31/2009		AS; CVC

Complete *Status: Weekly meetings in process.*
As of August 03, 20009 active treatment hours are now being tracked through Avatar. - Updated as of 8/13/2009

3	Implement tracking system beginning August 1, 2009	8/3/2009		AS; CVC

Complete *Status: Group, group leaders, & patient rosters being entered into AVATAR to build tracking system. Tip-sheets & training for group leaders being developed. Implementation date is 8/03/09.*

As of August 03, 20009 active treatment hours are now being tracked through Avatar. Group leaders have been trained and a step-by-step training guide has been provided on how to post attendance in Avatar. Ongoing training and assistance is available as needed. - Updated as of 8/13/2009

4	Create treatment mall for forensic patients	7/31/2009		JH

Status: Forensic treatment mall for Wards 8, 10 and 12 is on track and scheduled to open on July 27th on JHP Ward 11. - Updated as of 7/20/2009

5	Develop report from Avatar that tracks hours scheduled and hours attended.	10/5/2009		Branic

Status: As of August 03, 20009 active treatment hours are now being tracked through Avatar. The report will be developed to track the hours scheduled and hours attended within the next 60 days. - Updated as of 8/13/2009

3 *Provide data regarding the number of active treatment hours per week for all individuals at the facility during the review period.* ***- High Priority*** *Civil; Forensic; PID; COO; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Inventory unit based activities to gather baseline date	7/20/2009		Gouse

2	Work group identified to assess capacity of Avatar to track treatment hours.	7/31/2009		Seymour, Vidoni-Clark
	Complete *Status: Treatment Scheduling & Attendance Documentation meeting held 6/22/2009. As result of meetinig, TLC staff reviewed & critiqued AVATAR system. Major agenda item at AVATAR Steering Committee on 6/24/2009. Conference call to plan Netsmart WebX demo. Vinitha Cheruku will coordinate all comments for 6/29/2009 demo. TLC, Unit, Community Groups & Activities Form drafted. Distributed for comments on 6/24/2009.* *As of August 03, 20009 active treatment hours are now being tracked through Avatar. - Updated as of 8/13/2009*			
3	Use clinical chart audit tool to track the number of hours reflected in IRP	8/31/2009	Clinical chart audit results, Tab #11	BG
	Complete *Status: Implement audits in July - Updated as of 7/1/2009*			
4	Once system is developed, monitor treatment hours per individual	8/14/2009		CVC, JH
5	Develop report from Avatar system to track hours scheduled and hours attended	10/5/2009		Branic
	Status: As of August 03, 20009 active treatment hours are now being tracked through Avatar. The report will be developed to track the hours scheduled and hours attended within the next 60 days. - Updated as of 8/14/2009			

4 *Identify barriers to individuals' attendance at scheduled activities.* ***- High Priority*** *Civil; Forensic;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop management report to track and trend data to determine barriers to individuals' attendance.	8/14/2009		Branic

5 *Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.* ***- High Priority*** *Civil; Forensic; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Convene workgroup to identify way to track alignment between TLC and IRP	7/15/2009	TLC addendum form,Tab # 46	Vidoni-Clark, Gouse
	Complete *Status: Meeting held on 7/16 and draft form developed - Updated as of 7/21/2009*			
2	Disseminate form to clinical administrators	7/30/2009	TLC addendum form	Vidoni-Clark; Gouse
	Complete			
3	Develop monthly progress note auditing form and operational instructions	8/15/2009	Monthly therapeutic progress note auditing form/instructions, Tab # 44	Gouse
4	Meetings with PID & TLC staff to develop forms & process to link IRP objectives, TLC groups, & TLC group progress notes.			Vidoni-Clark

6 *Monitor Mall alignment based on at least a 20% sample (October 2007 to March 2009).* *Civil; Forensic; PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Mall Alignment Monitoring Form being finalized with PID & TLC staff.	8/14/2009	TLC alignment form/instructions, Tab # 73	Vidoni-Clark, PID
2	Begin audits	9/8/2009		CVC

7	*Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*			*PID;*
	Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1	Anaylze and publish data	10/23/2009		PID

V.D.6

Compliance Status from DOJ Report: Noncompliance

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

DOJ Recommendations (Report 3)	***Responsible Party***
Same as in V.D.1 through V.D.5.	*COS;*

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

V.E. Treatment Planning Is Outcome-Driven

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

Findings See sub-cells for findings.

Compliance Status: See related sections

DOJ Recommendations (Report 3)	***Responsible Party***
Please see sub-cells for findings and compliance.	

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

V.E.1

Compliance Status from DOJ Report: Partial

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

Findings The Hospital continues its observations of IRPs, but is not yet observing a 20% sample consistently. The IRP manual, form and instructions were modified to provide additional focus on updating objectives based upon the individual's progress.

There are several criteria that measure whether the IRP is modified (objectives and interventions) based upon the individual's response to treatment. Data from observations show the following: In Phase I of IPR conferences, the teams are providing a synopsis of the interventions and their effect in a range of 50% to 62% of observed reviews during March, 2009 through May, 2009; In Phase II, teams engaged the individual in order to obtain substantive input in IRP objectives and interventions in over 80% of cases observed each month during the period of March, 2009 to June, 2009; reviewed the progress in each focus area with the individual in 36% of cases in March, 2009, but in 77% of cases in June, 2009; provided the individual with choices of interventions for the new objectives in 36% of cases in April, 2009, but in 69% of cases in June, 2009. Tab # 9. IRP training continues for 13 teams, and teams participated in a module around engagement and discharge/transition planning. IRP training outline, tab # 1; IRP training data, tab # 2 .

The clinical chart audit tool and instructions also evaluate whether treatment is updated based upon the individual's progress, but as noted, the pilot results suggest modification to the tool or instructions, or additional training, is also needed. According to those results, in 100% of cases, the treatment teams modified IRP objectives and interventions based upon the individual's progress or lack thereof. Clinical Chart audit results, Tab # 11.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals.* — ***- High Priority*** — *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Institute IRP training on all units	9/30/2009		Gouse
	Status: Training has been completed on 4 units and in underway on the remaining 13 units. - Updated as of 7/17/2009			
2	Revise IRP manual to include examples, operational instructions and needs list.	7/31/2009	IRP manual	Gouse
	Status: Disseminate material to clinical administrators - Updated as of 7/17/2009			

2 *Develop a Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement.* — ***- High Priority*** — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop clinical chart monitoring tool and instructions		Clinical chart audit tool and operational instructions, Tab # 10	Gouse
	Complete *Status: Clinical chart monitoring tool and instructions has been developed and piloted. Audits for July are underway. - Updated as of 7/17/2009*			

3 *Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least a 20% sample during the review period.* — *PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train clinical administrators on using clinical chart audit tool	7/15/2009	Clinical administrator meeting agenda and sign-in sheet,Tab # 48	Gouse
	Complete *Status: Clinial administrators trained on July 9, 2009 - Updated as of 7/21/2009*			
2	Train discipline chiefs on process monitoring and clinical chart audit tools	7/15/2009		Gouse
	Complete *Status: Training held on 7/16/09 - Updated as of 7/21/2009*			
3	Ensure that discipline chiefs shadow current reviewer for IRP process observation	7/31/2009		Gouse
	Status: Discipline chiefs scheduled to observe current reviewers during July - Updated as of 7/21/2009			
4	Continue IRP process audits and begin clincial chart audits		IRP audit results, Tab # 8 ; Clinical chart audit results,Tab # 10	PID, Gouse

4	*Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*			*PID;*
	Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
	1 Anaylze and publish data	(Ongoing)	IRP process audit resutls, Tab # 9; Clinical chart audit results, Tab # 11	PID
	Status: Ongoing - Updated as of 7/26/2009			

V.E.2

Compliance Status from DOJ Report: Noncompliance

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

Findings See V.E.1.

Hospital policy requires that Psychiatry, Nursing, Social work and treatment providers complete a monthly note addressing the individual's progress or lack thereof. Discipline Update forms, tab #s 17, 28, 34. Medical records policy, tab # 13 . The notes are specifically required to include the individual's progress in meeting the objectives in the IRP and in participation in the various interventions provided by each discipline. Further, IRPs are expected to be conducted by day 7, 14, 30, 60 and every 60 days thereafter. IRP Policy, tab # 3. Each discipline either has begun (social work) or will begin by September audits (nursing, psychiatry) of their respective monthly notes; a new audit tool was developed to audit the monthly therapeutic note. Tab # 45.

The IRP process monitoring evaluated the presence of monthly notes in the chart prior to the IRP conference, but it should be noted that a discipline received "credit" only if the note was completed using the correct form. Data suggests significant improvement is needed as compliance across disciplines was mostly below 50%. Observers commented that many times summary progress notes were in the record but were not on the Hospital approved form or completed two days before the IRP conference.

The discipline audit tools address whether the content of the notes reflect ongoing monitoring of effectiveness of treatment and the person's condition. Only social work began audits of the update notes during the review period, and their results show that 83% of the notes were adequate around the individual's progress toward discharge. Tab # 33.

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Same as in V.E.1.*			*Civil; Forensic; PID; COS; Jana Taylor*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as in V.E.1			
2 *Implement the schedule of IRP reviews as specified in the revised policy.*			*Civil; Forensic; COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Review policy and revise as needed		Revised IRP policy, Tab # 3	PID
3 *Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines.*			*Civil; Forensic; Med; COS; Discipline Chiefs, Sepehri*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Psychiatry, social work, and nursing, and treatment providers to complete monthly notes per policy	6/1/2009		Discipline chiefs; Arons

2	Discipline chiefs to monitor compliance with monthly notes through 20% audit sample		SW audit results (monthly updates), Tab # 33; Psych Update Audit results, Tab # 18; Nursing Update audit results, Tab # 30	Discipline chiefs; Arons
3	IRP Process to monitor monthly notes	(Ongoing)	IRP process audit results,Tab # 8	PID

Status: ongoing - Updated as of 7/26/2009

4 *Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.* — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Clincial audit tool to review for monthly reviews by clinical adminstrators of patient's progress	8/31/2009	Clinical chart audit tool,Tab # 11	Clincial adminstrators

V.E.3

Compliance Status from DOJ Report: Partial

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

Findings See V.E.2.

A number of the newly implemented forms increase focus on the need to modify an IRP based upon such factors as use of seclusion, restraint or frequent use of PRN or STAT medications. A new tip sheet was developed and is in the IRP manual identifying when a special IRP meeting is appropriate. IRP Manual at tab # 8. The clinical formulation update includes a specific section addressing use of restraint, seclusion, or emergency medication. Clinical formulation update, tab # 7. Similarly, the Psychiatric Update prompts the psychiatrist to address use of seclusion, restraint or involuntary medication. Tab # 17. Depending on the results, a special IRP can be held.

Data from the most recent seclusion and restraint audit shows that the Hospital is not yet modifying IRPs if restraint or seclusion is utilized. In 17% of cases, a treatment team debriefing was held following a restraint or seclusion episode (March through June 2009). In 9% of cases, treatment teams addressed the episode in the next IRP meeting. Seclusion/Restraint Audit tool, Tab # 54; Seclusion/Restraint audit results, tab # 55. In contrast, the clinical chart audit conducted in July found that in 100% of cases, the IRP was modified based upon use of STAT medication or restraint or seclusion. Because of the disparate results, PID is reviewing the tools to determine what changes may be necessary to improve the accuracy of the data.

The Hospital is now monitoring frequent use of restraint or seclusion or STAT medications as high risk indicators. A tracking mechanism is underway by which the Risk Manager/ PID will review UI reports and notify the Medical Director of any uses that hits the triggers in the Restraint policy or two or more STAT medications in a 24 hour period. Tab # 56.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as in V.E.1. — *COS;*

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

V.E.4

Compliance Status from DOJ Report: Partial

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

Findings The Hospital updated its IRP policy and the IRP Manual to increase the focus on discharge planning within each focus area. Discharge

considerations are to be incorporated within each focus area as clinically appropriate, and that the community integration focus area is used for individuals with particular challenges to discharge. IRP Policy, tab # 3 ; IRP Form, tab # 5; IRP manual. Additional training on discharge/transition planning was provided to clinical staff in late August, 2009. IRP Training outline, tab # 1; IRP Training data, tab # 2. Staff were also provided with information about using motivational techniques. IRP Manual at tab #3 and #5.

The IRP process monitoring address discharge planning in several criteria. First, observers rate whether the team during Phase I identified barriers to discharge. Data from March through June, 2009 show discharge barriers were addressed in Phase I in 92% of cases in April, 2009, but in 100% of cases observed in March, May and June, 2009. The teams' performance improved in providing the individual with an opportunity to be an active participant in discharge planning - scores here ranged from a low of 25% in March, 2009, to 91% in April, 92% in May, and 85% in June, 2009. IRP Process audit results, tab # 9. However, in some cases, the written IRP still includes non-individualized discharge goals or issues.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Ensure that the policy regarding IRP provides instruction to individualize the discharge criteria.* — ***- High Priority*** *PID; COS; Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Insert standard into IRP policy		IRP policy, Tab # 3	Jana Taylor
	Complete *Status: Standard has been inserted into IRP policy under Discharge Planning. - Updated as of 6/23/2009*			

2 *Revise the IRP manual to provide operational guidance with clinical examples to facilitate the individualization of discharge criteria.* — ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise operational instructions for IRP	7/15/2009	IRP manual	Gouse
	Complete			
2	Disseminate operational instructions to clinical administrators and review individualization of discharge criteria	7/31/2009		Gouse

3 *Revise the IRP manual to include strategies to increase the motivation of individuals to participate in their IRPs.* — ***- High Priority*** *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise engagement tip sheet	7/15/2009	Engagement tip sheet, IRP Manual	Gouse
	Complete			
2	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions. *Status: Ongoing - Updated as of 6/18/2009*	9/30/2009 (Ongoing)		Gouse
3	Jointly train psychiatrists, nurse managers and clinical administrators on engaging individuals.	8/28/2009	Training data and handouts, Tab #	Gouse; Snyder

4 *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. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions* — ***- High Priority*** *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop training module	8/1/2009		Gouse

2	Train nurse managers, clinical adminstrators and psychiatrists in clinical leadership meeting.	8/26/2009	Training materials and data, Tab #	Gouse; Snyder

5 *Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content.* — *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See V.B.1 recommendation # 5	8/15/2009		

6 *Provide aggregated data regarding results of competency-based training of all core members of the treatment team.* — *COS; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop post test related to training module on individualized discharge criteria.	8/15/2009	IRP Training Curricula, Tab # 1	Gouse
	Complete *Status: Training on discharge held on August 25, 2009 - Updated as of 8/27/2009*			
2	Administer post test.	8/15/2009	IRP Training Data, Tab # 2	Snyder
	Complete *Status: Training on discharge held on August 25, 2009 - Updated as of 8/27/2009*			
3	Report aggregated data	8/30/2009	IRPTraining Data, Tab # 2	Snyder
	Complete			

7 *Develop Clinical Chart Monitoring form including complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning.* — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop clinical chart monitoring form and operations.		Clinical chart audit tool/instructions, Tab # 10	Gouse
	Complete			

8 *Monitor this requirement using both process observation and clinical chart audit tools based on at least a 20% sample during the review period.* — *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement clinical chart monitoring tools with 10% sample.	7/1/2009	Clinical chart audit results, Tab # 10	Gouse
2	Implement IRP process monitoring tools with 20% sample	10/1/2009	IRP process audit results, Tab # 9	Gouse

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

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Anaylze data and publish results			PID

V.E.5

Compliance Status from DOJ Report: Partial

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

Findings See findings in Sections V.E.1-4.

The previously developed Progress note for mall groups was modified to include the specific treatment objective as well as the intervention tied to

the objective, in an effort to improve the quality and usefulness of the notes. Written guidelines are now available. Therapeutic monthly progress note/instructions, Tab # 44. An audit tool for the therapeutic monthly note was developed, and will be implemented in September, 2009. Therapeutic monthly note audit tool/instructions, Tab # 45.

Further, psychiatry, nursing and social work developed and began using assessment updates that focus the clinician on evaluation the individual's progress or lack thereof. Psychiatric update/instructions, tab # 17 ; Social work update/instructions, tab # 34; Nursing update/instructions, tab # 28. These assessment updates will be used as a basis of the clinical formulation update that will be completed before each IRP. Further, IRP training and the revised guidelines for the IRP conference focus IRP reviews to the individual's current symptoms, behaviors and functional abilities. IRP training outline, tab # 1; IRP Manual.

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Same as in V.A.1 to V.A.1.5.*			*Civil; Forensic; COS; Coleman, Robinson*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as in V.A.1 to V.A.1.5.			
2 *Same as in V.B.1.*			*COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as in V.B.1.			
3 *Same as in V.E.4.*			*COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as in V.E.4.			
4 *Fully implement the new template for the Monthly Therapy Progress Note.*			*Civil; Forensic; Med; Coleman, Robinson*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Develop operational instructions and train discipline chiefs as train the trainer for revised montlhy note	7/26/2009	Therapeutic progress note and instructions,Tab # 44	Gouse
Status: Monthly therapeutic progress note revised. Rehabilitation Services staff began using revised progress note July 6, 2009. - Updated as of 7/15/2009			
2 Audit sample of monthly progress note.	9/30/2009		Gouse

VI. Mental Health Assessments

Summary of Progress

1. The Hospital revised the previously provided Assessment and Medical Records policies to ensure internal consistency. The Policy sets out clear content standards for assessments as well as timeframes for assessments (8 hours for nursing, 24 hours for psychiatry, 5 days for social work, rehabilitation services and psychology) and updates.

2. The Hospital developed instructions for all discipline initial assessment forms for psychiatry, nursing, psychology, social work, and rehabilitation services and implemented all revised forms. Audit tools have also been developed for all forms, with instructions (instructions to accompany the nursing initial assessment audit tool are being developed). Psychiatry conducted audits of the Comprehensive Initial Assessment, and will begin audits of the Psychiatric Update in September, 2009. Psychology conducted audits of the Initial Psychological Assessment, and will begin audits of other types of psychological assessments in Fall, 2009. Social work audited both the initial assessment and social work update. Rehabilitation Services audited its initial assessments. Nursing audited the Nursing Update and Comfort Plans. Results are reported below.

3. Psychiatry and Psychology audited the completion of the risk assessment portion of their respective initial assessments.

4. The Hospital continues to monitor and report on the timeliness of discipline assessments through discipline specific audits.

5. The Hospital revised and then piloted a clinical chart audit tool and instructions that evaluates the quality of the clinical formulations and content of the IRPs. As a result of the pilot, the tool, instructions and training are being reviewed, as the Hospital believes the data is not consistent with the IPR observation data in some respects.

6. Four new psychiatrists began work in July, 2009. Caseload ratios are not yet met, however, as several psychiatrists are out on medical leave.

7. Implementation of PBS has not moved forward since the last visit. A PBS team is being recruited, but recruitment was somewhat delayed for budget reasons. The PBS consultant has not returned since the visit, but a new contract in the upcoming fiscal year is expected.

VI. Mental Health Assessments.

By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.

Findings See sub cells below.

Compliance Status: See sub cells below.

VI.A. Psychiatric Assessments and Diagnoses

Findings See sub-cells below

Compliance Status: See sub cells below.

VI.A.1

Compliance Status from DOJ Report: Partial

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 aligned the Medical Records and Assessment polices to ensure the timelines are consistent, and guidelines were completed for both the Comprehensive Initial Psychiatric Assessment and the Psychiatric Update . CIPA form/instructions, tab # 14; Psychiatric Update form/instructions, tab # 17; Assessment policy, Tab # 12; Medical Records policy, tab # 13. Under the policies, psychiatric assessments must be completed within 24 hours of admission and monthly thereafter, with weekly progress notes required for the first sixty days. The initial assessment is to be completed using the Comprehensive Initial Psychiatric Assessment (CIPA) form (now in AVATAR), and the monthly updates, beginning in August, 2009 must be completed on a revised Psychiatric Update form (not yet in AVATAR). CIPA form/instructions, tab # 14; Psychiatric Update form/instructions, tab # 17. The CIPA and Psychiatric Update forms include a plan of care, and the Update prompts the psychiatrist to address progress, lack thereof and responses to treatment. Staff also use a generic progress note form for weekly notes or to report other information or events between weekly notes. Medical records policy, tab # 13. Information from these notes is then rolled into the weekly or monthly discipline notes.

In both June and July, 2009, the Hospital conducted audits of the Comprehensive Initial Psychiatric Assessment using the previously provided tool and instructions. CIPA audit tool/instructions, tab # 15. A twenty percent sample of CIPAs were reviewed in June and July; overall, audits showed improvement in the quality of the CIPAs. CIPA audit results, tab # 16 . Three indicators were rated over 90%, twelve over 80% and below 90%, 8 over 70% and below 80%, and three below 70%. The audit results were shared with physicians at their regular monthly meetings with the Medical Director. An audit tool for the psychiatric updates with instructions is developed, and audits will begin in September, 2009. Psychiatric Update audit tool/instructions, tab # 18 .

The Hospital's plan is to measure timeliness of Assessments through AVATAR once all discipline forms are active. In August, the Initial Comprehensive Psychiatric Assessment, the Social Work Initial Assessment and the Rehabilitation Services Assessments began to be completed in AVATAR, so data is limited. All discipline audits include a timeliness indicators, but psychiatry did not always complete the data field, so it is not available.

Results of the social work initial assessment audit show that during a four month period of April to June, 2009, only 53% were timely. (This is likely due to the fact social work had not been counting the day of admission as day one of their five days to complete an assessment.) Psychology initial assessments were timely in 92% of cases, and rehabilitation services were timely in 50% of cases. Nursing did not audit the initial assessment.

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Ensure the revised policy for Assessments contain timeframes for the completion of the psychiatric reassessments that align with the revised policy, Medical Records.*		***- High Priority***	*PID; Jana Taylor*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Revise the stated reassessment time frame.		Assessment policy,Tab # 12	Jana Taylor
Complete *Status: The reassessment time frame was revised in the policy. - Updated as of 6/22/2009*			
2 *Develop guidelines for completion of the psychiatric update and self-auditing of these updates.*		***- High Priority***	*Med;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Develop guidelines for completion of Psychiatric Update.	6/30/2009	Psychiatric udpate and instructions, Tab # 17	Arons
2 Develop audit tool for psychiatric update.	8/7/2009	Psychiatric update audit tool and instructions,Tab # 17	Arons
3 Implement psychiatric update audit tool	8/17/2009		Arons

3 *Ensure the integration of additional information that becomes available following admission to the facility to permit a more complete review/assessment. This information should include, but not be limited to, psychosocial history, substance abuse history, psychiatric risk factors, strengths, diagnostic formulation, differential diagnosis, and management of identified additional risks.* — ***- High Priority*** — *Civil; Forensic; Med; CNE; COS; Sepehri; Discipline chiefs*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Audits of discipline updates will include assessment of whether new information learned during hospitalization is incorporated into updates.	6/1/2009		Discipline chiefs
2	Ensure clincial chart audits include review of whether new information available after initial assessments are incorporated into clinical formulation section of audit tool ***Complete***		Clinical chart audit tool,Tab # 10	Gouse

4 *Ensure consistent and full implementation of the new templates for initial comprehensive assessments and psychiatric updates.* — ***- High Priority*** — *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Audit 20% of admissions to check for completion and timeliness of CIPA ***Complete*** *Status: Underway. - Updated as of 6/25/2009*	6/1/2009	Audit results, CIPA,Tab # 16	Arons
2	Begin audits, initially with 10% sample, of psychiatric updates to check for timeliness and completeness *Status: Not yet begun. - Updated as of 6/25/2009*	8/17/2009		Arons

5 *Provide monitoring data regarding the timeliness and content of psychiatric assessments and reassessments based on at least a 20% sample during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures.* — *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	CIPA Auditing is being done monthly. *Status: Partial implementation. Audits of psychiatric updates not yet begun - Updated as of 6/25/2009*	6/1/2009	CIPA audit results, Tab # 16	Arons
2	Analyze data and publish results	8/21/2009		Arons

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

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

VI.A.2 — ***Compliance Status from DOJ Report: Partial***

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 a dedicated section on risk assessment that includes basis of risk as well as mitigating factors and necessary precautions. Comprehensive Initial Psychiatric Assessment form, tab # 14. Risk also is screened in the first eight hours through the initial nursing assessment, and within 5 days through a psychological risk screen. Initial Nursing assessment/instructions, tab # 26; Initial Psychological Assessment forms, Part A and B; tab # 19 . These forms are now in use hospital wide (since January for psychiatric assessments,

since December for psychological assessments and since July for nursing assessments). Further, consideration of risk factors has been incorporated into the clinical formulation and clinical formulation update, the initial interdisciplinary recovery plan (IIRP) and the IRP. IIRP tab # 4; IRP, tab # 5 ; Clinical formulation, tab # 6 ; Clinical formulation update, tab # 7. These forms have also been in use since June, 2009.

Audits were completed of the CIPA for an eighteen percent sample of admissions from April to June, 2009. Data shows that the violence risk assessment section was completed in 87% of cases and appropriate precautions were identified in 77% of cases. CIPA audit results, tab # 16. The IRP Process Observations also evaluates to determine if risk factors are reviewed during the IRP conference. Data show that risk factors are reviewed in most cases -- 94% (March), 85% (April), 92% (May), and 100% (June). Results of the IPA audits of psychology assessments show that in 92% of cases, the violence checklist was completed and the suicide checklist was completed in 100% of cases. IPA audit results, tab # 21. The risk assessment summary was adequately completed for violence in 88% of cases and in 92% of cases for suicide risk.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as VI.A.1.* — ***- High Priority*** *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Require risk assessment as part of initial psychiatric assessment and monitor through self-audit process whether risk assessment is completed.	6/1/2009	Audit results, CIPA, Tab # 16	Arons, PID
Status: Underway - Updated as of 6/29/2009			

2 *Ensure an integrated system of admission risk assessment (psychiatric and psychological).* — ***- High Priority*** *Med; COS; Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to prior recommendation			
2 Provide training to psychiatry and psychology staff on risk assessment	7/31/2009	Training data and handouts, Tab # 74	Arons, Gouse; Snyder
Complete *Status: Training held on July 15, 2009 and August 19, 2009 - Updated as of 8/27/2009*			

3 *Monitor risk assessment as part of the initial psychiatric assessment, based on at least a 20% sample during the review period.* — *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include monitoring of risk assessment items as a part of the self audit of the Comprehensive Initial Psychiatric Assessment and conduct audit on 20% of new admissions monthly.	6/1/2009	CIPA Audit Tool,Tab # 15: Audit results, Tab # 16	Arons; PID
Status: Items included in Audit. - Updated as of 6/29/2009			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze and publish data	8/14/2009	CIPA audit results, Tab # 16	PID

VI.A.3

Compliance Status from DOJ Report: Partial

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

Findings The Hospital uses the DSM-IV as its diagnostic manual. Both the audit tools for the CIPA and the Psychiatric Update include an assessment the diagnoses, including whether all Axes are completed and whether the diagnoses are consistent with the symptoms and clinical presentation. CIPA

audit tool/instructions, tab # 14; Psychiatric Update tool/instructions, tab # 18. While only the CIPA audits have been initiated, the Psychiatric Update audit tool also evaluates whether there is an adequate justification for a deferred Axis II diagnosis and if there is an adequate justification for a R/O or NOS diagnosis. The psychiatric update audit process is expected to begin in September, 2009.

The CIPA audit found the diagnoses section were adequate in 83% of cases reviewed between April and June, 2009. This means either one or more Axes were not completed, codes were inaccurate or diagnosis did not reflect the individual's clinical presentation in 17% of cases. Please note that due to an error in the tool, there was no assessment as to whether the diagnosis reflected the clinical presentation, but that has been resolved going forward.

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

The Hospital's Medical Director is leading a special study looking at patients diagnosed with Axis II, Diagnosis Deferred, after several months, to see if there is documentation that it is still necessary to retain this diagnosis, or if it is possible either to change diagnosis to "None" or to make a specific Axis II diagnosis. He is also looking at Psychotic Disorder, Not Otherwise Specified, to see if the diagnostic criteria that are required are met and documented, or whether some other diagnosis should be made. The purpose is two fold, to identify those individual cases in which diagnoses may need to be updated or where additional documentation is needed to support continuation of the diagnosis, and to determine if there are any patterns among physicians. The study is still in progress.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as in VI.A.1 and VI.A.6.* — ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, VI.A.1 and V.A.6.	6/1/2009		BSA

2 *Develop and implement monitoring indicators regarding diagnostic accuracy in the psychiatric reassessments.* — ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop audit tool for psych update that includes an indicator around diagnostic accuracy, including resolution of R/O and NOS diagnoses	7/31/2009	Psychiatric Update audit tool/ instructions, Tab # 18	Arons
2 Implement audits of psych updates	8/7/2009		Arons

3 *Provide data regarding diagnostic accuracy based on at least a 20% sample of psychiatric assessments and reassessments during the review period.* — *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 nDevelop audit tool of comprehensive psychiatric assessment that assesses accuracy of diagnoses	6/1/2009 (Ongoing)	CIPA audit tool/instructions, Tab # 15	Arons
Complete *Status: Audits ongoing. Tool includes assessment of diagnostic accuracy - Updated as of 6/29/2009*			
2 Develop audit tool for Psych Updates that includes idicator around diagnostic accuracy, including resolution of NOS and R/O diagnoses	8/7/2009	Psych update audit tool, Tab # 18	Arons

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze data and publish results	8/14/2009 (Ongoing)	CIPA audit results, Tab # 16	PID

Status: Ongoing for CIPA, within 30 days of Psych Update audit. - Updated as of 7/26/2009

VI.A.4

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.3

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as above. — *Med;*

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

VI.A.5

Compliance Status from DOJ Report: Partial

By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;

Findings See VI.A.1 and VI.A.3.

The Hospital is largely completing psychiatric assessments within 24 hours of admission, although the quality of the assessments needs some improvement to meet consistent quality standards. CIPA audit results, tab # 16.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Same as in VI.A.1 and VI.A.2. — *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1 and VI.A.2	6/1/2009		

VI.A.6

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

Findings See sub cells

Compliance Status: See sub cells.

DOJ Recommendations (Report 3) — ***Responsible Party***

Please see sub-cells for findings and compliance.

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

1 See subcells for action steps

VI.A.6.a

Compliance Status from DOJ Report: Partial

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

Findings Same as VI.A.1, VI.A.2, and VI.A.3

Compliance Status: Partial.

DOJ Recommendations (Report 3)	*Responsible Party*
Same as in VI.A.1, VI.A.3 and VI.A.6.	*Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1, etc.			
Status: go - Updated as of 6/29/2009			

VI.A.6.b

Compliance Status from DOJ Report: Partial

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

Findings The revised Assessment Policy and protocols from the Psychiatry Training Department require that psychiatrists write a note, rather than merely countersign trainee notes. Assessment Policy, tab # 12 (page 3, subsection e). There has been some improvement in implementing this, but it is still too common a practice for attending doctors to merely countersign notes. The CIPA audit shows that in 83% of cases the CIPA was either completed by an attending or if completed by the resident, was accompanied by a note of the attending indicating approval or revising the Assessment or plan of care. CIPA audit results, tab # 16; CIPA audit tool/instructions, tab # 15(question 27). Further a small sample of notes completed by medical students or externs were reviewed; 75% of them were followed by a note of the attending physician addressing the student's note.

Compliance Status: Partial

DOJ Recommendations (Report 3)	*Responsible Party*
1 *Provide information to specify how all trainees, including students and residents, have been oriented to the facility's policy and procedure regarding the recognition and reporting of patient abuse and neglect.* ***- High Priority***	*Med; Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Conduct orientation sessions for all trainees, including students and residents related to patient abuse and neglect.	6/1/2009	Abuse and Neglect Training Data, Tab # 135	Snyder
Complete *Status: Trainees were part of the initial training on abuse and neglect and data was previously provided. For new trainees, this training is provided during new employee orientation. - Updated as of 6/25/2009*			

2 *Implement corrective actions to ensure that attending physicians follow up on diagnostic and treatment questions/issues raised in notes written by trainees and provide documentation of the follow-up.* ***- High Priority***	*Med; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Remind Attendings to review and comment on all trainee notes, not just countersign	6/1/2009		Arons
2 Audit conducted by Supervisor of medical students	7/1/2009	Audit results, Tab # 52	Arons
Complete			

3	Evaluate whether modification in AVATAR is needed to link a follow up note by attending to resident or student's note	9/15/2009		Seymour, Arons

Status: Avatar team is examining the workflow and system options open to us to determine the possible set of solutions. This includes using the Progress Note or a specialize progress note. - Updated as of 8/13/2009

3 *Provide self-assessment data regarding implementation of this requirement.* *Med; PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Audit tool needs to be developed and implemented.	6/1/2009		Arons

Status: Dr. Atdjian has conducted pilot effort. - Updated as of 6/30/2009

VI.A.6.c

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.3 concerning NOS and R/O diagnosis and special review.

Training has been held around cognitive remediation. On May 6, 2009, a grand rounds was held for psychiatric and psychology staff around recovery, skills training and cognitive remediation. Grand Rounds, May 6, 2009 Cognitive Remediation, tab # 72; In addition, the Hospital's neuropsychologist provided training to TLC staff around cognitive remediation. Nursing staff are also receiving training around cognitive remediation as part of TLC training. Tab # 153.

Compliance Status: Partial.

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.* ***- High Priority*** *Med; PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Same as in VI.A.1, VI.A.2, VI.# and VI.A.4	6/1/2009		BSA
2	Diagnosis reviewed in each IRP conference, and psychiatrist and psychologist both attend	(Ongoing)		Arons

Status: Ongoing - Updated as of 7/26/2009

2 *Provide CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.* ***- High Priority*** *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Arrange for CME session on the assessment and management of cognitive and other neuropsychiatric disorders	4/15/2009	Training data and outline from session, Tab # 72	Snyder

Status: Grand Rounds was held on this topic. - Updated as of 6/25/2009

3 *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliations.* ***- High Priority*** *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See prior action step	6/25/2009		

4 Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS. - *High Priority* *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monitor through CIPA and Psychiatric update audits.	6/1/2009	Audit results, CIPA, tab # 16; Psych update audit tool and instructions, Tab # 18	Arons

Status: Audits underway for CIPA. Will begin in August for Psych update. - Updated as of 6/30/2009

VI.A.6.d

Compliance Status from DOJ Report: Partial

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

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

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Same as in VI.A.1 through VI.A.6.a and VI.6.c. *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as in VI.A.1 through VI.A.6.a	8/21/2009		Arons

VI.A.7

Compliance Status from DOJ Report: Partial

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 and to ensure consistency among policies. Assessment Policy, tab # 12. The new psychiatric update form with operational instructions has been implemented but it is not yet in AVATAR. Psychiatric Update form/instructions, tab # 17. The form focuses on clinical course since last update; identifying residual or target symptoms, use of PRNs, seclusion or restraint and adverse reactions to medications; updating risk assessment and diagnosis; and describing medication changes or failure to change medications and relevant risks/benefits. It also has been modified to address lab findings and any behavioral or psychodynamic issues that are affecting progress. A psychiatric update audit tool with instructions has also been developed, but audits will begin in September, 2009. Psychiatric Update audit tool/instructions, tab # 18. The tool specifically assesses whether the update includes an appropriate plan that integrates behavioral and psychiatric interventions.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Ensure consistent implementation of the new template for the psychiatric update.* - *High Priority* *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Finalize revised psychiatric update and guidelines	7/31/2009	Psychiatric update form and instructions, Tab # 17	Arons
Complete *Status: Psychiatric update and instructions developed. - Updated as of 7/31/2009*			
2 Develop audit tool for psych update with instructions	8/7/2009	Psychiatric update audit tool and instructions, Tab # 18	Arons
Complete *Status: Audit tool and instructions developed. - Updated as of 8/7/2009*			
3 Implement audits	8/17/2009		Arons

2 *Implement corrective actions to ensure that the content of the psychiatric updates meets all requirements of this Agreement.* - ***High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See prior action steps	6/1/2009		BSA
2 Audit results to be shared with psychiatrists at regular meetings and individually	8/14/2009	CIPA audit results, Tab # 16	Arons

3 *Same as in VI.A.1.* - ***High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Psychiatric Update has section that requires ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization. ***Complete***	6/1/2009	Psychiatric Update, Tab # 17	Arons

VI.B. Psychological Assessments

Findings See findings in specific sub-cells

Compliance Status: See specific findings.

VI.B.1

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.

Findings The Psychology Department includes 13 staff psychologists, a neuropsychologist (20 hours per week) with four externs, three interns and two post-doctoral candidates, and an Acting Director of Psychology who also serves as Director of Psychology Training. These numbers do not include the 5 clinical administrators who are also psychologists by training. Recruitment is underway for the Director of Psychology and a psychologist is expected to begin work in mid-September.

The Psychology Department developed a Manual (provided last site visit and available again during this visit) which includes standards for completion of referrals as well as templates for each type of assessment. The Hospital's Assessment Policy also required that referrals be completed within 30 days, and with the exception of neuropsychological evaluations or where the individual refuses the evaluation, psychological evaluations are completed within 30 days. Guidelines for the IPA were modified to include a prompt for addressing history of head trauma or brain injury and a related modification was made to the IPA audit guidelines, although this was done in August, so it was not included in the audits conducted to date. IPA form/Guidelines, tab # 19; IPA audit tool/instructions, tab # 20. (The form is not able to be modified at this time due to it is in AVATAR, and priorities are to introduce all discipline forms before modifying others.) In addition, psychology is completing standards and audit tools for a general psychological evaluation as well as a risk assessment. The tools should be available during the site visit, and audits will begin in October, 2009.

Due to staffing reductions as a result of budget cuts, the Hospital is not able to hire an additional neuropsychologist at this time.

The IPA audits show that in 92% of cases, the IPA Part A is completed within five days of admission and that in 88% of cases, Part B is completed within 11 days of admission. IPA Audit results, tab # 21. Overall, the data shows high quality in completion of the IPA.

Compliance Status: Partial

DOJ Recommendations (Report 3)		*Responsible Party*
1 *Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools)*	- ***High Priority***	*Med; PID; Psy;*

according to the planned roll out schedule that address the psychological assessment process. At a minimum, monitor:

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

b The quality of each section of the evaluation;

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

d 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	Monitoring tool development by psychology for IPA *Status: Implemented audits of IPA. - Updated as of 6/30/2009*	6/1/2009	IPA audit tool/instructions,Tab # 20 ; IPA audit results, Tab # 21	Gontang
2	Develop standards for risk assessments and other types of psychology assessments *Status: Ongoing - Updated as of 7/26/2009*	9/30/2009	Psychology Evaluation Form, Tab # 22	Gontang
3	Develop audit tools for each kind of psychological assessment	9/30/2009		Gontang
4	Conduct audits on each type of assessment	9/30/2009		Gontang
5	Publish results of audits and share with staff	10/30/2009		PID, Gontang

2 *Present the above as trended data.* *PID; Psy;*

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

3 *Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment.* ***- High Priority*** *Med; Psy;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	IPA instructions to include prompt for head injury. ***Complete*** *Status: IPA cannot be modified at this time due to AVATAR build. This is captured in operational instructions for IPA. - Updated as of 6/18/2009*	7/31/2009	IPA form and instructions, Tab # 19	Arons; Gontang
2	Modified audit tool for IPA to ensure it reviews for information about history of head/brain injury	7/31/2009	IPA audit tool/instructions, Tab # 20	Gontang

4 *Develop a FTE for neuropsychology that assures full time coverage of this service.* ***- High Priority*** *Med; COO; Psy;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	No action step will be developed for this item. *Status: This item will not be followed. - Updated as of 6/25/2009*	6/1/2009		

VI.B.2

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

Findings See sub-cells for findings.

Compliance Status: See sub cells.

DOJ Recommendations (Report 3)			*Responsible Party*
Please see sub-cells for findings and compliance.			
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See subcells			

VI.B.2.a

Compliance Status from DOJ Report: Substantial

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

DOJ Recommendations (Report 3)			*Responsible Party*
Continue current practice.			*Med; Psy;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Continue current practice.	6/1/2009		BSA

VI.B.2.b

Compliance Status from DOJ Report: Substantial

be based on current and accurate data;

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

Compliance Status: Substantial

DOJ Recommendations (Report 3)			*Responsible Party*
Continue current practice.			*Med; Psy;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Continue current practice	6/1/2009		BSA

VI.B.2.c

Compliance Status from DOJ Report: Substantial

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

Findings Prior practice continues.

Compliance Status: Substantial

DOJ Recommendations (Report 3)			*Responsible Party*
Acceptable level of practice continued to be found on this item.			*Med; Psy;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Continue current practice	6/1/2009		BSA

Maintain current level of practice. — *Med; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice	6/1/2009		BSA

VI.B.2.d

Compliance Status from DOJ Report: Partial

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

Findings Assessment routinely include determinations that specifically address the purpose of the evaluation.

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

Develop clear guidelines for the Conclusions and Recommendations sections of the IPA. — ***- High Priority*** *Med; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop guidelines for conclusion and recommendations section of IPA	8/7/2009	Guidelines for IPA, Tab # 19	Gontang

VI.B.2.e

Compliance Status from DOJ Report: Substantial

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

Findings See cell VI.B.2.d

Psychologists have access to current research.

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

Continue current level of practice. — *Med; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice	6/1/2009		BSA

VI.B.3

Compliance Status from DOJ Report: Partial

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 Hospital is implementing this requirement through the ward based psychologists and the IRP conferences. Prior to the IRP conference, psychologists review the record and evaluate whether further testing is recommended. They then share their assessment with the team for incorporation into the IRP or document their recommendation in a progress note before the IRP conference if they are unable to attend the conference.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Implement developed timeline.* — ***- High Priority*** *Med; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Complete IPAs on all individuals who have not had a psych assessment of any kind within last 3 years to determine if assessment required.	10/30/2009		Arons; Gontang

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.*	*- High Priority*	*Psy;*

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

VI.B.4

Compliance Status from DOJ Report: Substantial

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

Findings Current practice has continued. See also VI.B.1

Compliance Status: Substantial

DOJ Recommendations (Report 3)	Responsible Party
Continue current level of practice.	*Med; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue current practice	6/1/2009		BSA

VI.B.5

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.

Findings Several steps were taken to address this requirement. Each unit now has a psychologist assigned to it to provide support and each are expected to attend IRP conferences. Ward staffing in Forensic and Civil Services, tab # 43 . Second, the Assessment policy specifically requires that psychologists communicate and interpret results for treatment teams along with the implications of the results. Assessment policy, tab # 12; Initial Psychological Assessment, A and B, tab # 19. The IPA specifically requires the signatures of the psychologist and the date the results were presented to the treatment team. Additionally, the Psychological Evaluation template includes a provision for treatment teams to respond to the recommendations through the IRP meeting. Psychological evaluation form, tab # 22. Finally, the Clinical Formulation Update includes a section in which the Clinical Administrator is to include information about the results of any psychological evaluation and recommendations since the last IRP; there is a related indicator included in the Clinical chart audit tool/instructions. Clinical formulation update/instructions, tab # 7.

According to results from the recent audits of the IPA, ninety percent of the IPAs include the signature of the clinical administrator, indicating the results have been shared with the treatment team. IPA audit results, tab # 21. With respect to results of referrals, according to the clinical chart audit, in 8% (2 out of 24 reviewed cases), the clinical formulation/update identified individual needs that require a service or assessment referral and service referrals were completed. All of those two cases has the referral recommendations incorporated into the IRP or if not, were the reasons for not including them clearly documented. Clinical chart audit results, tab # 11.

IRP observers have noted that treatment teams are discussing results of psychological evaluations and ensuing recommendations during the Phase I of the IRP conference with more frequency, through the clinical formulation update and the presence of the psychologist at the IRP meetings. In addition, the Hospital is monitoring the attendance of psychologists at IRP meetings, which is a strategy designed to improve the integration of psychiatric and psychological assessments and treatments. Attendance of psychologists at IRP Conferences is lagging behind some other disciplines, at 44% in March, 2009, 54% in April, 2009, 67% in May, 2009, and 54% in June, 2009. This is likely due to vacancies in psychology positions as well as their increased participation as a discipline in the TLCs.

Compliance Status: Partial

DOJ Recommendations (Report 3)		Responsible Party
1 *Develop policies and procedures that address the proper documentation of the treatment team's response to*	*- High Priority*	*Med; PID; COS; Jana Taylor*

all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Insert this requirement into IRP policy for responses to discipline-specific recommendations.		IPR policy, Tab # 3	Jana Taylor
	Complete *Status: Inserted requirement for the treatment team to respond to discipline-specific recommendations. - Updated as of 6/22/2009*			
2	Assess compliance through clinical chart audit tool and IRP process monitoring tool	7/31/2009	Clinical chart audit tool/instructions, Tab # 10; IRP process tool/instructions, Tab # 8	Gouse; PID
3	Conduct audits	(Ongoing)	IRP Audit results, Tab # 9 ; Clinical chart audit results, Tab # 1	Gouse, PID
	Status: Ongoing for IRP process, to begin in July for clinical chart audit - Updated as of 7/26/2009			

2 *Monitor through chart auditing process that treatment teams document their response to the results of psychological assessments other than the IPA.* *COS;*

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

VI.C. Rehabilitation Assessments

Findings See sub-cells below.

Compliance Status: See sub cells below.

VI.C.1

Compliance Status from DOJ Report: Partial

When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.

Findings

The Hospital's Assessment Policy provides for a Rehabilitation Assessment for every newly admitted patient. Assessment Policy, tab # 12. Rehabilitation Services has finalized its assessment form and guidelines and staff are utilizing it, but data confirms that not every admission is getting an assessment within 5 days are required by Hospital policy: 50% of the assessments reviewed were timely completed. Rehabilitation services staffing remains insufficient, although two additional staff have been selected and the Hospital is awaiting results of criminal background checks before they can begin work. The hiring of additional staff may be delayed due to budget realities in the District government. The shortage is particularly severe in JHP.

Managers in Rehabilitation Services completed an audit of the assessment, with a 12% sample size. Results show that assessments covered the level of functioning in six categories from a low of 80% of the time (motor skills) to a high of 100% (cognitive). The audit also shows that in 80% of cases, the Assessment included specific strategies to engage the individual in meaningful activities, in 97% of cases included a description of activities the individual reported interest in, and in 60% included information about prior activities. Rehabilitation Services Audit Tool/instructions, tab # 24; Rehabilitation Services Audit results, tab # 25. Only fifty percent of rehabilitation assessments were completed within the five days required by policy, according to audit. This is likely due to staff shortages in rehabilitation services. Rehabilitation services audit results, tab # 25.

Also during the last review period, the monthly therapeutic note was modified and guidelines were developed. Monthly therapeutic note/guidelines, tab # 44. Audits of the quality of therapeutic progress notes have not yet begun (set for September, 2009) but the audit tool and instructions are completed. Therapeutic progress note audit tool/instructions tab # 45.

The TLCs now have all disciplines leading groups, although Rehabilitation Services staff continue to have a significant presence. See tab # 153 for the treatment mall staffing by discipline.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* — ***- High Priority*** — *Civil; Forensic; COO; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Identify critical must fill vacancies and calculate cost	6/15/2009	List of vacancies approved to be filled, Tab # 42	Canavan, Baron
Status: List has been prepared and is under review by leadership - Updated as of 6/18/2009			
2 Hire staff for positions on critical positions list	8/2/2009 (Ongoing)		Seymour
Status: Recuriting critical position - Updated as of 8/25/2009			
3 Continue to assess need for RSA staff	(Ongoing)		CVC, JH
Status: Ongoing - Updated as of 7/26/2009			

2 *Audit and present data from forensic charts as well.* — *Civil; Forensic; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Rehabilitation services to audit 20% of both civil and forensic Rehab assessments on an ongoing basis	7/31/2009	Rehab audit results, Tab # 25	Coleman, Robinson
Status: Forensic Services audited 4 assessments and Civil has audited 5 assessments. All the audits have been placed on the shared drive for PID analysis as of 6/24/09. Neither Forensic or Civil Services audited any assessments between 6/25/09 and 7/1/09. During the week of July 6, 2009 Forensic Rehabilitation Services audited 1 assessment and placed findings on the shared drive for PID analysis and Civil audited 5 assessments and placed the findings on the shared drive for PID analysis.During the week of July 13, 2009 Forensic Rehabilitation Services audited 1 assessment and placed findings on the shared drive for PID analysis. For the month of July, a total of 3 assessments were audited in Forensic and 6 in Civil and findings were placed on the shared drive for PID analysis. - Updated as of 7/29/2009			
2 PID to provide data analysis	7/31/2009	Rehab audit results, Tab # 25	PID
Status: Ongoing. - Updated as of 7/29/2009			

3 *Develop policies so that all clinical disciplines are providing a required number of mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.* — ***- High Priority*** — *Civil; Forensic; Med; PID; COS; Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Added language to the IRP policy to require the Clinical Administrators to schedule meeting times to accommodate all treatment team members to attend.		IRP policy, Tab # 3	Jana Taylor
Complete *Status: Language inserted into the IRP policy to require scheduling that allows all treatment team members to attend. - Updated as of 6/22/2009*			

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

Compliance Status from DOJ Report: Partial

be accurate as to the individual's functional abilities;

Findings The newly designed rehabilitation assessment form is implemented but not all admissions are yet getting assessments due to staffing shortages. See VI.C.1. Data from the period of March through July, 2009 (12% sample civil and forensic) shows generally high rates of functional assessments, ranging from a low of 80% in motor skills to 100% in cognitive skills. Other ratings include 93% for leisure and perceptual, 83% psychosocial, and 97% for behavior. Rehabilitation Services Assessment audit results, tab # 25. The quality of the assessments is high, but only 50% are completed within 5 days due to staffing issues.

Compliance Status: Partial

DOJ Recommendations (Report 3)		*Responsible Party*
1 Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.	*- High Priority*	*Civil; Forensic; COO; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VI.C.1. recommendation #1 action steps	6/15/2009		

2 Audit and provide data for forensic as well as civil units.	*- High Priority*	*Civil; Forensic; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.1 recommendation #2			Coleman, Robinson

VI.C.2.b

Compliance Status from DOJ Report: Partial

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

Findings The newly designed assessment is implemented but not all admissions are yet getting assessment due to staffing shortages. See VI.C.2.a.

Compliance Status: Partial

DOJ Recommendations (Report 3)		*Responsible Party*
1 Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.	*- High Priority*	*Civil; Forensic; COO; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.2.a recommendation #1			Coleman, Robinson

2 Audit and provide data for forensic as well as civil units.	*- High Priority*	*Civil; Forensic; PID; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.1 recommendation #2			Coleman, Robinson

VI.C.2.c

Compliance Status from DOJ Report: Partial

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

Findings The newly designed assessment is implemented but not all admissions are yet getting assessments due to shortage of rehabilitation services staff. See VI.C.2.a In an effort to improve the quality of the assessments, guidelines were developed and implemented to provide additional support to rehabilitation staff completing the assessment forms. Rehabilitation Assessment form/guidelines, tab # 23.

Rehabilitation Services completed an audit of a 12% sample of records. Rehabilitation staff scored high on the assessment of each area of

functioning, ranging from a low of 80% in the area of motor skills assessment, to a high of 100% on cognitive functional assessment. Rehabilitation Services Audit results, tab # 25 However, performance was not as high on indicators relating to the scope and content of the assessment - - such as including past rehabilitation therapies (60%), individual's self-reported interests (97%), life skills prior to and during course of illness (80%).

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* — ***- High Priority*** — *Civil; Forensic; COO; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.2.a recommendation #1			Coleman, Robinson

2 *Audit and provide data for forensic as well as civil units.* — ***- High Priority*** — *Civil; Forensic; PID; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.2.a recommendation #2			Coleman, Robinson

VI.C.2.d

Compliance Status from DOJ Report: Partial

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. Guidelines have been modified to provide additional guidance to staff in developing specific, individualized strategies to engage the individual in appropriate activities. Rehabilitation Assessment form/guidelines , tab # 23.

Rehabilitation Services completed an audit of a 12% sample of records. Rehabilitation staff scored high on the assessment of each area of functioning, ranging from a low of 80% in the area of motor skills assessment, to a high of 100% on cognitive functional assessment. Rehabilitation Services Audit results, tab # 25 However, performance was not as high on indicators relating to the scope and content of the assessment - - such as including past rehabilitation therapies (60%), individual's self-reported interests (97%), life skills prior to and during course of illness (80%). Audit results, tab # 25.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* — ***- High Priority*** — *Civil; Forensic; COO; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.2.a recommendation #1			Coleman, Robinson

2 *Revise that section of the instructions for the RSA to indicate the need for recommendations to include specific and individualized strategies.* — ***- High Priority*** — *Civil; Forensic; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise instructions to assist staff in completing assessments to improve specifcity of recommendations	6/30/2009	RSA instructions, Tab # 23	Coleman, Robinson

Status: Instructions have been revised and submitted to Chief of Staff for review and approval. Chief of Staff recommended edits, instructions under revision as of 7/1/09. Instructions still under revision anticipated completion date July 31, 2009. - Updated as of 7/29/2009

3 *Audit and provide data for forensic as well as civil units.* ***- High Priority*** *Civil; Forensic; PID; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps VI.C.2.a recommendation #2			Robinson, Coleman

VI.C.3

Compliance Status from DOJ Report: Partial

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

Findings Rehabilitation Services has not yet begun to address this requirement, and thus no progress is being made. With the current level of staffing, this requirement will not likely be met. Recruitment is underway for two additional staff. There are currently 12 certified rehabilitation services staff on the civil side, 3 on forensic side, and two pending hires.

The TLC at Forensic Services opened in July 2009. A schedule of all mall programs is included in this report. Schedule of TLC groups activities, tab # 69.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Continue to implement timeline for providing an RSA for all individuals previously admitted to the Hospital.* ***- High Priority*** *Civil; Forensic; Coleman, Robinson*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop plan to ensure previously admitted patients are referred for updated RSA if clinically indicated	8/12/2009		Coleman, Robinson

Status: Certified Rehabilitation Services clinicians have begun updating assessment for patients on Wards 10 and 12 prior to their treatment plan. For the month of July, the two Certified Rehabilitation Services clinicians in Forensic continue to update assessments for patients on Wards 10 and 12 prior to treatment planning conferences. - Updated as of 7/29/2009

2 *Continue to implement timeline for development of forensic mall services.* ***- High Priority*** *Forensic; Morin*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 In consultation with Post Trial Branch Chief and Nursing Services: 1) Plan transfer of patients so that all individuals participating in the Civil Side Mall are on one unit. 2) Transfer all Treatment Mall Patients to identified unit. In consultation with Chief of Staff and Director of Civil Programs: 3) Forensic treatment team from mall unit will meet with Treatment Mall coordinators and clinicians to explore how to improve linkage and ensure integrated planning. 4) Develop procedures for monitoring linkage between mall and treatment planning. 5) Implement monitoring. 6)Discuss ideas to promote linkage in biweekly clinical administrator meeting ***Complete*** *Status: Due dates: 1) Week of 5/4/09 2) Week of 5/18/09. Transfers Completed as scheduled. Subsequently, beginning June 29, 2009, patients from both Ward 1 and Ward 3 now attend the TLC Program in the Civil side of the hospital.* *3) Week of 5/25/09 Completed. Treatment plans from patient in the TLC are conducted in the treatment mall. Ward 1 began 6/1/09. Ward 3 will hold July 2009 treatment plans in the mall.* *4) Week of 6/1/09* *5) To be determined* *May, 2009 Status: 1) Completed 5/1/09* *2) Completed 5/7/09* *3) Pending* *4) Pending* *Forensic treatment team to hold treatment plans in the mall for greater involvement with mall staff beginning 6/1/09 - Updated as of 7/1/2009*			JH
2 Plan transfer of patients so that all individuals participating in the Mall are on one unit *Status: Patients on Wards 1 and 3 in Forensic Services are attending the TLC in the treatment mall in Civil Services as of 7/1/09. - Updated as of 7/1/2009*			

3	Develop plan for creation of treatment mall in forensic to include staffing, group therapies, curricula etc.	6/30/2009		Vidoni-Clark, Henneberry
	Complete *Status: Patient Needs Assessment in progress. Site for treatment mall identified, space utilization plan being developed, group therapies and curricula under development. As of July 8, 2009 draft treatment scheduled has been developed and is being discussed with disciplines. Forensic treatment mall (Therapeutic Learning Center 4) opened on July 27, 2009.Additional groups will be added as needed. - Updated as of 7/30/2009*			
4	Identify staff to lead groups	7/1/2009		Henneberry
	Complete *Status: Meetings with disciplines scheduled for June 15th. Meeting with disciplines held week of June 15 and discipline staff members who will participate in mall identified. - Updated as of 7/15/2009*			
5	Open Treatment Mall	7/25/2009	TLC 4 (Forensic) description/curricula, Tab # 69	Henneberry
	Complete *Status: TLC 4 (Forensic) opened on 7/27/09. - Updated as of 7/30/2009*			
6	Tours & orientation for staff providing services on TLC4- Forensic Mall			Vidoni-Clark
	Complete			

VI.D. Social History Assessments

Compliance Status from DOJ Report: Partial

By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the reationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.

Findings Social work is implementing a social work initial assessment and is auditing the completion. SWIA form/instructions, tab # 31 ; SWIA audit tool/instructions tab # 32; SWIA audit results, tab # 33. Audits of a 20 plus % sample of monthly admissions from April, 2009 through July, 2009 were conducted). Assessments were completed timely in 67% of cases in April, 82% of cases in May, 46% of cases in June, 2009; and 27% in July, 2009. Timely completion lags in JHP, possibly due to staffing issues. SWIA Audit results, tab # 33. Also contributing was a misunderstanding as to when the 5 day period begins - social workers were not counting the day of admission as day one, which has affected the data. Data shows that by June, 2009, 100% of the sample had completed appropriately the section of the SWIA concerning resolving information discrepancies. SWIA audit results, tab # 33.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Begin to audit a 20% sample of all newly admitted individuals using the new audit tool.* ***- High Priority***

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Begin audits of 20% of SWIA starting with April 2009. Admissions and monthly thereafter	5/20/2009 (Ongoing)	SWIA audit results, Tab # 33	Supervisory Social Workers
	Status: Completed, ongoing each month - Updated as of			
2	Begin audits of 10% of social work update notes for May 2009 and monthly thereafter, increasing to 20% sample by August 1, 2009	6/1/2009 (Ongoing)	SW monthly update note audits, Tab # 33	Supervisory social Workers
	Status: Completed, ongoing each month - Updated as of			

2 *Present trended data analysis as part of an overall performance improvement initiative.* *Med; Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Audit Forms will be entered into database and provided to PID for analysis	5/20/2009		Supervisory Social Workers
	Status: Audit Forms available on W Drive as of 5/20/09 - Updated as of			

2	Chiefs of Forensic and Civil Social Services will share audit findings with staff social workers on a monthly basis and develop plan of action for any identified issues *Status: Ongoing - Updated as of*	6/1/2009 (Ongoing)	Audit results for both SWIA and update, Tab # 33	Henneberry, Vidoni-Clark

VII. Discharge Planning and Community Integration

Summary of Progress

1. The Hospital maintains a database in which it is tracking issues that are delaying/preventing discharge of persons ready for discharge. DMH and the Hospital have instituted weekly meetings to review status of newly admitted individuals as well as those who are ready for discharge but not yet discharged. Individuals are tracked by issue preventing discharge, with a special focus on housing needs and those who are resistive to discharge. As of the writing of this report, the resistive to discharge list is down to 6 individuals.

3. DMH's Integrated Care Division, continues to focus on high risk individuals, providing oversight in an effort to improve the likelihood of successful community placement. The Division is actively involved in discharge planning with the Hospital, and also monitors post discharge services. In addition, DMH awarded an integrated care contract to serve 30 Hospital patients who are resistive to discharge or who have histories of multiple hospitalizations. Eighteen individuals are currently being served through this contract - one individual in the community, four to be discharged by August 31, 2009 and the remainder in the Hospital but transitioning to the community. Over twenty other individuals attend community programs in their transition to community placement.

4. The Social work initial assessment and monthly updates includes an increased focus on discharge planning. These are being monitored through the two audits currently implemented by social work.

5. The Hospital implemented a tracking "discharge resistive individuals" form and began auditing this form. The initial audit results suggest improvement is needed on developing specific strategies to address the resistance and increased involvement of community case managers are needed.

6. The Hospital continues to review 20% of closed records through a Discharge Record review although the old assessment tool was used during this period. Reviews were conducted on discharges occurring from March through June, 2009. Data indicates that improvement is needed in identification of strengths, individualizing assessments and in individualizing interventions.

7. The Hospital is monitoring individual participation in discharge planning in part through the IRP process monitoring tool.

8. The Hospital now operates four therapeutic centers (three in civil division, one in forensic) serving 210 individuals. Each discipline provides groups and activities in the various TLCs. Improved ward based programming was also implemented for those individuals who cannot attend the TLC. All centers offer an evidenced based written curricula. Staff are undergoing group leadership training.

VII. Discharge Planning and Community Integration.

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

Findings See sub-cells below

Compliance Status: See sub cells for findings.

VII.A.

Compliance Status from DOJ Report: Partial

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

Findings The Hospital reworked the IPR training around recovery planning and discharge/transition planning, which provided more clarity to staff about the role of recovery planning in effecting discharge. These concepts are also included in the IRP manual for easy reference for ward staff. In addition to being addressed in other IRP training modules, staff were trained through a dedicated training module around discharge/transition planning. IRP Training Materials, tab # 1; IRP training data, tab # 2. Staff were trained on the role of discharge goals in each of the focus areas, as well as within each of the treatment, rehabilitation and enrichment services "prongs" in IRPs. Staff also were trained on how the discharge criteria relate to the initial clinical formulation, to the IRP itself and then how to create criteria that reflect the individual's needs. Training occurred in late August, 2009.

In addition, the Hospital modified its IRP form and instructions to ensure discharge is addressed within each focus area, and the Community Reintegration focus area is now utilized only when there are challenges around discharge, i.e., discharge resistant, special needs that are not always readily available, or have history of many failed placements. See IRP Manual at tab # 8. Staff are expected to utilize interventions within each focus area that also address discharge needs. Discharge is also covered in the Psychiatric Update form and the Social work update forms. Psychiatric Update form, tab # 22; Social work update form, tab # 34.

The Hospital continued to sample 20% of civil discharges. In the first quarter, January, 2009 to March, 2009, 57% of cases reviewed were rated as meeting standards around discharge planning at admission, 33% were rated as partially meeting discharge planning at admission and continuing thereafter, and 10% were rated as not meeting standards. During the second quarter, April through June, 2009, 65% if cases were rated as meeting standards around discharge planning at admission, and 35% of cases were rated as partially meeting standards. No cases were rated as not meeting standards. Discharge Quality Assessment Tool, tab # 67 ; Quarterly Audit Results, January -March, 2009 and April - June, 2009, tab # 68. The audit also considered whether individualized discharge planning was a fundamental component of the IRP. It was rated as met 57% of the time, partially met in 29% of the time, and not met in 14% of the time in the period of January - March, 2009, and was rated as met 45% of the time, partially met 45% of the time, and not met 10% of the time in the period April, 2009 to June, 2009.

In addition, discharge planning is monitored through the two social work audit tools (28% sample). See SWIA audit tool, tab # 32 ; SW update audit tool, tab # 34. In the SWIA audits in the three month period of April through July, 2009, scores ranged from 82% to 92% on whether treatment goals and discharge plans reflect the individual's strengths and limitations, from 75% to 93% on whether interventions are specific and related to discharge planning, from 64% to 92% on whether all areas of discharge criteria are described in detail as to what is needed, from 75% to 100% on description of discharge barriers, from 62% to 87% on identification of skills needed for discharge, and 80% to 91% on identification of discharge needs. Similarly, in the SW update audit results for the two month period of May to July, 2009, scores ranged from 72% to 92% as to whether there was description of progress toward discharge, from 78% to 87% on status of discharge barriers, and 74 percent to 89 percent on descriptive assessment of services needed for discharge planning.

The Hospital is continuing to work closely with MHA, the Integrated Care Division (ICD), that monitors community support for the high risk discharged population; The Division is currently recruiting for a monitor that will be dedicated for post discharge monitoring of individuals discharged from Saint Elizabeths. Currently, meetings with ICD staff and representatives of the Hospital and community providers are held weekly at the Hospital to review newly admitted individuals and those for whom discharge continues to be challenging. The meetings includes the provider that is providing services under the new Integrated Care Contract provided during the last visit. The Integrated Care Contact that was awarded just prior to the last site visit is fully operational. Eighteen individuals are enrolled, with 1 in the community and three expected to be discharged in August, 2009. The other 14 are in various stages of engagement as Hospital staff and community staff work toward their discharge.

The ready for discharge list includes approximately six individuals who are considered discharge resistant. Ready for Discharge list, 8/26/2009, tab # 75. Each of the discharge resistant individuals have discharge plans that are in place. Further, the Hospital implemented a discharge resistant tracking form, and is auditing that process as well. Tracking Resistive Patients form, tab # 76; Resistive patient tracking audit tool, tab # 77 ; Resistive patient tracking audit results, tab # 78. An initial audit was conducted in the first week of August, and shows substantial improvement is needed in ensuring the cases move forward appropriately. According to the audit, there still is insufficient involvement on the part of the community case manager with Hospital staff and the individual in care and there needs to be more specific strategies in place to address the individual's resistance to outplacement.

Compliance Status: Partial

DOJ Recommendations (Report 3)		***Responsible Party***
Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.	***- High Priority***	*COS;*

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

1	Develop examples of needs, objectives and interventions for IRP manual **Complete**	7/15/2009	IRP manual	Gouse
2	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions. *Status: Ongoing - Updated as of 7/21/2009*	(Ongoing)		Gouse
3	Modify IRP form *Status: Revised IRP form - Updated as of 7/26/2009*		IRP Form, Tab # 5	Gouse

VII.A.1

Compliance Status from DOJ Report: Partial

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

Findings See VII.A.

The social work audits of both the initial assessment and updates include multiple indicators around discharge, including those relating to the individual's strengths and goals. In the SWIA audit (28% sample of admissions) of whether the initial assessment included treatment goals and discharge plans that reflect the individual's strengths, 83% were rated as adequate in April, 2009, 82% in May, 2009, 92% in June, 2009, and 87% in July, 2009. Similarly, during that same time period, 33% of SWIA in April, were adequate in a discussion of the individual's personal goals and whether they were realistic/achievable, 82% in May, 2009, 85% in June, 2009, and 85% in July, 2009. See also, SW update audit results, Tab # 33 (indicator 3).

The clinical chart audit tool tracks discharge planning through review of the clinical formulation/update (Indicator 30 in clinical chart audit tool, clinical formulation/update enables the treatment team to make preliminary determinations/final recommendations as to the discharge setting and changes necessary to effect discharge) and indicator 57 (discharge criteria identified for each focus area). Clinical chart audit tool, tab # 10; Clinical chart audit tool results, tab # 11. Eighty-five percent of clinical formulations were rated as adequate in whether they enabled the treatment team to make determinations around discharge, and 81% reflected discharge criteria within each focus area. Finally, discharge planning as part of the IRP conference is monitored through the IRP observations. Criteria include whether the team reviewed the barriers to discharge within each focus area (results are 69% did in March, 2009, 64% in April, 2009, 75% in May, 2009 and 62% in June, 2009) and whether the individual was given opportunity to actively participate in discharge planning (results are 25% in March 2009, 91% in April, 2009, 92% in May, 2009 and 85% in June, 2009). IRP Monitoring audit results, tab # 9.

Compliance Status: Substantial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Modify treatment team training to clearly identify how to develop discharge criteria and foci of hospitalization that utilize an individual's strengths and preferences in discharge planning.* ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop examples of discharge criteria and foci in operational instructions of IRP **Complete**		See prior action steps	Gouse

2 *Once training is completed, develop appropriate audit to monitor the implementation of this integration in both the IRP conference and the written IRP.* ***- High Priority*** *PID; COS; Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train Clinical Administrators on incorporating discharge criteria in each focus area and use of community integration focus area. *Status: Ongoing - Updated as of 7/21/2009*	6/11/2009 (Ongoing)	IRP form, Tab # 5 : IRP Manual	Gouse

2	Use Clinical Audit Tool to check if each focus area includes discharge criteria	7/1/2009	Clinical chart audit tool/instructiions, Tab # 10	Gouse
	Status: Clinical chart audit tool includes discharge criteria for each focus area and data will be collected starting in July. - Updated as of 7/21/2009			
3	Pulbish audit results		Clinical chart audit results tab #	PID

VII.A.2

Compliance Status from DOJ Report: Partial

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

Findings See findings in sub-cells VII.A and VII.A.1.

See also Assessment forms including Comprehensive Initial Psychiatric Assessment, tab # 14, Social work initial assessment, tab # 31; Initial Psychological Assessment, tab # 19.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP. ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions	9/30/2009 (Ongoing)		gouse
	Status: Ongoing - Updated as of 6/18/2009			
2	Develop examples of needs, objectives and interventions for IRP manual	7/15/2009	IRP manual	Gouse
	Complete			

VII.A.3

Compliance Status from DOJ Report: Partial

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

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

The Social Work Initial Assessment form includes a section on barriers to discharge, and the guidelines provide instructions on completion of the assessment in this aspect. Social Worker Initial Assessment and Guidelines, tab # 31 ; SWIA audit results, tab # 32. Further, the IRP training includes a specific module around discharge/transition planning, and examples of how to incorporate this within the focus areas of the IRP are provided in the IRP manual.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP. ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions.	(Ongoing)		Gouse
	Status: Ongoing - Updated as of 6/18/2009			

2	Develop examples of needs, objectives and interventions for IRP manual	7/15/2009	IRP manual	Gouse
	Complete			

VII.A.4

Compliance Status from DOJ Report: Partial

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 Discharge Monitoring review found little improvement in ensuring IRPs included measurable interventions that focus on building skills needed for community placement; in the first quarter 2009, only 5% was rated as met, while 76% was rated as partially met. By the second quarter, 2009, these numbers were at 0% met, 60% partially met, and 40% not met. Please note that this indicator requires that the individual be scheduled for 20 hours of active treatment per week in order to be rated as met, and during this period, the specific interventions were not incorporated into the IRP. TLC interventions are now included in the IRP through the TLC addendum.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria and the skills necessary for successful community tenure, and how to document this in the IRP. — ***- High Priority*** COS;

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Unit based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions	9/30/2009 (Ongoing)		Gouse
	Status: Ongoing - Updated as of 6/18/2009			
2	Develop examples of needs, objectives and interventions for IRP manual	7/15/2009	IRP manual	Gouse
	Complete			

VII.B.

Compliance Status from DOJ Report: Partial

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

Findings See findings, VII.A and VII.A.1

The IRP Process audit assesses whether the individual is an active participant in IRP planning. Data show that 25% of cases in March, 2009, 91% of cases in April, 2009, 92% of cases in May, 2009 and 85% of cases in June, 2009, the individual was given an opportunity to be an active participant in discharge planning. IRP Process audit results, tab # 9. The updated IPR Manual also provides guidance to treatment teams on this requirement, and a dedicated training was provided to ward staff. On observation, individuals in care vary widely in discharge planning, but in most cases observed discharge was discussed in detail with the individual.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to specific treatment objectives, and how to document this in the IRP. — ***- High Priority*** COS;

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Unit- based training by consultants focusing on engagement of individual and identifying appropriate objectives and interventions			Gouse

2	Develop examples of needs, objectives and interventions for IRP manual	7/15/2009	IRP manual	Gouse
	Complete			

VII.C.

Compliance Status from DOJ Report: Noncompliance

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

Findings See VII.A and VII.A.1

The Hospital reworked the IPR training around recovery planning and discharge/transitions planning, which provided more clarity to staff about the role of recovery planning in effecting discharge. These concepts are also included in the IRP manual for easy reference for ward staff. In addition to being addressed in other IRP training modules, staff were training through a dedicated training module around discharge/transition planning. IRP Training Materials, tab # 1; IRP training data, tab # 2. Staff were trained on the role of discharge goals in each of the focus areas, as well as within each of the treatment, rehabilitation and enrichment services "prongs" in IRPs. Staff were trained in on how the discharge criteria related to the initial clinical formulation, to the IRP itself and how to create criteria that reflect the individual needs. Training occurred in late August, 2009.

This is being assessed using the clinical chart audit. Data from the pilot audit shows that 81% of cases reviewed were rated as adequate in including discharge criteria in each focus area. Clinical chart audit, tab # 11.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

Revise IRP to include a section specifically on Discharge Criteria. — ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise IRP form and operational instructions to include and define discharge criteria in each focus area	7/30/2009	IRP form and instructions, Tab # 5 ; IRP manual	Gouse
	Complete *Status: Operational instructions for IRP are drafted and will be finalized and given to clinical administrators on 7.30.09. - Updated as of 8/27/2009*			
2	Review requirement to address discharge criteria under each focus area	7/9/2009	Clinical administrator meeting agenda, tab #	
	Complete *Status: Reviewed with clinical administrators the need to include discharge criteria under each focus area as they relate to that speciific focus area - Updated as of 7/26/2009*			

VII.C.1

Compliance Status from DOJ Report: Partial

measurable interventions regarding his or her particular discharge considerations;

Findings See VII. C.

Compliance Status: Partial compliance

DOJ Recommendations (Report 3) — ***Responsible Party***

Revise IRP training module as needed to assure that this item is routinely addressed by all treatment teams. — ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise training to include module on discharge	8/31/2009	IRP training curricula, Tab # 1	Gouse
	Complete *Status: Develop specific training module on incorporation of discharge planning into IRP - Updated as of 8/27/2009*			
2	Conduct training with clinical leadership group	8/24/2009	IRP training data, Tab # 2	Gouse; Snyder
	Complete *Status: Training occurred on 8/25/09 - Updated as of 8/27/2009*			

VII.C.2

Compliance Status from DOJ Report: Partial

the persons responsible for accomplishing the interventions; and

Findings See VII. C.

This is monitored through the clinical chart audit, indicator 51 and 53. According to audit results, in 92% of IRPs reviewed during the audit pilot, each intervention included start date, frequency, duration and identified staff member responsible for the interventions; and the interventions specified what the staff will do to assist the individual in achieving his or her objective in 100% of cases reviewed. Clinical chart audit results, tab # 11.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Include this item as part of the clinical chart audit of the IRP. ***- High Priority*** *PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Include discharge criteria in clinical chart audit tool.	7/1/2009	Clinical chart audit tool, Tab # 10	Gouse
	Complete *Status: Completed - Updated as of 6/24/2009*			
2	Analyze and publish results of clinical chart audits	8/31/2009	Clinical chart audit results, Tab # 11	PID

VII.C.3

Compliance Status from DOJ Report: Partial

the time frames for completion of the interventions.

Findings See VII. C. and VII.C.2

Compliance Status: See VII.C.

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Modify IRP training to assure that this item is covered.* ***- High Priority*** *COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VII.C.2			

2 *Develop separate process and content audits for the IRP.* ***- High Priority*** *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop IRP process and clinical chart audit tool and instructions	6/30/2009	IRP process tool/instructions, Tab # 8 ; Clinical chart audit tool/instructions, Tab # 10	Gouse
	Status: Audit tool and instructions drafted, will be tested week of June 15, 2009 and modified by June 30, 2009 - Updated as of 6/18/2009			
2	Train clinical administrators in chart audit tools	6/15/2009	Training for clinical chart auditors, Tab # 48	Gouse
	Complete *Status: Training on tool held on June 11, 2009 - Updated as of 6/18/2009*			
3	Begin audits	6/15/2009		Gouse
	Status: Audit tool and instructions drafted, will be tested week of June 15, 2009 and modified June 30, 2009 - Updated as of 6/18/2009			
4	Report and analyze results, using to improve performance	7/30/2009	IRP Process audit results, Tab # 8; Clinical chart audit tool results, Tab # 11	PID

VII.D.

Compliance Status from DOJ Report: Partial

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

Findings

The Hospital is now providing several transition programs for community placement. First, twenty seven individuals are attending day programming in the community. List of individuals attending day treatment, tab # 79. In addition, 18 individuals have been working with the new Integrated Care provider on returning to the community. (This contract was provided for the last site visit) They are in various stages of transitioning to the community, with 3 targeted for discharge in August, 2009. Others meet with community case managers each week or more often as appropriate, are looking for housing and other supports with the case manager etc.

The Hospital is operating four treatment mall programs based upon the Illness and Recovery Model (TLC I) and the Boston University Rehabilitation Model (TLC II-IV); A treatment mall program (TLC IV) opened in JHP for maximum and medium security individuals. As of August 21, 2009, there were 210 individuals participating in the Treatment mall programs. Number of individuals participating in Treatment Mall by program, tab # 80. The Hospital is using TLC I to target individuals with expected discharge dates in the next ninety days. Each of the other TLCs work toward motivating individuals toward discharge, but do not have the specific transition programming as in TLC 1. Individuals are involved in selecting their groups; the various mall programs operate anywhere from four to six different groups each hour, so individuals have choice in interventions. See Treatment mall schedules and Ward schedules, tab # 69, 101. For individuals who do not attend the treatment mall, there is ward based programming.

The Hospital is implementing a process to monitor fidelity to the TLC curricula. See TLC fidelity process and related documents, tab # 73. It is first being piloted in TLC I (pilot will not include group observations but these will be made part of audit process) and data may be available at the time of the site visit.

In addition, the Hospital instituted a tracking and audit system for those individuals identified as resistive to discharge. See Section VII.E. for more information.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions.* — *Civil; Forensic; PID; COS; Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Meeting with Social work, Occupational Therapy & TLC staff to determine skills. Plan to develop manual based curriculum.			Vidoni-Clark
2	Make available as appropriate transition programs in community.		List of patients who are attending day programs, Tab # 79	JH, CVC

2 *Train auditors to acceptable levels of reliability.* — *PID; Sepehri, Wilhoit, Moore*

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

3 *Provide operational definitions of all terms in a written format to aid in data reliability and validity.* — *PID; Sepehri, Wilhoit, Moore*

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

4 Report as trended data analysis. PID;

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

VII.E.

Compliance Status from DOJ Report: Partial

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

Findings The Hospital implemented a number of initiatives around ensuring individuals are referred to appropriate services in the community. It has updated its discharge instruction sheet, effective July 20, 2009, to provide more detailed information around discharge medications and discharge arrangements. Discharge plan of care, tab # 81. This is given to the individual as well as provided to the outpatient provider, and is used by the Integrated Care Division to monitor discharge services.

Second, the Hospital began tracking progress of those individuals on the resistive to discharge list. See Resistive Patient Tracking form tab # 76. It then developed an audit tool, and conducted an initial audit in July, 2009. See Resistive Patient Audit tool, tab # 77 ; Resistive patient audit tool results, tab # 78. The Discharge Record Audits results show that the Instruction Sheet (old form) was given in 90% of cases during the period of April through June, 2009. Discharge Audit results, tab # 68.

See also Sections VII. C and VII D for additional information.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Develop a method for auditing the social work documentation of follow up meetings on systemic discharge barriers.* ***- High Priority*** *Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement new process with DMH to review resistive patients at least monthly and jointly develop strategies to address identified issues ***Complete***	6/15/2009	Resistive to Discharge Tracking Form, Tab # 76	Sepehri
2	Include strategies in the IRP interventions for the individuals *Status: Ongoing, Start 6-29-09 - Updated as of*	7/1/2009 (Ongoing)	Resistive to discharge tracking Form, Tab # 76	
3	Establish audit tool to evaluate effectiveness of process and success in discharge resistive individuals ***Complete*** *Status: Audit tool and operational instructions completed. Auditing of patients discussed the month of July 2009 will be audited at the end of the month and ongoing for the following months. - Updated as of*	7/21/2009 (Ongoing)	Audit tool for resistive patients, Tab # 77	
4	Revised hospital discharge plan of care sheet/instructions ***Complete***		Revised hospital discharge plan of care instructions, Tab # 81	

2 *Institute a regular clinical case review for those individuals who are ready for but resisting discharge that assures that interdisciplinary collaboration occurs in determining how best to help these individuals transition to a less restrictive level of care.* — ***- High Priority*** *Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement new process with DMH to review resistive patients at least monthly and jointly develop strategies to address identified issues			
	Complete *Status: 6-15-09 discuss new process during Monday Core Service Agency Meeting . 6-15-09 present the "Resistive Patient Tracking Form" to meeting participants for feedback. - Updated as of 6/15/2009*			
2	Establish audit tool to monitor the effectiveness of this process and data to show whether resisitive patients length of stay decreased.	7/13/2009 (Ongoing)	Resistive to discharge tracking audit tool, Tab # 77	
	Complete *Status: 7-21-09 establish audit toolAudit tool and operational instructions completed. Auditing of patients discussed the month of July 2009 will be audited at the end of the month and ongoing for the following months. - Updated as of 6/18/2009*			
3	Train social work staff to discuss with the treatment team during the treatment team meeting that month or at daily clinical rounds (which ever comes first) the startegies identified at the Monday Core Service Agency meeting and ensure implementation of the startegies	6/26/2009	Sign-in sheet from social work training on 6-23-09	
	Complete *Status: By 6-26-09 train social work staff to discuss their role/responsibility process. 6-29-09 social work staff to begin documentation on "Resistive Patient Tracking Form" to monitor effectiveness of the process. - Updated as of 6/18/2009*			
3	Document on "Resisitive Patient Tracking Form" the identified strategies from the Monday Core Service Agency Meeting and place in record	6/15/2009	Resistive to discharge tracking form, Tab # 76	Sepehri
	Complete *Status: 6-15-09 provide spreadsheet listing all resistive patients and those facing barriers to discharge to all meeting participants - Updated as of 6/18/2009*			

3 *Develop a method to document the recommendations and follow up to these reviews in the individual's record.* — *Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Resistive Patient Tracking Form will be placed in Patient's record & social worker will document in monthly updates	6/29/2009 (Ongoing)	Resistive to discharge tracking form, Tab # 76	
	Complete *Status: Ongoing - Updated as of 6/19/2009*			

4 *Develop a method for auditing the above documentation.* — *Sepehri, Wilhoit, Moore*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish audit tool to monitor the effectiveness of this process and data to show whether resistive patients length of stay decreased.	(Ongoing)	Resistive to discharge tracking audit tool, Tab # 77	
	Complete *Status: Audit tool and operational instructions completed. Auditing of patients discussed the month of July 2009 will be audited at the end of the month and ongoing for the following months. - Updated as of 7/21/2009*			

VII.F.

Compliance Status from DOJ Report: Noncompliance

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 Hospital continues to work with the Department of Mental Health to assess needs of discharged patients and effectiveness of services. The Hospital and the ICD within the Authority worked to refine the discharge process so that the Hospital provides sufficient information to enable it to do more detailed auditing of post discharge services. Under the new processes, the information around services in the Hospital Discharge Plan of Care will be entered into the Authority's information system. From there, ICD tracks the length of time until the individual is seen by the outpatient provider, and monitors the services that were identified at discharge as being appropriate and recommended for the individual. Cases will be

reviewed at regular intervals (weekly for first 30 days, monthly for the next 60 days). See Excerpts from the Standard Operating Procedures, Division of Integrated Care, tab # 82. Among the aspects monitored will be treatment, housing, day activity, and community support.

Data are available reflecting the prior audit process, tab # 83, but data are not yet available as this intensified level of monitoring will begin in September/October, 2009, with the addition of a dedicated staff.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Present an overview of the completed monitoring system including audit instruments and key indicators.* — ***- High Priority*** — *PID; Berhow*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft monitoring system overview		Division of Integrated Care SOPs, Tab # 82	Sepehri Berhow

Status: This has been in place since October 2008. Updates and expansion to include all SEH discharges and modification of process related to 4th Care Management position to follow SEH discharges forthcoming. Position was posted and closed. Once staff is in place modification will be implemented with iniital reports expected in September 2009. - Updated as of 8/7/2009

2 *Develop a plan to train auditors to reliability.* — *Berhow*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Care Management staff was trained in October 2008. New hire will be trained once in position.	9/30/2009 (Ongoing)		Berhow

Status: 3 Care Managers already trained, 4th will be trained once hired in August 2009. - Updated as of 8/6/2009

3 *When system is implemented, assure distribution of audit findings to key stakeholders.* — *PID; Berhow*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monthly Reporting	8/7/2009	Care Management Monthly Report found in Division SOPs, Tab # 83	
Complete *Status: Monthly reporting already underway - Updated as of 8/6/2009*			
2 DOJ Specific Monthly Reporting	9/30/2009 (Ongoing)	SEH post discharge report in Division SOPs	

Status: Specific DOJ post discharge report drafted and ready for implementation once 4th Care Manager is in position and trained. Anticipate first report in September 2009. - Updated as of 8/6/2009

VII.F.1

Compliance Status from DOJ Report: Noncompliance

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

DOJ Recommendations (Report 3) — ***Responsible Party***

As part of the overall quality improvement monitoring system referenced in VII.F (above), the Hospital must determine how it is going to effectively monitor this portion of the Agreement. — ***- High Priority*** — *PID; Berhow*

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

1	DMH to expand QA post discharge	6/15/2009 (Ongoing)	Updated Integrated Care Division SOP's, Tab # 82	Sepehri/Berhow
	Status: 4th Care Management position posted and closed, interviews to begin week of 8/10/2009. Position developed to specifically monitor discahrges from SEH and continuity of care. - Updated as of 8/7/2009			
2	1) Meet with DMH-Director of Integrated Care Jana Berhow to discuss the expansion of quality assurance post discharge	6/15/2009		Sepehri/Berhow
	Complete			
3	MHA to revise audit process to ensure it captures all information required by agreement	8/7/2009	Integrated Care Division SOP's, Tab # 82	Berhow
	Complete *Status: Completed eCura events, reports and process flow and procedures as evidenced in updated SOP's for implementation upon hire of 4th care management position - Updated as of 8/7/2009*			
4	First reports expected 30 days after position is in place. Estimate position in place by 8/31/2009	9/30/2009 (Ongoing)		

VII.F.2

Compliance Status from DOJ Report: Substantial

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

Findings See VII. F

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

Utilize staff from the Division of Integrated Care to provide audit data for the quality improvement instruments developed in conjunction with VII.F (above). — *Berhow*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop 4th Care Manager position to monitor dishcarges and report findings		Integrated Care Divison SOPs, Tab # 82	
	Status: Development complete for implementation once position is filled. - Updated as of 8/7/2009			

VIII. Specific Treatment Services

Summary of Progress

1. The Hospital expanded its self-assessment activities. In addition to completing IRP Process observations and review of discharge records, psychiatry, nursing, psychology, social work and rehabilitation services developed audit tools and completed self audits of the one or more types of assessments.

2. The Hospital completed the implementation of its redesigned treatment mall program to make it more individualized and recovery based with a written curricula. There are now four TLCs operating, three on civil side and one at JHP (TLC IV), which serves maximum and minimum security individuals. TLC I serves individuals whose treatment needs are focused on community living skills, and will utilize the Illness and Recovery Model, SAMHSA. TLC II serves those with projected lengths of stay of 12 weeks to 2 years who present with a range of behaviors including impulsiveness, aggression, poor attention span and distraction by psychosis. TLC III serves those whose anticipated length of stay is over 2 years, and will focus on rehabilitation, enrichment, enjoyment and therapeutic learning. TLC II, III and IV are based upon the Psychiatric Rehabilitation Model, Boston University. All programs will have the capacity to serve cognitively impaired and will have expanded substance abuse services. Individuals will be able to choose interventions. All have written curricula.

3. Medical staff completed a series of medication guidelines governing treatment of the elderly, use of mood stabilizers, use of anti-psychotics, polypharmacy, use of STAT medications, benzodiazepines, clozaril and ant-cholinergics.

4. Pharmacy continues its monthly reviews of each individual's medication regimen as well as its review of medical records using an instrument that is designed to evaluate use of high risk medications. The tool was recently modified, instructions developed and audits using the revised tool will begin in September, 2009. Results are presented to Pharmacy and Therapeutics Committee. Pharmacy (approved by the Pharmacy and Therapeutics Committee), revised the medication variance reporting form and process as well as the Adverse Drug Reaction reporting form and instructions. However, reports of ADRs and to a lesser degree, medication variances, are not at the level one would expect in a hospital this size.

5. The new mortality review process was implemented this review period, with and an interdisciplinary review using a sentinel event process for deaths that have occurred this period. External review will be provided by DMH.

6 The Hospital's implementation of positive behavioral support slowed significantly in this review period. While a few behavioral guidelines, structural assessments and one PBS plan were developed, no additional training occurred, and the consultation interrupted due to contract and budget issues. Despite these issues, three positions were identified and approved for recruitment for development of a PBS team; recruitment is underway. Further, it is expected that a contract for the upcoming fiscal year will be in place for renewed consultation with the PBS consultant.

7. Substantial progress has been made in nursing services. Nine nursing procedures were finalized and implemented, including those around key areas such as restraint and seclusion, medication administration, insulin administration and change of shift. Comfort plans were updated for over 90% of individuals and nursing care hours are now being monitored. Staff were redeployed mid August, with a goal of one RN each unit, each shift. Data will be available during the site visit. Two other nursing initiatives are underway. First, each unit will be creating and implementing a provision of care plan for each unit, that the teams work together to develop. Second, a new initiative, EARN is being implemented. This initiative is built on the concept of Hourly rounds used in medical/surgical units. It is first being implemented on RMB 3, and will be expanded to other units throughout the Fall, 2009.

8. The RMB 3 program was completely revised. Fifty percent of individuals who were on the unit in March, 2009 are no longer there, and now individuals with behavioral issues are integrated throughout all the units. RBM 3 has become a unit for those individuals who need more intensive assessment, since they have not responded to traditional therapies. Some individual on the unit attend a TLC for some part of the day, and there are groups on the unit that involve all disciplines and reflect a range of interventions. Key administrative staff positions were filled, and trauma informed care training is underway.

9. The Infection Control Program also made significant progress. The new Infection Control Coordinator revised the infection control manual and included additional procedures around food borne viruses, scabies and lice. He has conducted hand hygiene observations

and is trending data around health care related infections. The Infection Control Committee has been revitalized.

10. An Environmental Survey was completed during this quarter and results provided to the Senior staff, infection control committee, and risk management and safety committee.

11. The Director of Consumer Affairs was hired completed a consumer satisfaction survey. In addition, a consumer handbook was developed, and information around medications is now completed and will be available to consumers.

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

Compliance Status from DOJ Report: Same as in VIA1, VIA2, VIA4, VI5, VIA6a and VIA6c regarding psychiatric assessments; same as in VIA7 regarding psychiatric reassessments

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

Findings See VI.A.1- 7.

The Hospital implemented the revised Comprehensive Initial Psychiatric Assessment and created instructions to accompany it in Spring, 2009; it was activated in AVATAR in July, 2009. Comprehensive Initial Psychiatric Assessment form/instructions, tab # 14. It also revised the Psychiatric Update and created instructions for that as well. Psychiatric Update/instructions, tab # 17. In general, the CIPA is completed within 24 hours as required, but the quality is not consistent, as not all sections are not always being completed. CIPA audit results, tab # 16 . Audit results were shared with the physicians at their regular meeting with the Medical Director. The audits for the Psychiatric Update have not begun as the tool was just finalized, but will begin in September, 2009. Ultimately timeliness will be determined from AVATAR reports, but that data is not yet available. Data from the IRP Process Monitoring Audit suggests the initial assessments are being done timely, but the reassessments are either not completed on the correct form or not being completed at all. However, the IRP process audit is not designed to track this, so implementation of the CIPA and Psychiatric Update audits will be the source of this data in the future.

Compliance Status: Partial

DOJ Recommendations (Report 3)			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 xxx*			*Med; PID; Jana Taylor*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Finalize Psychiatric update form and develop instructions	6/1/2009	Psychiatric Update form and instructions, Tab # 17	Arons
Complete *Status: Psychiatric assessment done within 24 hours and psychiatric updates done before each treatment plan update - Updated as of 6/30/2009*			
2 Continue audits of the comprehensive initial psychiatric assessment. *Status: Ongoing - Updated as of 7/27/2009*	(Ongoing)	CIPA audit results, Tab # 16	Arons
3 Develop audit tool and instructions for psychiatric update ***Complete***	7/31/2009	Psychiatric update audit tool and instructions, Tab # 18	Arons
4 Begin audits of psychiatric updates	8/31/2009		Arons
2 *Same as in VI.A.7.*			*Med; PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.b

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.1- 7.

The Hospital implemented the revised Comprehensive Initial Psychiatric Assessment and created instructions in Spring, 2009, and it was activated in AVATAR in July, 2009. Comprehensive Initial Psychiatric Assessment form/instructions, tab # 13. It also revised the Psychiatric Update and created instructions for that as well. Psychiatric Update/instructions, tab # 17. In general, the CIPA is completed within 24 hours as required, but the quality is lacking, as not all sections are being completed. The audits for the Psychiatric Update have not begun as the tool was just finalized, but will begin in September, 2009. Ultimately timeliness will be determined from AVATAR reports, but that data is not yet available.

Compliance Status: Partial

DOJ Recommendations (Report 3)			Responsible Party
Same as in VI.A.7.			*Med; PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.c

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.1-7

The Hospital implemented the revised Psychiatric Update and created instructions for that as well in July, 2009. Psychiatric Update/instructions, tab # 17. Both forms include sections in which the physician is expected to address any changes in diagnosis and treatment and it is covered in the Psychiatric Update audit tool and instructions. The audits for the Psychiatric Update have not begun as the tool was just finalized, but will begin in September, 2009. Ultimately timeliness will be determined from AVATAR reports, but that data is not yet available.

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

DOJ Recommendations (Report 3)	***Responsible Party***
Same as in VI.A.7.	*Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.d

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.1-7 and VIII.A.1.c

The Hospital implemented the revised Comprehensive Initial Psychiatric Assessment; it was activated in AVATAR in July, 2009. Comprehensive Initial Psychiatric Assessment form/instructions, tab # 14. It also revised the Psychiatric Update and created instructions for that as well. Psychiatric Update/instructions, tab # 17 . Both forms include a section in which the doctor is to address risk and benefits of chosen interventions. In general, the CIPA is completed within 24 hours as required, but the quality is lacking, as not all sections are being completed. CIPA audit results, tab # 16. The audits for the Psychiatric Update have not begun as the tool was just finalized, but will begin in September, 2009.

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

DOJ Recommendations (Report 3)	***Responsible Party***
Same as in VI.A.7.	*Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.e

Compliance Status from DOJ Report: Partial

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.1-7 and VIII.A.1.c.

The Hospital implemented the revised Comprehensive Initial Psychiatric Assessment and created instructions in Spring, 2009, and it was activated in AVATAR in July, 2009. Comprehensive Initial Psychiatric Assessment form/instructions, tab # 14. It also revised the Psychiatric Update and created instructions for that as well. Psychiatric Update/instructions, tab # 17. Both forms include a section on assessment of high risk behavior. Audits if the CIPA were completed in June and July, 2009. Data shows that the risk assessment sections were completed in their entirety in 87% of cases. Where needed, appropriate precautions were identified in 77% of cases. CIPA Audit results, tab # 16. There are no audit results yet for the Psychiatric Update.

Compliance Status: Partial

DOJ Recommendations (Report 3)	***Responsible Party***
Same as in VI.A.7.and VI.A.2.	*Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1 and VI.A.2 action steps	6/1/2009		

VIII.A.1.f

Compliance Status from DOJ Report: Partial

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

Findings See VI.A.1-7.

Both the CIPA and Psychiatric update forms include a section on pharmacological plan of care that includes addressing the risks associated with medication regimen prescribed. The CIPA audit shows that in June, 2009, 83% of CIPAs had an appropriate pharmacological plan of care but only 59% addressed the risks. There are no audit results yet for the Psychiatric Update.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as in VI.A.7.			*Med; PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.g

Compliance Status from DOJ Report: Partial

documentation of reasons for complex pharmacological treatment; and

Findings See VI.A.1-7

Both the CIPA and the Psychiatric Update forms include sections addressing rationale for using complex pharmacological plan of care. The CIPA audit shows that 83% of CIPAs had an appropriate pharmacological plan of care but only 59% addressed the risks of the medication regimen. However, the Psychiatric Update audits have not yet begun, so no data are available.

Currently in AVATAR, physicians are required to select a reason code for prescribing medications or changing medications. Orders are reviewed and verified by Pharmacy, and Pharmacy will contact physicians if there are concerns around drug interactions or other issues. See drug communication data, tab # 88. In addition, Pharmacy continues to implement a medication chart audit process and results are presented to Pharmacy and Therapeutics Committee and to the Medical Director. Medication Chart audit tool/instructions, tab # 65 (Please note the audit results reported reflect this tool, however the tool was revised, and future audits will be conducted using the new tool. See Medication audit tool revised/instructions included in tab #65. The new tool includes additional questions around documentation and whether current medications were titrated to maximum level before new medications were added). The audit reviewed 162 cases over a four month period. Of those cases, 153 involved individuals taking anti-psychotic medication. Of those, 12% (19 patients) were taking three or more anti-psychotic medications. Medication Monitoring Analysis results, Tab # 66. Further, there were 8% or 13 cases where the individual was prescribed 3 or more psychotropic medications within the same class. Within this group, 85% (11 cases) included documentation by the doctor as to the rationale for the medication regimen. Finally, the audit revealed that there was one individual who was prescribed 4 or more psychotropic medications from different classes. The audit finds that the physician of this patient documented rationales for the use of four or more psychotropic medications. The audit results were also shared with physicians at the regular meetings with the Medical Director.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as in VI.A.7.			*Med; PID; Pharm;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		

VIII.A.1.h

Compliance Status from DOJ Report: Partial

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 Use of STAT or PRN medication is to be addressed in the Psychiatric Update, and in the clinical formulations prior to the IRP conference. Psychiatric Update form/instructions, tab # 17; Clinical Formulation Update Form tab # 7. Audits of the Psychiatric Update are not yet underway, but the initial clinical chart audit suggests that 84% of clinical formulations or clinical formulation updates included a description of PRN or STAT medications or use of seclusion or restraint. Tab # 11.

A management report that tracks use of stat and prn medication is available to all medical staff daily. The report was refined to track separately use of psychiatric and medical medications and the Medical Director clarified that no psychiatric medications may be ordered PRN. Email from Medical Director re Use of PRN/Stat medication, tab # 84. Emergency use of psychiatric medications is only through a STAT order. Information is available by ward or physician. A review of the data available shows that for the month of July, 2009, there were 15 patients with five or more STAT administration of psychiatric medications. Of those, nine were on admission units. There was 1 individual with 22 STAT medication orders, and 4 others with 10 or more during the month. PRN/STAT medication report (five or more), tab # 85. There do not appear to be any instances of use of a PRN order for behavioral indications or for general "agitation" since the conversion to AVATAR.

The Hospital is monitoring the use of PRN/Stat medications in several ways. In addition to the above cited report in AVATAR, the Hospital is included an assessment of use of STAT/PRN medication in the medication audits. Medication Audit form/instructions, tab # 65 (Includes prior tool and just revised tool). The Medication audit tool was revised to include a review for physician documentation around repeated use of STAT medications but audit data are not yet available using this tool. Medication Audit form revised/instructions, tab # 65. In addition, the Hospital has developed a monitoring system by which PID will monitor the use of 3 or more STAT medications in a twenty four hour period. See high risk indicator tracking log template, tab # 56. PID will alert the Medical Director for Civil or Forensic of any cases, and will track the results of the Medical Director review. This system was implemented in mid-August, 2009, so data are not yet available.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as in VI.A.7.* — ***- High Priority*** *Med; PID; COS; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Audit the IRP process and conduct clinical chart audits; Publish results	(Ongoing)	IRP process audit results, Tab # 9; Clinical chart audit results, Tab # 11	BG; PID
	Status: Ongoing - Updated as of 7/27/2009			
1	See Vi.A.7 and related action steps; See also VIII.A.1.a recommendation #1	6/1/2009		
2	Modify IRP manual to include review of use of PRN and Stat meds		IRP Manual	
	Complete			

2 *Implement corrective actions to ensure compliance with the requirements regarding the use of PRN/Stat medications.* — ***- High Priority*** *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Develop system for review of PRN and STAT medications.	3/31/2009	Tracking report for high risk indicators, Tab # 56	Hartley; Arons
	Status: System design underway - Updated as of 6/18/2009			
2	Clarify definitions of prn/stat medication with physicians	7/31/2009	Medical director email to physicians re: clarification of stat/prn, Tab # 84	

3 *Develop and implement a clinical chart audit tool to assess compliance with the new template for the psychiatric update. The tool must include indicators to assess the following:* *Med;*

a *Face-to-face assessment of the individual following the administration of Stat medications;*

b *The prescription of PRN medications for specified behavioral indications;*

c *Critical review by practitioners of the use of PRN/Stat medications during the interval, including the circumstances leading to the use, the individual's response and the appropriateness of the medication order;*

d *The adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop clinical chart audit tool and instructions	6/1/2009	Clinical chart audit tool/instructions, Tab # 10	BG

Complete

4 *Provide monitoring data based on 20% sample during the review period.* *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Pilot clinical chart audit tool for 60 days and revise as needed	6/1/2009	Clinical chart audit tool and instructions, Tab # 10	BG

Status: Pilot will include review of one chart each by clinical administrators and discipline chiefs. Will expand to 20% by October, 2009 - Updated as of 6/30/2009

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze and publish audit results	8/14/2009	Clinical chart audit results, Tab # 11	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.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

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.

DOJ Recommendations (Report 3)			***Responsible Party***
Please see sub-cells for findings and compliance.			
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See action steps below			

VIII.A.2.a.i

Compliance Status from DOJ Report: Partial

clinically justified;

Findings See VIII.A.1 around PRN/Stat and Polypharmacy.

The Hospital completed its medication guidelines, which now include guidelines around mood-stabilizing medications, anti-psychotics, use of STAT/PRN medications, use of anti-cholinergics, use of benzodiazepines, treatment of the elderly, clozaril, and polypharmacy. Medication guidelines, tab # 87. The guidelines were reviewed with medical staff and are available on the intranet. Medical staff were involved in their development and they will be updated as necessary.

Medication audits were completed during the months of March through July, 2009, on 162 individuals, using the prior tool. (Auditors reviewed 162 charts of patients on eight wards. The plan is to review all charts from every ward each twelve month period) A new tool is developed and will be implemented in audits beginning in late August, 2009 to September, 2009. Medication audit revised tool/instructions, tab # 65 Among some of the noteworthy findings are:

1) In 12% of cases, there were medications that should have been considered as alternatives given the individual's age or other risk factors;
2) In 9% of cases, there were individuals that had conditions or indications for which medication might be appropriate but were not being used;
3) Fifty five percent (55%) of the 29 Geriatric individuals whose charts were audited are being prescribed medications that can cause delirium;
4) Thirty eight percent (38%) of individuals whose charts were audited are prescribed anti-cholinergic medications;
5) Thirty one percent (31%) of the 62 individuals who are prescribed anti-cholinergic medications have been taking it more than ninety days;
6) Sixteen percent (16%) of those taking anti-cholinergics carry a cognitive disorder diagnosis;
7) Fourteen percent (14%) of those taking Second generations anti-psychotics carry a diabetes diagnosis, 12% have documented evidence that the physician evaluated diabetes risk, and 2% are having their BMI monitored;
8) Thirty three percent (33%) of individuals whose charts were audited are taking benzodiazepines and of those, 21% have been taking them longer than 90 days. Nineteen percent (19%) of those taking benzodiazepines carry a substance abuse diagnosis and 37% carry a cognitive disorder diagnosis.

Medication Audit results, tab # 66.

The Hospital also has researched the issue of pancreatitis relating to use of Depokate, and has developed a protocol consistent with the literature. See Letter to Dr. El-Sabaawi, tab # 86.

Summary data is now available about drug communications from Pharmacy to doctors. See Tab # 103.

Compliance Status: Partial

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).*	***- High Priority***	*Med; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct audits of CIPA and Psychiatric update to evaluate psychopharmalogical plan of care	7/31/2009	Audit form/instructions, CIPA, Tab # 14 ; Audit form/instructions, Psychiatric Update, Tab # 17	Arons
2	Pharmacy to continue with medication audits *Status: Onoing - Updated as of 7/27/2009*		Medication audit results, Tab # 66	Pharmacy
3	Complete medication guidelines **Complete**		Medication guidelines, Tab # 87	Arongs

2 *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* ***- High Priority*** *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Review drug utilization results with psychiatrists and GMO's *Status: Ongoing - Updated as of 6/18/2009*	8/14/2009	Drug utilization review report, Tab # 89	P and T Committee
2	Review medication audit and CIPA audit results with psychiatric staff *Status: Ongoing - Updated as of 7/27/2009*	(Ongoing)	Medication audit results, Tab # 66; CIPA audit results, Tab # 16	Arons
3	Discuss medication guidelines at psychiatric staff meetings and ensure they are available on the intranet *Status: Ongoing - Updated as of 7/27/2009*	8/28/2009 (Ongoing)		Arons

3 *Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).* ***- High Priority*** *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Implement System to flag and report patients in high risk situations to appropriate managers	4/21/2009		hartley
1	Develop and implement monitoring tools with indicators and operational instructions for new generation antipsychotic medications. **Complete**		Medication chart audit tool and instructions, Tab # 65;Medication chart audit results, Tab # 66	Anand
2	Develop and implement monitoring tools with indicators and operational instructions for polypharmacy.		Medication chart audit tool and instructions, Tab # 65 ; Medication chart audit results, Tab # 66	Anand
4	Develop and implement monitoring tools with indicators and operational instructions for anticholinergic medications.		Medication chart audit tool, Tab # ; Medication chart audit results Tab #	Anand

5 Develop and implement monitoring tools with indicators and operational instructions for benzodiazepines.		Medication chart audit tool and instructions, Tab # 65; Medication auidt results, Tab # 66	Anand

4 Provide monitoring data regarding high risk medication uses, based on at least a 20% sample during the review period. *PID; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Pharmacists will monitor individuals on high risk medication regimens to make sure risk/benefit is documented in record	(Ongoing)	See prior action steps	Zerislassie
Status: Ongoing - Updated as of			

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

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Analyze and publish results	8/14/2009	Medication audit results,Tab # 66	PID

VIII.A.2.a.ii

prescribed in therapeutic amounts, and dictated by the needs of the individual;

Findings Same as above

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Same as above. *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above	6/1/2009		

VIII.A.2.a.iii

tailored to each individual's clinical needs and symptoms;

Findings Same as above

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Same as above. *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above	6/1/2009		

VIII.A.2.a.iv

meeting the objectives of the individual's treatment plan;

Findings Same as above.

Compliance Status: Partial

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 same as above	6/1/2009		

VIII.A.2.a.v

evaluated for side effects; and

Findings Same as above.

Compliance Status: Partial

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above	6/1/2009		

VIII.A.2.a.vi

documented.

Findings Same as above.

Compliance Status: Partial

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above	6/1/2009		

VIII.A.2.b

monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:

Findings Same as above

Compliance Status: See sub cells.

DOJ Recommendations (Report 3)	*Responsible Party*
Same as above.	*Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Same as above	6/1/2009		

VIII.A.2.b.i

Compliance Status from DOJ Report: Partial

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 finalized for use of benzodiazepines, anti-psychotics, mood stabilizing medications, polypharmacy, clozaril, anti-cholinergics, STAT medications, and medications use for the elderly. Medication guidelines, Tab # 87 . The guidelines are on the intranet, are reviewed with physicians during regular medical staff meetings and are updated as needed.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Finalize and implement individualized psychotropic medication guidelines that address Other Findings 1-4 by this consultant above.* ***- High Priority*** *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Medication guidelines to be finailzed. ***Complete***	7/31/2009	Medication guidelines,Tab # 87	Anand
2	Review guidelines with the Medical Staff	8/21/2009		Arons
3	Publish guidelines on the intranet.	8/24/2009		Arons, Perry

2 *Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.* ***- High Priority*** *Med; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Each monthly meeting of psychiatrists includes a discussion of one of the medication guidelines in rotation to assure continual updating based on professional practice, current literature, and relevant clinical experience at the Hospital.	6/1/2009		Arons

Status: Under continual and steady implementation. - Updated as of 6/25/2009

VIII.A.2.b.ii ***Compliance Status from DOJ Report: Partial***

develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of

Findings See sub-cell VIII.A.1.h.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Same as in VIII.A.1.h. *Med; PID;*

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

VIII.A.2.b.iii ***Compliance Status from DOJ Report: Partial***

establish a system for the pharmacist to communicate drug alerts to the medical staff; and

Findings The Pharmacy has the capacity and is communicating drug alerts to physicians. In addition, the Hospital developed a tracking system and is aggregating and categorizing those alerts in a systemic manner. Summary of Drug Alert Information, tab # 88. This information is presented to the Pharmacy and Therapeutics Committee on a regular basis Drug alerts are also available on the Hospital's intranet. Between February, 2009 and August 4, 2009, there were a total of 22 drug alerts, including 18 safety alerts and 4 recalls. Information on drug alerts is presented to Pharmacy and Therapeutics Committee.

Compliance Status: Substantial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Present aggregated data regarding all drug alerts that were communicated by the Pharmacy Department to the prescribing practitioners.* *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop system to collect data on drug alerts.	7/31/2009		
	Complete *Status: Complete - Updated as of 6/25/2009*			
2	Submit data on drug alerts to P and T committee			Zerislassie
	Complete *Status: done monthly - Updated as of 7/31/2009*			
3	Placed on the Intranet for all prescribers to have access to			
	Complete			

2 *Present documentation of review by the P&T Committee of drug alerts.* *Med; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Share Drug Alert Summary with P&T committee members and discuss the particular effect that the alerts had with our patient. Will continue at Monthly P&T meetings.	(Ongoing)	P and T Committee meeting minutes, Tab # 90	Arons
	Complete *Status: Ongoing - Updated as of 6/25/2009*			

VIII.A.2.b.iv ***Compliance Status from DOJ Report: Partial***

provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.

Findings

Medication Variances:

The Hospital revised its Medication Variance policy, form and process and developed instructions to aid staff in completing the form. Medication Variance Reporting and Assessment Policy, tab # 91; Medication variance reporting form/instructions, tab # 92. Under the revised policy, staff who discover the medication variance must complete the medication variance incident report form, page one, and submit it to Pharmacy. The Pharmacy then reviews the report, and assigns the matter to the appropriate discipline chief depending on the type of variance to complete an assessment of the event. The individual reviews the matter, identifies critical breakdown points and contributing factors and then completes Part II of the form, and returns it to Pharmacy. The assessment evaluates the type of variance (prescribing, transcribing/documentation, dispensing/storage, administration, procurement, or other - more than one can apply and there are subparts, i.e., security is part of other) and the contributing factors (communication, dispensing/storage or administrative systems, information systems or environmental factors, human factors and product issues, again there are subcategories). Each quarter, Pharmacy presents an analysis of the medication variances to Pharmacy and Therapeutics Committee. The new policy and form were finalized in July, 2009. In addition, Hospital policy requires the completion of a root cause analysis when the variance resulted in some harm to the individual in care. The new reporting requirements are on the intranet. It is being phased in, first with the physicians and pharmacy, and will be used Hospital wide beginning in September, 2009.

Data relating to Medication variances is presented monthly to Pharmacy and Therapeutics Committee, and reflects a 10 month period (fiscal year); included is trends by ward, type of variance, and number of variance. Reported variances range from a high of 80 in February, 2009, to a low of 15 in November, 2008. Thirty nine were reported in July, 2009. Pharmacy and Medication Monthly report (8/11/09), tab # 93. Data shows that 56% of errors were prescribing errors, 17% were administration or transcribing/documenting errors, 7% dispensing errors, and 3% monitoring errors. (Note, the report reflects the prior reporting system. As the new reporting system is introduced, data reports will be modified to reflect the new system). Six errors reached the individual but did not cause harm, and one reached the individual and required monitoring to determine no harm was done.

The Risk Manager conducted an intensive case analysis into a medication variance when anti-seizure medication was abruptly discontinued. The results were presented to the P and T committee, and recommendations were made. Tab # 100.

Adverse drug reports:

Despite training and campaigns to increase reporting, it is clear many ADRs continue to go unreported. The Hospital is modifying its ADR reporting form and is developing instructions in reporting. ADR Reporting form/instruction, tab # 94. The form is structured like the MVR form, with a section completed by the Reporting, and a second section that is completed by the individual who is reviewing the incident. The form requires the reporting to report general identifying information, as well information about the description of the reaction to include any relevant history, medications suspected/involved, seriousness of the reaction, level of care required to address the reaction, and actions taken by the reporter. There is also an assessment section, which is to be completed by the individual who reviews the reported incident. It will include the detection method (how discovered), reaction summary, probability causality assessment, preventability assessment, body systems involved, medication involved, pertinent medication history, actions taken to avoid future reactions, outcome of reaction and reporter level of staff.

The newly ADR form was developed but is not implemented as of the writing of this report but is anticipated to be implemented in September, 2009. Therefore information what will be available in the future is not yet available to be reported on or trended. Further, the low number of ADR reports makes trending of data difficult. Tab # 102.

Pharmacy is monitoring the failure to report ADRs through the medication chart audits, and not surprisingly data is indicating that possible ADRs are going unreported. In every incident that an ADR was identified through the chart audits, there was not a single incident of an ADR report being submitted. Medication Chart audit results, tab # 66.

Drug Utilization:

The Hospital's conducted one drug utilization review this review period, electing to study individuals taking cogentin, Benadryl or Artane and who have a diagnosis of cognitive disorder, tardive dyskinesia, or dementia. Drug Utilization Review, tab # 89. Fourteen individuals on eight different wards were identified as fitting the study parameters.

Mortality Review Process:

The Hospital modified it mortality review process to provide for investigation by the Risk Manager, Review by the Mortality Review Committee, as well as review by an interdisciplinary review panel through a sentinel event review process. External review will be completed by DMH or specific contractors. The policy was revised to include recommendations by DOJ. Patient Death Review policy tab # 95. The deaths of four individuals were reviewed this rating period.

Compliance Status: Partial.

DOJ Recommendations (Report 3)	***Responsible Party***
1 *Adverse Drug Reactions: Present summary information to address the following:*	***- High Priority*** *Med; PID; Pharm;*
a Development of written instructions to guide staff in the proper use of the data collection tool;	
b Number of ADRs reported during the review period compared with the number during the previous period;	
c Classification of ADRs by outcome category compared with the number during the previous period.	
d Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;	

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

f *Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise ADR form and develop instructions	8/17/2009	Revised ADR form,Tab # 94	Zerislassie
	Status: Have met with Prescribers to get input on format of revised form. - Updated as of 7/31/2009			
2	Train staff on new ADR forms	8/24/2009		Pharmacy

2 *Drug Utilization Evaluation (DUE):* ***- High Priority*** *Med; Pharm;*

a *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.*

b *Perform DUEs and present a summary outline of the following:*

c *Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends and provide a summary of corrective/educational actions taken to address these trends/patterns.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Identify subject for DUE	7/10/2009		P and T Committee
	Complete *Status: Report of cases fitting subject is underdevelopment - Updated as of 6/25/2009*			
2	Analysis of Data and Summary	8/10/2009	DUE review report, Tab # 89	P and T committee
	Status: Not begun yet waiting on report to be completed - Updated as of 6/25/2009			
3	Present recommendation at August or Sept P&T meeting	8/12/2009		

3 *Medication Variance Reporting (MVR): Present summary information to address the following:* ***- High Priority*** Med; Pharm;

a *Revisions of the data collection tool to ensure:*

b *Development of written instructions to assist staff in the proper use of data collection tool;*

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

d *Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;*

e *Clinical information regarding each variance (category E or above) and the outcome to the individual involved;*

f *Information regarding any ICA conducted for each reaction that was classified as category E or above and for any other reaction; and*

g *Outline of ICAs, including description of variance, recommendations and actions taken.*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise tool and develop instructions ***Complete***	7/3/2009	MVR reporting form/instructions, Tab # 92	Zerislassie
2	Train staff on new tool *Status: Inservice/presentations will be provided at various discipline meeting. Form and guideline will be placed in annual training schedule with Training and Education department - Updated as of 7/31/2009*	8/13/2009		Zerislassie
3	Revise data report and present data to P and T committee. ***Complete***	7/6/2009		PID, Zerislassie

4 *Mortality review: Ensure that the revised policies/procedures regarding mortality reviews address the following:* ***- High Priority*** *PID; Jana Taylor*

a The integration of the special investigator's report regarding possible abuse/neglect by staff as a contributing factor in the first level review.

b The performance of an independent external medical mortality review and the integration of information from this review in the final level interdisciplinary review.

c Tracking mechanisms to ensure that interdisciplinary 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 Mortality review policy	8/14/2009	Revised patient death review policy, Tab # 95	Jana taylor
Complete			
2 Implement new policy around death reviews	(Ongoing)		
Status: Ongoing - Updated as of 7/27/2009			

VIII.A.3

Compliance Status from DOJ Report: Partial

By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.

Findings The Hospital continues to be successful in recruiting psychologists and psychiatrists. Four psychiatrists were hired in July, 2009. See list of hiring, tab # 96. Two psychologists were hired to fill vacancies created by retirements or resignation, with one starting 8/24 and one 9/15.

However, despite this success, the Hospital is not meeting required caseload ratios for psychiatrists, in part due to several incidence of long term medical leave. Data as of July 29, 2009 show on 10 of 17 units (including three of five admission units), caseload ratios are met. On three units, he caseload exceeds the standard by one individual and on another unit, the caseload ratio is exceeding standards by two. One JHP admissions unit exceeds caseload ratios by 3 respectively; on another unit, the psychiatrist is on medical leave, and a psychiatrist has been assigned to cover that unit - between that unit and his own unit, he is responsible for 43 patients. Caseload Summary Chart, tab # 37.

Although there are no specific requirements of caseloads for psychologists, there currently are thirteen psychologists (not including clinical administrators who are also psychologists), one half time neuropsychologist and two supervisors. Each ward is supported by a psychologist. List of Psychologists tab # 39; Psychology staff ward assignments, tab # 43. One additional psychologist has been selected, and are expected to start by September 15, 2009.

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

DOJ Recommendations (Report 3) ***Responsible Party***

Ensure compliance with this requirement in all acute care and long-term care units in the facility. ***- High Priority*** *Med; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Hiring of psychiatrists to meet recommendations.	6/30/2009	List of psychiatrists by ward and board certification, Tab # 37	Arons
Status: Recruitment of psychiatrists is ongoing. - Updated as of 6/30/2009			

VIII.A.4

Compliance Status from DOJ Report: Same as in VA2e and VIA7

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.

DOJ Recommendations (Report 3)			*Responsible Party*
Same as in V.A.2.e and VI.A.7.			*Med; COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as in V.A.2.e and VI.A.7.	6/1/2009		

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. Progress on PBS plans somewhat stalled during this review period, but some minimal progress has been made. Only a handful of behavior guidelines and PBS plans have been completed and those are just being implemented. A video of an overview of PBS has been watched by 37.4 % of staff. Modifications have been made to psychology reports so that it is clear when the results were shared with the treatment teams/treating psychiatrists. Integration of psychiatric and behavioral treatments is addressed in the Psychiatric Update recently implemented as well as in the clinical formulation update and IRP.

The Hospital is recruiting for a PBS team. The PBS team leader position is advertised as are two PBS technician positions. PBS team position descriptions, tab # 40. Recruitment was delayed due to the District's overall budget issues, but authority was granted to recruit for these positions in late July, 2009, and they were immediately advertised. To date, there have been no qualified candidates that have applied for the PBS team leader, so consideration is underway to increase the grade level for the position. In addition, hiring of the PBS technicians may be delayed somewhat so that the team leader can be involved in the selections.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as above.			*Med;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as above.	6/1/2009		
Status: No behavioral plans exist at this time. Psychiatrist will be required to acknowledge receipt of plans and determine if they are consistent with psychiatric formulations. - Updated as of 6/30/2009			

VIII.A.4.b

ensure regular exchanges of data between the psychiatrist and the psychologist; and

Findings Same as above.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
Same as above.			*Med;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Psychologist and psychiatrist to both attend all treatment planning meetings to assure meaningful discussion about integration of psychiatric and behavioral modalities.	6/1/2009	IRP process audit results, Tab # 9	Arons

VIII.A.4.c

integrate psychiatric and behavioral treatments.

Findings Same as above

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
Same as above.			*Med;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Psychiatric and behavioral interventions to be integrated.	6/1/2009	IRP process monitoring results, Tab # 9	

VIII.A.5

Compliance Status from DOJ Report: Same as in VIA7 and all subsections of VIIIA1 and VIIIA2

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: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.			*Med; PID; Pharm;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Pharmacy to conduct monthly reviews of all patients medication regimens ***Complete***	6/1/2009	Pharmacy and medication monthly report, Tab # 93	Pharmacy, Therapeutics committee.
2 Pharmacy to conduct monthly record audits of 4-50 records and report results ***Complete*** *Status: Ongoing - Updated as of 7/31/2009*		Pharmacy and medication monthly report, Tab # 93	Pharmacy, PID

VIII.A.6

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.

Findings A substance abuse screening is included in the new Comprehensive Initial Psychiatric Assessment (CIPA) and in the Psychiatric Update. Comprehensive Initial Psychiatric Assessment, tab # 14; Psychiatric Update, tab # 17. The IRP includes a specific focus area relating to substance abuse, and incorporates stage of change principles. IRP Form/instructions, tab # 5. Stage of change also has been a focus of IRP training. IRP training materials, tab # 1. The IPR instructions and IRP manual also provide guidance on completion of the substance abuse related focus area in the IRP, including framing of needs and outcomes, objectives that reflect the individual's stage of change as well as interventions.

Audits of the CIPA are looking at whether a substance abuse assessment is being completed. Data is available from two months, June and July, 2009 and show that in 82% of cases, the substance abuse section of the CIPA was completed. It also showed that the stage of change identified in the CIPA aligned with the substance abuse assessment in 75% of cases. CIPA Audit results, tab # 16. The clinical chart audit tool, piloted in July - August, 2009, also looked at whether the results of the substance abuse assessment/treatment was included in the clinical formulation or clinical formulation update. The audit found it was addressed in 81% of the clinical formulations reviewed. Clinical chart audit results, tab # 11.

Thirty seven staff at the Hospital have completed substance abuse training to lead groups and 18 are leading groups while an additional 8 are in group leadership training. Substance abuse services are being provided to 29 in TLC 1, 24 in TLC II and 48 in TLC IV.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Ensure implementation of substance recovery services consistent with the transtheoretical model of change.* *Med; Chief Substance Abuse Services*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include substance abuse screen in the CIPA, IPA and SWIA forms	6/1/2009	CIPA form/instructions, Tab # 14; IPA form/instructions, Tab # 19; SWIA forms/instructions Tab # 31	Arons, Sepehri
Complete			
2 Ensure TLCs and unit schedules include substance abuse groups.		TLC schedules, Tab # 69, TLC curricula	Vidoni-Clark; Henneberry

2 *Ensure that substance abuse self-assessment indicators also address the following:* *Med; COS; Chief Substance Abuse Services*

a *There is at least one objective related to the individual's stage of change;*

b *The interventions are appropriately linked to the objective and are aligned with the Mall schedule; and*

c *The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement Comprehensive initial psychiatric assessment includes detailed substance abuse screening	6/1/2009	CIPA form and instructions, Tab # 14	Arons
Complete			
2 Implement audits of CIPA and provide results		CIPA audit results, Tab # 16	Arons; PID
Status: Ongoing - Updated as of 7/27/2009			

3 *Provide monitoring data based on at least a 20% sample during this review period. The data should include and initial screening and the IRP management of substance use disorders.* *Med; PID;*

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

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

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

VIII.A.7

Compliance Status from DOJ Report: Partial

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 Audits of individuals with tardive dyskinesia were conducted in June and July, 2009. TD audit tool/instructions, tab # 63. Experience during the audits suggested that the tool requires some changes, and a new tool was developed for audits going forward. TD Audit tool/instructions revised, tab # 63. Data from the initial audit shows that 74% of those with TD diagnosis received AIMS test on admission or annually but only 36% received AIMS test twice a year, 57% had evidence of a consultation with neurology, 50% evidenced a consideration of which medication should be prescribed, 43% had TD related interventions in the IRP and 57% included monthly justification for use of anti-psychotic medication. TD audit results, tab # 64.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Develop and implement corrective actions to address the deficiencies outlined by this consultant regarding the monitoring and management of individuals suffering from TD.* ***- High Priority*** *Med; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 64	6/1/2009	Management report, persons with Diagnosis of TD, Tab # 97	Arons
Complete			
2 Implement TD audits including evaluation of whether AIMS test is completed according to policy.	7/31/2009	TD audit results, Tab #	Arons
3 Implement psychiatric update form that includes assessment of abnormal movements.	7/31/2009	Psychiatric Update form/instructions, Tab # 17	Arons
4 Ensure TD is addressed in IRP		IRP manual	Gouse, Arons
Status: Ongoing - Updated as of 7/27/2009			

2 *Implement the self-auditing tool for TD.* ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement TD self audit tool	6/1/2009 (Ongoing)	TD audit tool and instructions, Tab # 63	Arons
Status: Ongoing - Updated as of 6/26/2009			
2 Report TD audit results	8/14/2009 (Ongoing)	TD Audit results, Tab # 64	Arons, PID
Status: ongoing - Updated as of 7/27/2009			

3 *Provide monitoring data based on a review of a 100% sample during the review period.* *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Audit cases of persons with diagnosis of TD; Chart of each person with diagnosis shall be reviewed at least quarterly	6/1/2009 (Ongoing)	TD audit results, Tab # 64	Arons
Status: Ongoing - Updated as of 6/26/2009			
2 Continue to update AVATAR diagnosis database to reflect accurate diagnoses on Axis I	6/1/2009	Management report, persons with Diagnosis of TD, Tab # 97	

4	*Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*		*PID;*	
	Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
	1 Anaylze results and publish report	8/21/2009	TD audit results, Tab # 64	PID

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

During the prior review period, the Hospital took key steps in developing positive behavioral support through enhanced psychological and ward based services; progress did not continue at the same pace during the most recent review period, though some progress was made. The Hospital completed 3 structural assessments, 0 functional assessments, 2 behavioral guidelines, and 1 PBS plan and weekly behavioral notes. At least one additional plan is expected to be completed by mid September.

In addition, the Hospital is establishing a separate PBS team that will provide services and support hospital wide. Recruitment is underway for a PBS team leader (psychologist), and two PBS technicians (these may be deferred to allow the team leader to be involved in the selection process). Positions Descriptions have been developed, and the positions announced. PBS team Position Descriptions, tab # 40; PBS position vacancies, tab # 41. While recruitment continues, a psychologist has been detailed to complete PBS plans on RMB 3.

Some psychology staff received additional training through a local university, and 37% of staff completed the PBS overview training provided by a consultant. However, contractual and budget issues delayed a new contract with the consultant, and consequently, the Hospital did not receive any additional support from the consultant since the last DOJ visit. The Hospital is working with her to enter into contract in the upcoming fiscal year, FY 2010.

The Hospital implemented recommendations around the reconfiguration of RMB 3. It is no longer a behavior management unit. It is now a unit for more intensive assessment and treatment for individuals who have not stabilized on other units; individuals assigned to the units do not necessarily exhibit serious behavioral issues. See letter from Ellen Efros to Shanetta Cutler, August 14, 2009, tab # 98. The Hospital changed the individual profile on RMB 3, integrating individuals on RMB 3 with more acute behavioral issues to other units. Almost fifty percent of patients on the unit at the time of the DOJ visit have been transferred to other units or discharged. Tab # 99. There are currently six patients on RMB 3 for whom PBS plans are needed; it is expected that 2- 3 PBS plans will be completed by the time of the DOJ visit. A full time clinical administrator and nurse manager were assigned to the unit, and a number of patients attend the TLCs at least part-time or are attending DD programs in the community. Pharmacy makes regular rounds to provide consultation services. A full array of groups led by all disciplines are available on the unit for those who cannot attend the TLC for all or part of a day. It is also implementing a new initiative, (EARN - engage, assess, reassure/reorient, meet needs) and training of staff began in late July, 2009. A psychologist has been identified for the unit (to start mid September), so the other psychologist has been detailed to the PBS team leader position pending a selection. Trauma informed care training is on-going on the unit, and comfort items are available. Finally, the Hospital is entering into a contract with a consultant to provide technical advice around the program on RMB 3.

Compliance Status: Partial

VIII.B.1.a

Compliance Status from DOJ Report: Noncompliance

ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment re

Findings See VIII.B.1

There are currently 13 psychologists in the psychology department and 1 part time neuropsychologist (who has 4 externs, 3 interns and 2 post-doctoral candidates working with him), excluding supervisors and clinical administrator psychologists. Psychologists are completing Initial Assessments for all admissions which include a behavioral intervention screen. Initial Psychological Assessment, parts A and B/instructions, tab # 14. Psychology also developed and is using a audit tool to evaluate the completion of the IPA. IPA Audit tool/instructions, tab # 15 . Results the audit show that 92% of individuals are assessed within 4 days of admission. IPA audit results, tab # 21. Recruitment is underway for the PBS team leader and two PBS support technicians. Only one PBS plan has been completed and implemented. Please note that the IPA tool has not been modified to include a specific reference to head trauma because it is already in development for AVATAR. However, IPA instructions now require the assessing psychologist to address head trauma in the history section. It also has been added to the IPA audit tool instructions, effective with September 2009 audits.

No new behavior plans incorporate seclusion or restraint.

Compliance Status: Partial

DOJ Recommendations (Report 3)	***Responsible Party***
1 *Discontinue the process of transferring to RMB 3 those individuals in need of PBS plans and provide that service on the ward on which the individual currently resides.*	***- High Priority*** *Civil; CEO*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	PBS Team will be formed and PBS plans and guidelines will be developed and implemented	8/14/2009	PBS team PDs, Tab # 40; PBS vacancy announcements, Tab # 41	Gontang; Arons; Seymour
	Status: PDs have been developed for PBS team leader and PBS specialists. Recruitment underway - Updated as of 6/18/2009			
2	Plan formulated for redesign of RMB 3 by workgroup of clinical executives. Plan to be circulated to staff	4/30/2009	Letter to DOJ outlining changes to RMB 3, Tab # 98	Vidoni-Clark
	Status: RMB 3 re-configured from behavioral management unit to a continuing care unit for patients who require more in-depth assessment & intervention. 50% change in patient population since last DOJ visit. Staff changes as well. - Updated as of 6/18/2009			
3	Patients who require PBS plans are no longer routinely transferred to RMB 3		Letter to DOJ outlining changes to RMB 3, Tab # 98	Vidoni-Clark
4	Unit is structured around small group programming & incorporates the full integration of all disciplines. Patients receive 5 group interventions per day & daily afternoon outdoor exercise.		Letter to DOJ outlining changes to RMB 3, Tab # 98	Vidoni-Clark
4	Full time Clinical Administrator & Nurse Manager appointed to unit		Letter to DOJ outlining changes to RMB 3, Tab # 98	Vidoni-Clark Hartley

Complete

2 *Free the PBS psychologist from unit/ward/treatment team duties as the first step in developing a stand-alone PBS service. Fill out the PBS team with the addition of at least one RN and two PNAs.* ***- High Priority*** *Med; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Establish PBS team to serve as consultants to entire hospital to include psychologist, two positive behavioral specialists and data staff		PBS PDs, Tab # 40 ; Vacancy Announcement Tab #41	Arons; Gontang
Status: Meeting was held with HR to create PDs for PBS team leader and positive behavioral support specialists. PDs developed, awaiting approval of CA to proceed with recruitment - Updated as of 6/18/2009			

3 *Within the next 6 months, transfer at least 50% of those individuals on RMB 3 due to the need for more intensive behavioral treatment to other units and provide the behavioral treatment on those units.* ***- High Priority*** *CEO*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
A PBS Team will be formed and PBS plans and guidelines will be developed and implemented	5/18/2009	PBS PDs, Tab # 40 ; Vacancy Announcement Tab #41	Arons; Gontang
Status: Meeting was held with HR to create PDs for PBS team leader and positive behavioral support technicians. PDs developed and posted. - Updated as of 6/18/2009			
Plan formulated for redesign of RMB 3 by workgroup of clinical executives and RMB 3 staff. Plan to be circulated to staff.	4/30/2009		Vidoni-Clark
Status: Overview of RMB-3 will be discussed in September clinical leadership meeting - Updated as of 6/18/2009			
3 Tranfer 50% of those patients who were on RMB 3 at time of DOJ visit off unit	7/31/2009	Patient rosters, RMB 3 March, 2009 and July, 2009, Tab # 99	CVC

Complete

4 *Within the next 6 months, develop PBS plans for at least 50% of the remaining individuals on RMB 3 who are in need of intensive behavioral treatment.* ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
A PBS Team will be formed and PBS plans and guidelines will be developed and implemented	5/18/2009	PBS PDs, Tab # 40 ; Vacancy Announcement Tab #41	Arons; Gontang
Status: Meeting was held with HR to create PDs for PBS team leader and positive behavioral support specialists. PDs developed, awaiting approval of CA to proceed with recruitment - Updated as of 6/26/2009			
Plan formulated for redesign of RMB 3 by workgroup of clinical executives and RMB 3 staff. Plan to be circulated to staff.	4/30/2009		Vidoni-Clark
Status: Overview of RMB-3 will be discussed in September clinical leadership meeting - Updated as of 6/26/2009			

VIII.B.1.b ***Compliance Status from DOJ Report: Partial***

ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the indiv

Findings See VIII.B.1

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Continue training with consultant.* ***- High Priority*** *COS;*

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

1 Idenfity funding for extension/expansion of contract with consultant	9/30/2009		Canavan
Status: Funds not yet identified - Updated as of 7/27/2009			
2 Issue new contract with consultant for continued services	9/30/2009		Feinberg

2 *Implement a significant number of Behavior Guidelines and PBS plans.* ***- High Priority*** *Civil;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Provide additional training to nursing and psychiatric staff			Arons; Gontang
Status: Awaiting contract with consultant - Updated as of 6/18/2009			
Provide additional training to psychologists			Arons; Gontang
Status: Awaiting contract with consultant - Updated as of 6/18/2009			
3 Psychologist to complete development of at least 3 PBS plans for designated patients on RMB 3			Arons; Gontang

3 *Present quantifiable and trended data on all auditing of behavioral interventions.* *Med; Psychology,CIA*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop presentation model so that when audits are done, reports can be presented with quantifiable and trended data.	8/31/2009		
2 Obtain new contract with consultant to aid in auditing behavioral interventions	8/31/2009		

VIII.B.1.c

Compliance Status from DOJ Report: Partial

ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;

Findings See VIII.B.1

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Continue training with consultant.* ***- High Priority*** *Med; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Obtain new contract for services with consultant: identify funding and contractual mechanism	8/31/2009		Canavan; Seymour

2 *Refine token economy process so that it is in line with current best practices.* ***- High Priority*** *Civil;*

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

3 *Present quantifiable and trended data on all auditing of behavioral interventions.* *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, VIII.B.1.b			

VIII.B.1.d

ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment re

Findings See VIII.B.1.

There are currently 13 psychologists in the psychology department and one neuropsychologist, excluding supervisors and clinical administrator psychologists. The neuropsychologist is assisted by 4 externs, 3 interns and 2 postdocs. Psychologists are expected to attend IRP meetings, but vacancies has adversely affected attendance. One additional psychologist is scheduled to start about September 15, 2009.

Psychologists are completing Initial Assessments for 92% of admissions within 4 days. IPA Audit results, tab # 21. Part B of the IPA (which is either completed with Part A, or within 11 days of admission depending on the individual) includes a behavioral intervention screen; audit results show that in 100% of cases, the behavioral intervention screening was completed, the behavioral observations were completed in 96% of cases and the appropriateness for behavioral plans section was completed in 100% of cases. IPA Audit results, tab # 21. Finally, the audit results show that in 100% of cases, the recommendation section was completed, and in 86% of cases, the recommendations were specific.

Compliance Status: Partial

VIII.B.1.e

Compliance Status from DOJ Report: Partial

ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and

Findings See VIII.B.1.

Psychologists have been trained in completing a behavioral progress note. Behavioral progress notes were completed in the PBS plan that was developed and implemented. The BCC has not been implemented.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Include monitoring data about progress notes in auditing data discussed in Cell VIII.B.1.c (above).* — *Med; PID; COS;*

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

2 *Implement training of unit staff on any unit that has an individual receiving intensive behavioral treatment interventions.* — ***- High Priority*** *Civil; COS; Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Contract with consultant for additional services; identify funding	8/31/2009		Canavan; Seymour

3 *Implement the BCC in consultation with training/consultation provided by Angela Adkins.* — ***- High Priority*** *Med; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop position descriptions for PBS team leader and PBS technicians	6/1/2009	PBS PDs, Tab # 40	Gouse
Complete *Status: Position descriptions developed - Updated as of 7/26/2009*			
2 Ensure posting of vacancy announcements	7/1/2009	Vacancy announcements for PBS teams, Tab # 41	Gouse
Complete *Status: Vacancy announcements posted. - Updated as of 7/26/2009*			

VIII.B.1.f

Compliance Status from DOJ Report: Noncompliance

ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs.

Findings See VIII.B.1.

There are currently 13 psychologists in the psychology department and one part time neuropsychologist, excluding supervisors and clinical administrator psychologists. An additional psychologist has accepted an offer and will begin work by September 15, 2009. Recruitment is also underway for a PBS team leader (psychologist) who will not have ward based responsibilities.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Assure that the PBS service is a stand-alone service, whose psychologist does not also have unit/ward/treatment team responsibilities.* ***- High Priority*** *Med; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Establish PBS team to serve as consultants to entire hospital to include psychologist, two positive behavioral specialists and data staff		PBS PDs, Tab # 40 ; Vacancy Announcement Tab #41	Arons; Gontang

Status: PDs and vacancy announcements completed. RMB 3 ward psychologist removed from all duties other than those relating to developing PBS plans for patients on her ward. - Updated as of 6/18/2009

2 *Continue to recruit and hire psychologists so that there is at least one psychologist per ward/treatment team.* ***- High Priority*** *Med; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue recruitment and hiring of psychologists.	6/1/2009 (Ongoing)		

Status: Recruitment underway for two psychologists. One ward, (CT 3) has closed. - Updated as of 8/28/2009

VIII.B.2

Compliance Status from DOJ Report: Partial

By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.

Findings

The Hospital fully implemented the redesign of the treatment mall; there are three TLCs on the civil side serving 148 individuals (including some minimum security JHP patients), and one at JHP serving 62 maximum and medium security patients. List of TLC census, tab # 80. Twenty seven patients attend day programming in the Community. Tab # 79. Individuals complete a one week orientation program prior to attending the TLC, and work with TLC and ward staff to select groups. Tab # 101. TLC I is using the Illness Management and Recovery curricula, which is available during the site visit. The other TLCs are using the Boston University Rehabilitation Model curricula. TLC I is designed for those individuals with short term anticipated lengths of stay (0-12 weeks), TLC II serves individuals with lengths of stay of 12 weeks to 2 years, TLC III serves persons with anticipated lengths of stay over 2 years and TLC IV serves maximum and minimum security individuals at JHP. The programs include a range of groups, led by all disciplines, and include cognitive therapies. Ward based programming continues for individuals who are not able to attend the TLCs, and for those in the Gerimall and restorative care programs. See TLC schedules, tab # 69. Group leaders are participating in a twelve hour group leadership training using the curricula for psycho-educational group leadership; paraprofessional staff are being trained in group process. Thirty five have completed the 12 hour group training; 17 have completed the paraprofessional training. Tab # 153.

In early August, the Hospital began piloting scheduling of groups and tracking attendance in AVATAR. Prior to this time, the Hospital was unable to track attendance in a manner so that treatment hours can be adequately tracked. Once fully implemented (September for TLCs and October for ward based groups) accurate data on treatment hours scheduled and attended should be available. Presently the only data available around hours of treatment is from the clinical chart audit pilot; that data (for the month of July, 2009) shows that 26% of individuals are scheduled for 20 hours or more of treatment, 37% for 10-19 hours, 19% for 1-9 hours, and 19% for no hours. Tab # 11

An audit tool for fidelity to curricula was developed with instructions, and a pilot was undertaken. Group Fidelity Audit tool/instructions, tab # 73. Data is not yet available.

The Monthly therapeutic progress note was modified, and instructions developed. Monthly Therapeutic progress note/instructions, tab # 44. The revised note with instructions improve the linkage between the IPR objectives and interventions. An audit tool was also developed and will be implemented in September, 2009. Therapeutic Monthly Note audit tool/instructions, tab # 45. Guidelines were developed and implemented for the Initial Nursing Assessment and the Nursing Assessment Update. Tab # 26, 28.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop guidelines for the completion of the Comprehensive Nursing Assessment that give clear direction on how to complete Section VIII: Interventions for Recovery.* — ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop Comphrehensive Nursing Assessment and develop clear and understandable guidelines for registered nurses that will complete the assessment.	7/31/2009	Comprehensive Initial Nursing Assessment form/guidelines, Tab # 26	Hartley
	Status: The named parties convened for a series of meetings. - Updated as of 7/29/2009			
2	I	8/10/2009		Hartley

2 *Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3.* — ***- High Priority*** *Civil; Forensic;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure development of manual-based curricula for TLC	7/15/2009	TLC 2, 3 and 4 curricula	Vidoni-Clark
	Status: TLC I, 2, and 3 curricula finalized and implemented. TLC 4 curriculum developed, implemented, and being revised as necessary. - Updated as of 6/24/2009			
2	Ensure staff are trained on curricula	7/27/2009	TLC group leader training data and curricula, Tab # 153	Vidoni-Clark
	Status: Group leaders received training on Conducting Curriculum based groups in March 2009. - Updated as of 6/24/2009			
3	Develop audit tools to ensure fidelty to curricula	7/31/2009	TLC alignment audit form and instructions, Tab # 73	Vidoni-Clark
4	Auditing process drafted for TLC on adequacy of group leadership & fidelity to group curriculum. Implentation data 8/09,	8/1/2009		Vidoni-Clark
	Status: Auditing process is in two phases. First phase currently ongoing involves interviews of group leaders. Second phase involving observation of groups to begin in September . - Updated as of 7/23/2009			

VIII.B.3

Compliance Status from DOJ Report: Partial

By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.

Findings See findings for cell VIII.B.1 and 2.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3. — ***- High Priority*** *Civil; Forensic;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Curricula still in use.		TLC curricula	Vidoni-Clark
	Status: ongoing - Updated as of 7/23/2009			

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

Compliance Status from DOJ Report: Partial

behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;

Findings See findings for cell VIII.B.1 and B.2.

Compliance Status: Partial

VIII.B.4.b

Compliance Status from DOJ Report: Noncompliance

programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;

Findings See VIII.B.1. and B.2 and VIII.A.6.

Compliance Status: Partial

DOJ Recommendations (Report 3)

Responsible Party

1 *Implement treatment mall realignment project.* ***- High Priority*** *Civil; Forensic; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See prior action steps			CVC
1	Continue to implement TLC I, 2, 3, and 4.	6/30/2009		CVC
	Complete *Status: Ongoing - Updated as of 6/19/2009*			
2	Develop mechanism to ensure mall groups selected for each individual fit their identified needs and that individual has input into treatment program	7/31/2009	Description of process to select interventions, Tab # 101	CVC
	Status: Selection process based on individual patient need. - Updated as of 6/19/2009			
3	Ensure mall groups are specifically incorporated into IRP	7/15/2009	TLC addendum to IRP, Tab # 46	CVC, JH, BG
	Status: TLC IRP Addendum developed. Clinical administrators were trained on use of IRP addendum on 7/30/09 - Updated as of 6/19/2009			
5	TLC 4- forensic treatment mall to be implemented 7/27/09			
	Status: TLC 4 began on 7/27/09 - Updated as of 7/23/2009			

2 *Develop substance abuse treatment options based on the individual's stage of change.* *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop substance abuse treatment options based on individual's stage of change	6/1/2009	TLC curricula	Hamilton, Arons, Clark

VIII.B.4.c

Compliance Status from DOJ Report: Noncompliance

where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;

Findings A cognitive functioning screen is now completed on all new admissions. IPA form/instructions, tab # 19. Data from the IPA audit shows that the cognitive assessment -WTAR scores sections of the IPA were completed in 96% of cases, the cognitive assessment section - R-BANS section was completed 100% of the time, the WRAT grade level was included 88% of the time, and the cognitive summary 100%. Programming in the new TLCs includes groups and interventions for those with cognitive impairments. TLCs schedules, tab # 69. Staff at the TLCs attending a training on cognitive remediation, and a grand rounds was held as well. Cognitive remediation training data/handouts, tab # 72.

Further, a formal liaison relationship was established with the Department of Developmental Disability Services Administration that has been quite productive. Four individuals with a mental retardation diagnosis have been placed, and four others are connected with service providers. Staff are continuing to work together to serve this population.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Complete a survey of community supports for individuals with cognitive impairment.* — ***- High Priority*** *Sepehri*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Establish liaison with DDS to facilitate transiton of persons with MR diagnoses.	6/1/2009		Sepehri
	Complete *Status: Two DDS consumers were transitioned into the community on 7-20-09 with another three transitioning in the next month. - Updated as of 6/26/2009*			
2	List of Mental Health Service available to consumers who suffer from cognitive impairment.	8/4/2009		
	Status: Have requested but not yet received. - Updated as of 7/27/2009			

2 *Audit the integration of neuropsychological findings with the IRP diagnosis, objectives and interventions.* — ***- High Priority*** *Med; PID; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement clinical chart audit to ensure IRP diagnosis, objectives, interventions are consistent with findings of any neuropsychological findings	12/25/2008	Clinical chart audit tool/instructions, Tab # 10; Clinical chart audit resutls, Tab # 11	Gouse

VIII.B.4.d — ***Compliance Status from DOJ Report: Substantial***

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

DOJ Recommendations (Report 3) — ***Responsible Party***

Maintain current level of practice. — *Forensic;*

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

VIII.B.4.e — ***Compliance Status from DOJ Report: Noncompliance***

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 is improving, but further improvement is needed. While key events are noted, staff do not always or comprehensively document the individual's response to specific 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". However, changes to policies and forms that are just being implemented should improve practice. The IRP manual was significantly modified, and now includes instructions on updating the clinical formulation to address progress or lack thereof, and provides examples for writing and updating interventions within each focus area. IRP Manual. The Psychiatric Update form and instructions, the social work update and the nursing update all include prompts for addressing progress or lack thereof; the related audit tools will monitor completion of these sections of the Update. Psychiatric Update form/instructions, tab # 17; Psychiatric Update Audit tool/ instructions. Tab # 18; Social Work Update, tab # 34; Social Work Update Audit Tool, tab # 35; Nursing Update, tab # 28; Nursing Update Audit, tab # 29. Audits of the Updates for nursing and social work are underway, and psychiatry's will begin in September, 2009. The social work update audit found that in 83% of cases, the update included a description of progress toward discharge. Tab # 33.

The Hospital also modified the therapeutic monthly note to more directly address progress in meeting the objective for which the intervention is targeting. Therapeutic Monthly Note/Instructions, tab # 44. A audit tool with instructions was developed and will be implemented in September, 2009 so data are not yet available. Therapeutic Monthly Note Audit Tool/Instructions, tab # 45.

The clinical chart audit tool piloted in July, 2009, includes one indicator in assessing whether the team modified IRP objectives and interventions based upon progress or lack thereof. Data from the pilot suggest that in 100% of cases, the IRP objectives were and interventions were modified, but the Hospital is reviewing the tool, instructions and training around the audit to ensure rater reliability. Clinical chart audit tool results, tab # 11.

Compliance Status: Partial

DOJ Recommendations (Report 3)		*Responsible Party*
1 *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal.*	*- High Priority*	*COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue with unit-based IRP training with consultants *Status: ongoing - Updated as of 7/26/2009*	9/30/2009 (Ongoing)		
2 See action steps in V. A- V.E			

2 *Assure that this item is audited on both the IRP conference process auditing tool and the IRP chart review tool.*		*PID; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Finalize clinical chart audit form/instructions ***Complete***	7/24/2009	Clinical chart audit tool/instructions, Tab # 10	Gouse
Implement clinical chart audits ***Complete*** *Status: Tool will be piloted on small sample - Updated as of 6/18/2009*	7/31/2009	Clinical chart audit results, Tab # 11	Gouse
3 Publish results of clinical chart audits ***Complete*** *Status: Ongoing - Updated as of 7/26/2009*	(Ongoing)	Clinical chart audit results, Tab # 11	PID

VIII.B.4.f

Compliance Status from DOJ Report: Noncompliance

clinically relevant information remains readily accessible; and

Findings See VIII.B.4.e

Compliance Status: Partial

DOJ Recommendations (Report 3)		*Responsible Party*
Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Assure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box.	*- High Priority*	*COS;*

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

1	See prior action step	Gouse

VIII.B.4.g

Compliance Status from DOJ Report: Partial

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 See VIII.B.1.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Continue work with consultant.* — ***- High Priority*** *COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.B.1.b	9/30/2009		Canavan; Seymour

2 *Continue providing overview training in PBS for all clinicians.* — ***- High Priority*** *COS; Trg;*

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

3 *Implement, monitor and audit several PBS plans in the next 6 months.* — ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
See VIII.B.1.b			

4 *Train nursing staff in the implementation of specific behavioral plans and guidelines.* — ***- High Priority*** *CNE; COS; Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See VIII.B.1.b			

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

Compliance Status from DOJ Report: Partial

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 continues to improve pharmacy services. Pharmacy conducts monthly medication chart audits, Medication Monitoring Form/instructions, tab # 67 (please note that the tool is being revised and a copy is also included), and completed a review of 162 records during the period of March, 2009 to July, 2009. Medication Audit results, tab # 66. In addition, every individual's medication regimen is reviewed each time a new order is issued and is also reviewed monthly when pharmacists are verifying new monthly orders. The Hospital fully implemented a system by which all medications orders, except emergency orders, are verified by a pharmacist before filling prescriptions.

The Hospital also tracks pharmacist to physician communications. See Data summarizing communications, tab # 103. Between March 3, 2009 and August 20, 2009, 205 pharmacist to physician communications occurred. Of these, 21% were of major and 13% were of moderate significance. The three highest categories were omitted or expired orders (11%), order clarification (9%) and pharmacist clinical counseling, 8%). Forty three percent of the recommendations were expected to be accepted, 20% unresolved and 18% not identified. Two percent of the recommendations were expected to be declined. Tab # 103. In those cases where a pharmacist's recommendation is not followed and the pharmacist believes an

individual in care is at risk, he notifies the Medical Director for intervention.

Compliance Status: Partial

DOJ Recommendations (Report 3)		Responsible Party
1 *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department. The recommendations should include, but not limited to, the following categories:*	***- High Priority***	*Med; PID; Pharm;*
a Drug-drug interactions;		
b Side effects;		
c Need for laboratory testing;		
d Indications;		
e Contraindications;		
f Drug allergy;		
g Dosage issues;		
h Polypharmacy;		
i Drug-food interactions;		
j Incomplete orders; and		
k Orders that need clarification.		

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Track recommendations in Pharmacy system Pharmacists are continueing to enter in intervention/recommendations into Worx (pharmacy system)		Pharmcist to Physician communications data summary, Tab # 103	Zerislassie
Complete			

2 *Provide operational definitions and an explanation of the significance of pharmacists' recommendations in the categories of ""activities, drug information, pharmacist clinical counseling and therapeutic consultation and no change."* ***- High Priority*** *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Revise categories.	7/10/2009		Zerislassie
	Complete *Status: Categories have been revised and are in use - Updated as of 7/31/2009*			
2	Develop operational defintions	8/21/2009	Pharmcist to Physician communications data summary, Tab # 103	Zerislassie

3 *Develop tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from drug regimen reviews.* ***- High Priority*** *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop tracking system of follow up by doctor to pharmacists recommendations		Tab # 103	Zerislassie
	Complete *Status: Procedure in place and being used. - Updated as of 6/25/2009*			

4 *Develop and implement a self-monitoring mechanism regarding the requirements of VIII.C.1 and VIII.C.2.* *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Pharmacy to conduct monthly reviews of patient's medication regimens	8/4/2009	Pharmacy and medication monthly report, Tab # 93	Zerislassie
2	Pharmacy to conduct monthly chart audits, using tool	(Ongoing)	Medication review chart audit tool/instructions, Tab # 65; Medication audit results, Tab # 66	Zerislassie
	Complete *Status: ongoing - Updated as of 7/31/2009*			
3	Peer Review mechanism to be devised to act as self monitoring or QA mechanism	8/31/2009		
	Status: In process of being developed - Updated as of 7/31/2009			

VIII.C.2

Compliance Status from DOJ Report: Same as above

physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.

Findings Same as VIII.C.1

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Same as above. *Med; PID; Pharm;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Same as above	6/1/2009		

VIII.D. Nursing and Unit-Based Services

By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.

Findings See sub-cells for findings.

A new Chief Nurse Executive was appointed in May, 2009. The pace of reform has accelerated since that time, and a number of key initiatives are being implemented.

1) A new Initial Nursing Assessment form with instructions is implemented, in July, 2009. Staff were trained and the form is now being used. Initial Nursing Assessment form/instructions, tab # 26; Nursing Update form/instructions, tab # 28.

2) Comfort plans have been completed for a majority of individuals in care. Comfort plan form, tab # 104; Comfort Plan audit tool, tab # 105. Nurse managers and staff have been instructed to utilize the comfort plan as a device to encounter the individuals in care, making the plan a dynamic document that is revised and utilized to maintain interaction with individuals. The comfort plan is to be referenced in the nursing updates and reviewed at IRP planning; it is to be updated frequently. According to data from a chart audit assessing completion of comfort plans, 85% of audited plans included information about triggers and actions that can calm the individual; the lowest rated part was completion of the section of what is not helpful in calming the individual. Comfort plan audit data, tab # 106.

3) A Nursing audit tool was developed and piloted for the nursing update, Nursing Update form audit tool/instructions, Tab # 28, as was an audit tool for the initial nursing assessment. Initial Nursing Assessment audit tool/instructions, tab # 27. However, data suggests that the tools, instructions and/or training may need some modification.

4) A standard for Nursing Plan for Provision of Care was developed, a target number of patient care hours was set, and data is tracked against the standard. Nursing Plan for provision of care, tab # 107. The standard set is an average of 6 hours per day, and the data shows a current staffing assignment averaging 5.2 hours of care. (The Hospital is tracking daily hours of care in an effort to monitor how close it is to meeting the 6 hours per day standard. Data will be available during the site visit.) Nursing has determined the appropriate mix of professional and paraprofessional nursing staff needed for each ward, each shift. Data suggests that additional nursing staff (both RN and paraprofessional) may be needed. Nursing leadership for each unit are participating in the development of unit specific plans for provision of care, which will include greater specificity on how nursing services are delivered on the particular unit. Four unit plans for provision of care are underway and should be completed in mid September. Effective August 15th, RN staff were redeployed to ensure RN nursing coverage on each unit each shift. Data evaluating progress in meeting this target will also be available during the visit.

5) New templates for nursing procedures were implemented.

6) The following new nursing procedures were finalized, staff were trained and the procedures implemented: change of shift, tab # 109; intake/output, tab # 110; choking assessment, tab # 111; use of protective devices, tab# 112; use of restraint or seclusion, tab # 113; medication administration, tab # 114; and insulin administration, tab # 115 .

7) Nursing competency standards were created. Tab # 116. These are designed to ensure that before staff work directly with individuals in care, all nursing and unit based staff have successfully completed competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of medication, monitoring of symptoms and target variables, and documenting and reporting on the individual's status.

8) New Hospital policies were developed around hand-off communications and Medical Response, with input from medical and nursing staff. Hand Off Communication policy, tab # 71; Medical response policy, tab # 70.

9) There currently are four nurse manager vacancies; recruitment is underway.

10) Beginning August 15, 2009, nursing staff were redeployed to ensure each unit has an RN on duty each shift. While RNs were transferred between programs, staff were accommodated so that they continued to work their same shifts.

11) Nurse manager meetings are continuing. Nurse managers meet weekly in order to communicate, standardize practice, provide each other with technical assistance, and to finalize for management their suggested changes to policy and procedures and client flow. A plan to increase nursing administrative presence on off shift was developed. The first phase of implementation was to assign assistant directors of nursing to work primarily

the 7-3 shift and the 3-11 shift. A plan to provide 24/7 on site nursing administration is developed and in the approval process. Implementation is targeted for November, 2009.

12) Nurse education has trained staff on seven different topics, including therapeutic communications (non-confrontational techniques), stage of change, mental health diagnosis, physical assessment - diabetes, physical assessment - choking/swallowing, physical assessment - general/critical thinking and physical assessment vital signs. Tab # 120.

13) Nursing introduced a new program on RMB-3, EARN (Engage, Assess, Reassure and Reorient, and Needs Met). The program is based upon the "hourly rounds" concept widely implemented on medical surgical units nation-wide. The program will be introduced hospital-wide over the Fall. See EARN description, tab # 117. Under the pilot staff will make scheduled "rounds" of individuals to engage them, assess how they are doing, reassure them and meet their needs. The purpose is to develop trust between staff and the individual and to meet basic needs before they become urgent.

Compliance Status: See sub cells.

VIII.D.1 ***Compliance Status from DOJ Report: Partial***

Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;

Findings See VIII.D for overall description of progress.

Nursing established minimum competencies for nursing staff. According to the nursing competency procedure, newly hired nursing staff will be required to satisfactorily complete an orientation program. The procedure, in Part A, identifies the minimum competencies that that are required before the individual is determined to have completed initial training. In Part B, standards are set for annual competency determinations. Ratings on the completion of these competency standards will be incorporated into the employee's performance appraisal. Nursing Competency Structure, tab # 116. Attached is a procedure that is followed when a staff member fails to achieve competency. Tab # 127. A charge nurse competency template has been drafted and is under review by the Nurse Managers. Implementation is targeted for October 1, 2009.

The following training activities were undertaken or are continuing since the last review:

IRP planning;
Seclusion and restraint training,
Therapeutic Communication for all nursing front line staff
Mental Health Diagnosis (Schizophrenia) for all nursing front line staff
Physical Assessment (Diabetes Mellitus) for all nursing front line staff
Physical Assessment (General Survey) for RN and LPN
Physical Assessment (Vital Signs) for MHC, FPT & PNA
Stages of Change for all nursing front line staff
Physical Assessment (Choking) for all nursing front line staff
Diabetes Insipidus for all nursing front line staff
Mental Health Diagnosis (Schizoaffective Disorder) for all nursing front line staff

Nursing also established a template for nursing procedures that addresses purpose of policy, statement of the standards, definitions, general information, and then step by step procedures to implement the policy.

The hospital wide new employee orientation and the annual training programs are being revised to incorporate more national standards and curricula, but some revisions to the Annual training program (hospital wide portions) were made while the full curricula is retooled . Annual training, tab # 119.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Review the course outlines/content of hospital-wide orientation and nursing department orientation. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine competency.* — ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft the competency structure for the Nursing Department and present to CNE on or before July 30, 2009.	8/5/2009	Nursing competency standards, Tab # 116	Mayo, Hartley
	Complete *Status: Competency standards developed - Updated as of 8/27/2009*			
2	Review the course outlines/content of hospital-wide orientation and nursing department orientation.	8/14/2009	Revised annual training, Tab # 119	Lewis Mayo
	Complete *Status: Same as above. - Updated as of 8/27/2009*			

2 *Review the course outlines/content of hospital-wide annual update training and nursing department annual update training. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine if competency has been maintained.* — ***- High Priority*** *CNE;*

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

3 *Review all competency assessment tools to determine if competency measures meet the requirements of this agreement and generally accepted practice standards, and if the measures are currently applicable. Assure that RN competencies address RN judgment as it relates to physician order transcription, medication administration, seclusion and restraint use, and notifying a physician when a patient's physical status changes.* — *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Lewis Mayo will develop a competency on RNs for critical thinking as it relates to physician orders and medications. He will use the SBAR format and write a clinical procedure for questioning orders.	8/31/2009	Handoff communication policy, Tab # 71	Lewis Mayo
	Status: Michael Hartley and Lewis Mayo discussed this recommendation and developed a template for completion. - Updated as of 7/6/2009			
2	Finalize CNE's Plan for Provision of Care, which is a unit-based document that addresses the compentencies that nurses and nursing assistants must demonstrate.	8/14/2009	Nursing Plan for Provision of Care, Tab # 107	Michael Hartley

4 *Develop a nursing policy and procedure template that will assure that each policy/procedure (p/p) is in the same format and that it addresses: the purpose of the p/p; the policy statement that expresses the standard; definitions as needed; general information as needed to address context and integration with other p/p; and procedures. The procedures should be step-by-step directions addressing: who does what; when or at what intervals; where as applicable; how as applicable; and documentation requirements. Align forms and p/p as each of these are developed.*

- High Priority *Forensic; CNE; PID; Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review Dr. Lynn Delacy's recommended template, and use it as a template for the development of a nursing policy and procedure template.	6/26/2009		Michael Hartley and Jana Taylor
	Complete *Status: Completed prior to June 12, 2009. - Updated as of 7/29/2009*			
2	Draft Nursing Policy and Procedure Template as set forth in the recommendation.	6/26/2009		Michael Hartley and Jana Taylor
	Complete *Status: Completed prior to June 12, 2009. - Updated as of 7/29/2009*			
3	Distribute Nursing Policy and Procedure Template to Asst Directors of Nursing, Nurse Educators, Nurse Consultants and Program Analyst.	6/26/2009		Michael Hartley and Jana Taylor
	Complete *Status: Completed June 12, 2009. - Updated as of*			

5 *Develop a policy that describes 1 – 3 above and specifies actions taken when a staff member does not achieve or maintain competency.*

- High Priority *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review staff responsibilities regarding competency attainment and retention.	8/14/2009		Michael Hartley, Jim Gallo and Deon Merene
2	Review the aforementioned responsibilities in light of the two union contracts, DC Government Employment Policies, and other applicable laws, rules and regulations.	8/21/2009		Michael Hartley, Jim Gallo and Deon Merene
3	Draft a policy that specifies the actions taken when a staff does not attain or maintain compentencies.	8/28/2009	Procedure-failure to reach training competency, Tab # 127	Michael Hartley, Jim Gallo and Deon Merene
4	Finalize the policy.	9/7/2009		Michael Hartley

6 *Implement the policy.*

CNE;

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Implement the policy.	9/8/2009		Michael Hartley

7 *Report aggregate percentages of staff who attended training.*

- High Priority *CNE; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Enter names of employees that attend training into Hospital database.	8/21/2009	Nursing training data, Tab # 120	Kiana Hinton
	Status: Data is being entered into the database as quickly as possible. We have staggered data entry deadlines for the various courses. Staff identified to enter training and competency results to the database, and track their attendance and test scores. - Updated as of 7/29/2009			
2	Export information to Excel to develop reports that show the aggregate percentage of staff who attended trainings.	8/21/2009		Lewis Mayo and Shelita Snyder

8 *Report aggregate percentages of staff who achieved or maintained competency.* *CNE; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a method to aggregate percentages of staff who achieved or maintained competency.	9/11/2009		Michael Hartley, Michael Spencer, Lewis Mayo, Shelita Snyder, Ernest Dolison
	Status: A database has been developed to track training attendance and allows for the insertion of a person's grade or pass/fail on post-tests. Conversations must be held to learn whether the database will allow the hospital to report nursing staff that has maintained competency. - Updated as of 7/29/2009			
2	Implement policy that discusses the requirements for competency achievement and retention.	9/8/2009		Michael Hartley
3	Track staff who achieve and maintain competency requirements.	9/30/2009		Lewis Mayo, Kiana Hinton, Shelita Snyder and Ernest Dolison.
4	Begin running reports on aggregate percentage of staff who achieved or maintained competency.	10/30/2009		Lewis Mayo, Shelita Snyder and Ernest Dolison

9 *Develop and implement Nursing IRP training.* ***- High Priority*** *CNE; Trg;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train Nurse Managers about the IRP process and teach them how to conduct the IRP training for their staff.	6/4/2009	IRP training Curricula/Outline, Tab # 1	Beth Gouse
	Complete			
2	Nurse Managers develop and implement a training plan to train their staff on the IRP process	6/8/2009	Nursing training data, Tab # 120	Nurse Managers
	Complete *Status: Seemingly fewer than 40 to 50 active nursing staff members still need IRP training; figures must be confirmed. - Updated as of 7/29/2009*			
3	Nursing staff to participate in IRP on unit training activities.	(Ongoing)		Nurse Managers
	Status: Ongoing; primarily includes day shift nursing staff as IRP sessions are held during regular business hours. - Updated as of 7/22/2009			

10 *Add content to the physical assessment curricula related to GI issues (bleeding, bowel obstruction), infection, delirium, and diabetes.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review current physical assessment curricula and make recommendation revisions.	8/21/2009	Physical observation nursing procedure, Tab # 123, Nursing training data, Tab # 120	Lewis Mayo and Brenda Lateef

11 *Review and consider addressing other comments in the findings above.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Follow recommendation once all prioritized recommendations have been reviewed and considered.	8/21/2009		Michael Spencer

12	*At this time, consider using the requirements in this agreement as a nursing strategic plan rather than spend time developing/revising the draft plan.*	*CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 The CNE will consider this recommendation. He will, however, also develop a Plan for the Provision of Care for the Nursing Department that may serve as or supplement a nursing "strageic plan."	8/21/2009		Michael Spencer

VIII.D.2

Compliance Status from DOJ Report: Partial

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. for summary

The Hospital revised and implemented a new initial nursing assessment to be completed within 8 hours, and developed instructions to guide the assessment. Initial Nursing Assessment form/instructions, tab # 26. The instructions provide step by step instructions and include additional examples of questions that may be appropriate. An initial assessment audit tool was developed with instructions and piloted, but the initial data suggests the tool needs modifications, which will be completed in September, 2009. In addition, a nursing update form with instructions was finalized; the new form ties directly to the IRP focus areas and requires staff to report progress on the nursing interventions that relate to each focus area. Nursing update form with instructions, Tab # 28. An initial audit was completed but data is not available yet. Nursing Update audit results, tab # 30. The audit of the Nursing update shows that 54% of the updates were completed timely. Areas in which staff scored high included the completion of mental status section (87%), acceptance of medication section (98%), and section linking the assessment update to the three IRP focus areas. Areas in which improvement is needed include explaining why a comfort plan is not completed or updated (only 7% adequate), completion of sections on sensory deficits (50%), individual strengths (63%), and individual additional needs completed (69%).

The Hospital also is monitoring nursing staff attendance and participation in IRPs as well as the timeliness of assessments through the IRP process monitoring tool. Results from the reviews in February 2009 to June, 2009 show RNs attended 75% of IPR conferences in February, 83% in March, 100% in April, 100% in May, and 77% in June, but attendance of paraprofessional nursing staff was much lower - 35% in February, 6% in March, 54% in April, 50% in May, and 38% in June, 2009. IRP Process Observation Results, tab # 9. The results of nursing completing assessment updates before the IRP conference were consistently below 50%, but that may be due in part to the fact the new nursing update form was not in use during the rating period. Audits over the next few months are expected to show improvement. Indeed, data of the nursing update form audit for July 2009, shows 54% were completed timely. Finally, the IRP Process observations also looks at the participation by the RN and paraprofessional in the conference itself. The RN presented their assessment of present status from 23% (April) of the time to 90% (June). IRP training of nursing staff both by nurse managers and the expansion of the on ward IRP coaching by consultants are expected to continue to boost nursing participation and strengthen the quality of participation. Documentation on some units is improving: More nursing notes are detailing specific interventions that were utilized, noting those that worked and those that did not. This is an improvement over last time.

Nursing established minimum competencies for its staff. See previous discussion.

The Change of shift template was revised and incorporated into a new nursing procedure. Change of shift nursing procedure, tab # 109. It provides detailed instructions as to the content of the change of report, including the procedure to complete a narcotic count at the change of each shift, prior to change of shift report and specifically requires discussion of IRP objectives. In addition, a new nursing procedure around physical assessment and a new procedure and form for intake and output were finalized and training is underway. Physical assessment nursing procedure, tab # 123; Intake and output procedure, tab # 110.

Compliance Status: Partial

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Clarify expectations/align the Comprehensive Nursing Assessment with the content and timeline expectations reflected in the hospital policy.*	***- High Priority***	*CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Ensure that the guidelines for the Comphehensive Nursing Assessment and any corresponding policies clarify expectations regarding the assessment's content and time frames for completion.	7/31/2009	Initial nursing assessment form and instructions, Tab # 26	Michael Spencer
	Status: Partially complete as the guidelines clarify expectations with content and timeline expectations. Must ensure that any corresponding policy also meets recommendation. - Updated as of 7/29/2009			
2	Finalize nursing update form	7/6/2009	Nursing update form and instructions, Tab # 28	
	Complete			

2 *Using the nursing p/p template, develop a nursing p/p that provides step-by-step guidance to conduct and document the comprehensive assessment. Assure that the policy addresses: the process for linking the assessment to the initial IRP, the process for using "screens", and the process for evaluating/updating information that emerges during the time interval between admission and the IRP.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft a nursing policy that provides guidance to conduct and document the comprehensive nursing asssessment.	8/14/2009	Initial nursing assessment form and instructions, Tab # 26	Hartley
2	Incorporate the Operational Instructions into the nursing policy to insure the procedures for completion are clear to anyone that reads the policy.	8/14/2009	Initial nursing assessment form and instructions, Tab # 26	Hartley

3 *Implement the policy and the Comprehensive Nursing Assessment.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Finalize comprehensive nursing assessment and nursing assessment update forms.	6/15/2009	Initial nursing assessment form and instructions, Tab # 26 ; Nursing assessment update form, instructions, tab #	Hartley
	Complete *Status: Both forms have been finalized and implemented. - Updated as of 7/8/2009*			
2	Develop operational instruction to provide standards on completion of nursing assessment updates	6/22/2009	Nursing update form and instructions, Tab # 28	Hartley
	Complete *Status: Operational instructions for the nursing update has been finalized. - Updated as of 7/8/2009*			
4	Train all RN staff on completion of initial nursing assessment	7/3/2009	Nursing training data, Tab # 120	Hartley
	Complete *Status: Training will begin on admission units. RNs on non-admission units to be trained within ten days thereafter. - Updated as of*			
5	Train all RN staff on completion of nursing assessment update	7/3/2009	Nursing training data, Tab # 120	Hartley
	Complete			

4 *Finalize the monitoring tool, begin audits, act to resolve trends and monitor the effectiveness of actions.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Create audit tools and instructions for auditng quality of nursing assessments/updates	6/22/2009	Audit tool/instructions, Initial nursing assessment, Tab # 27; Audit tool/instructions, Nursing update, Tab # 29	Hartley
	Complete *Status: Audit tool for the nursing assessment and update has been drafted. - Updated as of 7/8/2009*			

2	Begin audits of nursing assessments and updates.	6/26/2009	Nursing training data , Tab # 120	Laverne Plater and Shirley Quarles
	Complete *Status: 20% audit will be conducted. The 20% audit began on July 20, 2009. - Updated as of 7/29/2009*			
3	Enter audit findings into a nursing database for trending.	8/5/2009	Nursing update audit results, Tab # 30	Hartley
	Status: Ongoing - Updated as of 7/29/2009			

5 *Develop a template for nursing progress notes that includes prompts to meet documentation requirements in this agreement.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop standards around use of "generic" progress note form for nursing purposes	8/31/2009		Hartley
1	Develop nursing update form (to be completed monthly) with instructions	8/28/2009	Nursing update form/instructions, tab #	Hartley

6 *Develop a policy for nursing progress notes that meets the documentation requirements in this agreement.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps, VIII.D. 2 recommendation #5			

VIII.D.3

Compliance Status from DOJ Report: Partial

Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;

Findings See VIII.D.

The Change of shift procedure and template were revised and incorporated into a new nursing procedure. Change of shift nursing procedure, tab # 109. It provides detailed instructions as to the content of the change of report; it includes a procedure for a narcotic count at the change of each shift, prior to change of shift report and specifically requires the discussion of IRP objectives. In addition, a new nursing procedure around physical assessment was finalized and training is underway. Physical assessment nursing procedure, tab # 123. Curricula will be available during the site visit.

The Hospital also recently finalized a Hand-off communications policy and a Medical response policy that are designed to provide specific guidelines for physician - nurse communications. Hands-off communication policy, tab # 71 ; Medical response policy, tab # 70. The Medical Response policy address emergent, urgent and non-urgent medical issues, and established protocols for each. In addition, the Performance Improvement Committee selected "communication" and "continuity of care" as two of its initiatives. Work-groups to address these initiatives are well underway. See PIC Initiative [Communications] work plan, tab # 121; Continuity of care subgroup report, tab # 122.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Revise the Physical Observations form and the Intake and Output form. Use the nursing p/p template to develop a p/p to accompany each form.* ***- High Priority*** *CNE;*

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

1	Complete nursing procedures in the identified areas using format that clearly states policy, and provides step by step operational instructions	7/31/2009	Physical observation procedure/form, Tab # 123; Input/output monitoring procedure/form, Tab # 110	Hartley
	Status: Critical nursing procedures have been identified. Template for procedures that are more implementation focused has been developed. Drafts for I&O and Physical Observation Forms have been developed and comments for improvement have been shared. - Updated as of 7/22/2009			
2	Nurse managers and team leaders/registered nurses to provide on unit coaching on implementation of new procedures	8/7/2009		Hartley
3	Train staff on all new nursing procedures	8/16/2009	Nursing training data, tab # 120	Hartley

2 *Implement the forms and policies/procedures.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.D.3, recommendation #1			

3 *Develop a joint medical nursing policy that at a minimum addresses: assessment data that the RN will provide to the MD; joint determination of the level of urgency of a physical status change; expected response times based on the level of urgency (emergent, urgent, and non-urgent); RN and MD follow up actions; assessments and documentation prior to transfer to an ED or acute care hospital; assessments, notifications, and documentation upon return from an ED or acute care hospitalization.* ***- High Priority*** *Med; CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop joint medical/nursing policy that addresses RN/MD interface in emergencies.	8/14/2009	Medical response policy (draft), Tab # 70.	Michael Hartley, Arons
	Status: CNE and Medical Director drafted a medical emergency response procedure that includes emergent, urgent and non-urgent responses with accompanying grids. Procedure also incorporates SBAR. - Updated as of 7/22/2009			
2	Finalize and implement nursing procedure.	8/24/2009		Michael Hartley

4 *Resolve barriers to using the draft Change of Shift Report template as designed; revise the form as necessary; finalize the procedure; implement the form and procedure.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Nurse Managers and team leaders to monitor change of shift reports to ensure they are being conducted properly.	7/31/2009		
	Complete *Status: Ongoing - Updated as of 7/8/2009*			
1	Develop step by step policy on the proper use of the Change of Shift report. Revise language on "departing" and "arriving" staff members, and make accountability clear.	7/31/2009	Revised change of shift policy and form, Tab # 109	Michael Hartley
2	Consider changing format of the change of shift form to allow for narrative sentences. If not, make sure staff do not write narratives across the columns on change or shift report.	7/31/2009	Revised change of shift policy and form, Tab # 109	Michael Hartley
	Complete			

5 *Consider developing templates to document nursing assessments for physical status change, and transfers to and from EDs or acute care hospitalizations.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Consider the recommendation when we discuss the joint medical/nursing policy.	8/28/2009		Michael Hartley

2 Review the existing documents used for transfers to and from ERs or acute care hospitalizations.	8/28/2009		Michael Hartley

6 *Develop a monitoring instrument; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken.* — *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Consider following recommendation and develop a monitoring instrument.	8/28/2009		Martha Pontes
1 Review the existing document(s) being used for transfers and phsyical status changes to determine whether revisions are needed.	8/28/2009		Martha Pontes

Status: The transfer policy and tool has been shared with Martha Pontes for her review and feedback. - Updated as of 7/22/2009

VIII.D.4

Compliance Status from DOJ Report: Partial

Ensure that nursing staff document properly and monitor accurately the administration of medications;

Findings See VIII.D.

AVATAR system issues around medication administration have been largely resolved, although there have been interruptions in the system for short periods. The Medication Ordering and Administration Policy was modified in July, 2009 to include a specific requirement for monitoring an individual's response to first administration to a medication, and to require staff to regularly inquire about potential side effects to the medication. Medication Ordering and Administration Policy, tab # 125. Nursing also developed a Nursing procedure around EMAR and medication administration, tab # 114. That procedure covers both the administration of medication as well as the reporting of administration of medication. Further, instructions have been developed for both reporting medication variances and adverse drug reactions. Medication Variance policy, tab # 91; Medication Variance Form/instructions, tab # 92; Adverse Drug Reaction Policy, tab # 126; Adverse drug reaction reporting form/instructions, tab # 94.

The Pharmacy and Therapeutics Committee is routinely monitoring the data around medication variances and adverse reactions. P and T Committee minutes, tab # 90. There is clear underreporting of adverse reactions, and medication variances; strategies are continuing, including meeting with medical and nursing staff, but to date, they have not been effective.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Same as in VIII.A.2.b.iv* — ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 see response to VII.A.2.b.iv			

2 *The P&T Committee should analyze aggregate data, identify trends, take action to address improvement opportunities, and monitor the effectiveness of actions taken.* — ***- High Priority*** *Med; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Committee meetings to discuss and document	6/1/2009	P and T committee minutes, Tab # 90	

Status: Underway - Updated as of 6/29/2009

3 *Revise the Medication Variance Reporting and Assessment policy to ensure direct coding for undocumented medications.* — *- High Priority* — *PID; Pharm; Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise medication variance policy and form.		Medication Variance Policy, Tab # 91; MVR form/instructions, Tab # 92	Zerislassie
Complete			

4 *Consider potential to eliminate duplicative reporting.* — *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise MVR policy and form		MVR policy, Tab # 91; MVR form and instructions, Tab # 92	Zerislassie
Complete *Status: Process has been revised to incorporate UI form into MV form online. Effectively reducing duplicative reporting. - Updated as of 7/31/2009*			

5 *Finalize the policy on monitoring patient response to first dose of medication.* — *CNE; PID; Pharm; Jana Taylor*

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

6 *Continue to develop processes to analyze and act on medication variances.* — *PID; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise MVR form and instructions and train staff	7/31/2009	MVR form/instructions, Tab # 92	Zerislassie
Complete *Status: Form revised and staf being trained - Updated as of 7/31/2009*			
2 Provide data to and ensure P and T committee monitors data during its meetings,		P and T Committee minutes, Tab # 90	PID
3 MVR form being presented at various disciplinary meetings			

VIII.D.5 — ***Compliance Status from DOJ Report: Partial***

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 Nursing established minimum competencies for nursing staff. According to the nursing competency procedure, newly hired nursing staff will be required to satisfactorily complete an orientation program. The procedure, in Part A, identifies the minimum competencies that that are required before the individual is determined to have completed initial training. In part B, standards are set for annual competency determinations. Ratings on the completion of these competency standards will be incorporated into the employee's performance appraisal. Nursing Competency Structure, tab # 116. Attached is a procedure that is followed when a staff member fails to achieve competency. Tab # 127. These competencies include specific competencies around medication administration and recognizing side effects. The Change of shift procedure and template were revised and incorporated into a new nursing procedure. Change of shift nursing procedure, tab # 109. It provides detailed instructions as to the content of the change of report; it includes a procedure for a narcotic count at the change of each shift, prior to change of shift report and specifically requires the discussion of IRP objectives

See also VIII.D.4.

Compliance Status: Partial

DOJ Recommendations (Report 3)		***Responsible Party***
1 *See recommendations for VIII.D.1, items 1-3, 5, 7 and 8.*	*- High Priority*	*CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See responses for VIII.D.1, items 1-3, 5, 7 and 8.			

2 Review practice and p/p for change of shift narcotic count. - ***High Priority*** *CNE; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the nursing p/p on crash carts to include clarity on who monitors, stocks and documents actions related to the crash cart. This p/p will specifically address the change of shift narcotic count.			
2 Review and modify as necessary procedure for change of shift narcotic counts			

3 Using the nursing p/p template, finalize the "Using eMAR for Medication Administration" (MED 501, Revised 2-18-09), assuring integration of requirements specified in this agreement. - ***High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop a procedure on medication administration to include step by step instructions and tips on educating the patient during medication administration.	8/14/2009	Nursing procedure on medication administration, Tab # 114	Martha Pontes, George Tanyi and Shirley Quarles
Complete *Status: Draft should be finalized by July 31, 2009. - Updated as of 8/28/2009*			
2 Train all RNs and LPNs on the procedure and monitor documentation to prove that patient teaching is occuring.	8/28/2009	Nursing training data, Tab # 120	Martha Pontes, George Tanyi and Shirley Quarles

4 The P&T committee should drill down the top three causes of medication variances to determine actions needed to reduce medication variances. *Med; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PRISM is being utilized to do this on a monthly bases.	(Ongoing)	P&T minutes from June,July,August, Tab # 90, PRISM REPORTS, Tab # 53	
Complete *Status: ongoing - Updated as of 6/25/2009*			

VIII.D.6

Compliance Status from DOJ Report: Partial

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

Hospital policy requires nursing to report medication variances and adverse reactions to medication. However, data around medication variances and ADR shows nursing is not often reporting. Nursing reported 6 ADRs in February and 2 in March, but none since then. Tab # 102. As to medication variances, nursing reported 7% of all reported. Tab # 93.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 Resolve differences between SEH policy and Draft Nursing policy relative to who can administer medications and relative to the different definitions for medication variances. - ***High Priority*** *CNE; PID; Jana Taylor*

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

1	Ensure consistency between hospital and revised nursing p/p on medication administration.	8/14/2009	Medication Administration, Tab # 125	Martha Pontes, George Tanyi and Shirley Quarles; Jana Taylor

2 *See VIII.D.4, Recommendation 2.* ***- High Priority*** *Med; CNE; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 All such failures to be viewed as errors and corrected.	6/1/2009		

VIII.D.7

Compliance Status from DOJ Report: Partial

Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;

Findings See VIII.D.4

The revised Medication Ordering and Administration policy requires nursing to ask individuals about possible side effects to medication. Tab # 125. The nursing procedure also includes specific instructions around first dose education and monitoring. Tab # 114.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

See VIII.D.5. Recommendation 3. *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to VII.D.5 Recommendation 3.			

VIII.D.8

Compliance Status from DOJ Report: Partial

Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;

Findings See findings for VIII.D and VIII.D..2

The revised nursing update form specifically requires a nurse to evaluate the individual's progress in meeting the IRP goals during each monthly update. This section is designed to ensure the nurse evaluates the individual's progress in meeting the IPR goals, and will also include an evaluation of the effectiveness of the nursing interventions to date. Tab # 28. Data from the initial audit shows that staff are completing the IRP related sections, but it is too early yet to evaluate the quality and comprehensiveness of the assessments. Tab # 30.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *See D.1. Recommendation 9* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to D.1 Recommendation 9.			

2 *See D.2. Recommendation 1-4 and 7.* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to D.2 Recommendation 1-4 and 7.			

VIII.D.9

Ensure that each individual's treatment plan identifies:

Findings Please see sub cells for findings.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

VIII.D.9.a

Compliance Status from DOJ Report: Partial

the diagnoses, treatments, and interventions that nursing and other staff are to implement;

Findings Progress has been made. Instructions have been developed to support completion of the IIRP. IIRP form/instructions, tab # 4. The IRP manual includes specific information about the role of nursing in IRP planning, it is included in nursing competencies, and nursing received overview training on IRP process; they are also participating in the coaching and on unit training. Also, the nursing update form as been revised, and instructions developed, which now tie the assessment updates specifically to the IRP nursing interventions Nursing update form/instructions, tab # 28. An initial audit was completed and some data is available. Nursing Update audit results, tab # 30. Areas in which staff scored high included the completion of mental status section (87%), acceptance of medication section (98%), and section linking the assessment update to the three IRP focus areas. Areas in which improvement is needed include explaining why a comfort plan is not completed or updated (only 7% adequate), completion of sections on sensory deficits (50%), individual strengths (63%), and individual additional needs completed (69%). In addition, while there has been progress in the nursing interventions in the IRP and in relating the Nursing Update to the IRP focus areas, additional work is needed on some units. Finally, the audit shows that only 54% of nursing updates were completed timely, so improvement is needed here as well.

The Hospital also is monitoring nursing staff attendance and participation in IRPs as well as the timeliness of assessments through the IRP process monitoring tool. Results from the reviews in February 2009 to June, 2009 show RNs attended 75% of IPR conferences in February, 83% in March, 100% in April, 100% in May, and 77% in June, but attendance of paraprofessional nursing staff was much lower - 35% in February, 6% in March, 54% in April, 50% in May, and 38% in June, 2009. IRP Process Observation Results, tab # 9. IRP observers are evaluating nursing attendance and participation in treatment plans. To date, there is no data available evaluating the quality of the nursing interventions in the IRP.

A revised choking nursing procedure is developed and is being implemented. Nursing Procedure, Choking, tab # 111.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *See D.1. Recommendation 9* ***- High Priority*** *CNE; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to D.1 Recommendation 9			

2 *See D.2. Recommendation 1-4, 6 and 7* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to D.2. Recommendation 1-4, 6 and 7			

3 *Using the nursing p/p template, revise the Guidelines Choking/Swallowing Assessment (NCP 600.25), re-titling this as Dysphagia Assessment. Provide clear direction for what information/behavior will trigger an assessment, what the assessment will entail, what referrals will be made, and what interventions will be provided.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Complete nursing procedure around Dysphagia Assessment using new format	8/5/2009	Nursing procedure around Dysphagia, Tab # 111	Laverne Plater
	Complete *Status: Draft completed. - Updated as of 6/19/2009*			
2	Nurse managers, consultants and educators to provide on unit coaching on implementing procedure.	8/28/2009		Hartley

4 *Align the Choking/Swallowing Assessment form with the policy. Change the title to Dysphagia Assessment. Review risk factors to assure that all relevant to the population at SEH are included.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Modify form as needed to conform to new procedure	7/31/2009	Nursing procedure around choking , tab # 111	Laverne Plater

5 *Clarify how the RN will be directly involved in developing the IIRP.* *CNE; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Train nurse managers on IRP overview and input into IIRP	7/1/2009	IRPTraining Data, Tab # 2	Gouse
	Complete			
2	Nurse managers will train nursing staff on their units.		IRPTraining data, Tab # 2, Nursing training data, Tab # 120	Nurse managers

Status: Nurse Managers have trained most of their staff on IRP involvement; fewer than 40 to 50 active nursing staff members still need IRP training. - Updated as of 7/27/2009

VIII.D.9.b

Compliance Status from DOJ Report: Partial

the related symptoms and target variables to be monitored by nursing and other unit staff; and

Findings The Change of shift procedure and template were revised and incorporated into a new nursing procedure. Change of shift nursing procedure, tab # 109. It provides detailed instructions as to the content of the change of report; it specifically requires the discussion of IRP objectives. The nursing update form recently implemented now requires nursing staff to assess progress against specific IRP focus areas and objectives. This is expected to ensure nursing target interventions to IRP objectives and become more aware of the individual's progress toward IRP goals.

Compliance Status: Partial.

DOJ Recommendations (Report 3) ***Responsible Party***

1 *See VIII.D.1. Recommendation 9.* ***- High Priority*** *CNE; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps for VIII.D.1 recommendation 9.			

2 *See VIII.D.2. Recommendations 6 and 7* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps for VIII.D.2. Recommendations 6 and 7			

3 Using the nursing p/p template, revise the nursing documentation policy/procedure. CNE;

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

VIII.D.9.c ***Compliance Status from DOJ Report: Partial***

the frequency by which staff need to monitor such symptoms.

Findings See VIII.D.

IRP policy requires the IRP to include frequency of interventions. The clinical chart audit process began in July, 2009. While it is likely some modification to the tool, instructions and/or training will be made to enhance reliability, initial results in the pilot show that in 92% of cases audited in July, 2009, the interventions included specific information about frequency of interventions. Clinical chart audit results, tab # 11. There are some cases, however, where the IRPs still do not specify the frequency of nursing observations or monitoring on a consistent basis, or the name of person who is to provide the intervention, although data is not available since nursing audit and clinical chart audits have not begun. The training on IRP will include some component of nursing discipline specific training.

Nursing also developed a procedure for administering insulin. Nursing Procedure, Insulin Administration, tab # 115. The procedure includes what to do if meals are delayed, and signs and symptoms of hypoglycemia and hyperglycemia.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Based on the planned dining room hours for each unit, immediately clarify when insulin should be administered.* ***- High Priority*** *Med; CNE; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Nursing willl revise the Diabetic Care policy and procedure to clarify insulin administration protocol. The p/p will discuss who is responsible for insulin administration, the time period insulin should be administered, and whether the adminsitration time will differ per unit.	8/14/2009	Nursing procedure on insulin administration, Tab # 115	Martha Pontes, George Tanyi
	Status: Martha Pontes has drafted a p/p on diabetes. George Tanyi will review prior to gaining approval from Michael Hartley. - Updated as of 7/22/2009			
2	CNE's Analyst and Nutrition Services Director Amelia Peterson-Koseki will meet on July 29, 2009 to discuss snacks for diabetic patients, delievery/pick-up responsibilities, and procedures in cases of delays and emergencies.	7/29/2009		Michael Spencer and Amelia Peterson-Koseki
	Complete *Status: Based on the Drug Inquiry Grouped by Medication Name report from Ermias Zerislassie, there are 47 patients prescribed insulin throughout the hospital. NSD has a plan in place to provide a take out meal for each insulin dependent person needing a meal in the event that a scheduled meal will be 30 minutes or more late. - Updated as of 8/11/2009*			

2 *Immediately review the signs of hypo and hyperglycemia with all nursing staff.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Distribute copies of the hypo and hyperglycemia flowsheets to nurse managers for discussion/distribution on units.	7/30/2009	Nursing procedure on insulin administration, tab # 115	Michael Spencer
	Complete			

1	Discuss hypo and hyperglycemia on units with nursing staff.	7/30/2009	Nursing procedure on insulin administration, tab # 115	Nurse Managers, Shirley Quarles, Laverne Plater, Lewis Mayo, Brenda Lateef, and Unit Team Leaders

Status: Nurse Consultants and Nurse Educators have visited some units and shared this information; a more aggressive training session is being developed to address this recommendation. - Updated as of 7/23/2009

2	Incorporate expectations that nursing staff understand the signs of hypo and hyperglycemia in diabetic policy to assure all staff are held accountable for this knowledge.	8/28/2009		Martha Pontes, George Tanyi
3	ncorporate expectations that nursing staff understand the signs of hypo and hyperglycemia in nursing competency requirements to assure all staff are held accountable for this knowledge.	8/28/2009		Lewis Mayo, Michael Hartley

3 *Using the nursing p/p template, develop policies that comprehensively address the care of patients with diabetes, including actions to take when meals are delayed.* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop process to check stocks on each unit every day		Nursing procedure on insulin administration, tab # 115	

Status: Status Update:Completed 04/27/2009. Not yet started - Committee should be chaired by a physician. Review diabetes management with PIC - Updated as of 6/18/2009

Participate in the hospital wide interdisciplinary committee with physicians, nurses, dietitians, and performance improvement staff to review current procedures and standards of care. Revise standards as necessary.	5/6/2009		

Status: Status 5/21/09: This topic is currently under consideration by the PIC.

4/27/2009 Not yet started but a NSD request has been made to review diabetes management with PIC
Status 5/21/09: This topic is currently under consideration by the PIC.

4/27/2009 Not yet started but a NSD request has been made to review diabetes management with PIC - Updated as of 6/18/2009

Review the list of patients with diabetes daily to assure that the patients have the appropriate meals and/or snacks available	4/13/2009		

Status: Nursing changed the insulin procedure effective immediately; all patients will receive insulin by the day shift not the night shift. Start reviewing the list and make a plan to assist with snack and meal delivery - Updated as of 6/18/2009

4	NSD to make daily rounds to ensure food is available on units for insulin administration coverage.		Nursing procedure on insulin administration, tab # 115	

4 *See VIII.D.1 recommendation 10.* *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See response to VIII.D.1 recommendation 10			

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

A new Infection Control Coordinator began work on March 23, 2009. He has completed an Infection Control Manual, revitalized the Infection Control Committee, and begun trending information about health care associated infections. He has conducted several hand hygiene observations.

Compliance Status: See sub cells.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

VIII.D.10.a

Compliance Status from DOJ Report: Partial

actively collect data with regard to infections and communicable diseases;

Findings

The Infection control manual was revised and finalized. Infection Control Manual, tab # 128. Procedures around tuberculosis, scabies, lice, cluster outbreaks and foodborne illnesses are included. The Manual also describes an overview of the Infection Control Program, and a Strategic Plan was completed. Infection Control Strategic Plan, tab # 129; Infection Control Committee Minutes, tab # 130.

The Hospital now is collecting data with respect to Hepatitis B and C, HIV, as well as other Health care associated infections (respiratory, urinary, eye, skin, GI, MRDOs, and reportable communicable diseases). The information is trended and reported to the Infection Control Committee. See Infection Control Report, March/April, 2009, and June, 2009, tab # 131.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***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.* ***- High Priority*** *Med; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a strategic plan for the infection control program.	7/1/2009	IC Manual, Tab # 128	Malcolm Cook
	Complete *Status: A strategic plan for the infection control has been created. - Updated as of 6/19/2009*			
2	Complete an annual Infection Control Facility Risk Assessment	7/1/2009	IC Strategic plan, Tab # 129	Malcolm Cook
	Complete *Status: An Infection Control Facility Risk Assessment has been completed and reveiwed with the infection control committee 7/2/09 - Updated as of 6/24/2009*			
3	Draft a policy and procedure outlining the roles and function of the ICC Committee.	7/1/2009	IC Strategic plan, Tab # 129, Infection Control Manual, Tab # 128	Malcolm Cook
	Complete *Status: A policy/procedure for the IC Program and ICC Committee functions has been created. See IC Manual - Updated as of 6/24/2009*			

2 *Develop a clear structure for the IC Program that includes a description of the ICC responsibilities and that addresses each requirement in VIII.D.10. of this agreement.* ***- High Priority*** *Med; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft a policy, which addresses the goals and the IC Program and ICC Responsibilities structure of the IC Program.	6/29/2009	IC strategic plan, Tab # 129; IC Manual, Tab # 128	
	Complete *Status: A policy outlining structure and ICC responsibilities has been developed - Updated as of 6/19/2009*			

2	Address each requirement in VIII.D.10 of the agreement	8/1/2009	IC Manual, Tab # 128, IC Monthly/Quarterly Reports, Tab # 131	

Complete

3 *Develop a TB Control policy/program based on generally accepted standards and CDC guidelines, including those related to risk level.* — *Med; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft policy and procedure for TB Control based on CDC guidelines	7/1/2009	IC Manual, Tab # 128	

Complete

2	Review draft policy with Infection Control Committee	7/8/2009		

Complete *Status: TB Policy will be reviewed with committee 7/10/09. After review it will go for the final edit. 7/20/09 - Updated as of 6/26/2009*

4 *Develop policies and procedures to identify cluster outbreaks.* — ***- High Priority*** *Med; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft a policy to identify cluster outbreaks based on national standards.	7/1/2009	IC Cluster Outbreak Policy, Infection Control Manual, Tab # 128	

Complete *Status: A policy to identify cluster outbreaks has been developed and will be reviewed during the next infection control committee. 7/10/09 Policy approved by the committee will go for final edit. 7/17/09 in final edit - Updated as of 6/19/2009*

2	Review policy with the ICC	7/9/2009		

Complete *Status: Policy will be reviewed with ICC. 7/2/09 Policy has been reviewed and approved by ICC. 7/10/09 see above - Updated as of 6/26/2009*

3	Finalize policy		IC Cluster Outbreak Policy, Infection Control Manual, Tab # 128	

5 *Develop policies and procedures for food borne illness, flu, and noro virus.* — *Med; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft a policy/prcedure for foodborne illness, flu and norovirus.	7/15/2009	Infection control manual, Tab # 128	

Complete *Status: in progress. 7/2/09 Policies for flu and norovirus have been approved by icc. Foodborne illness policy still being developed. 7/10/09 flu and norovirus policies going for final edit. 7/19/09 in final edit.*
A policy has been drafted and pending review by the ICC - Updated as of 6/22/2009

2	Review policy with ICC	7/9/2009	Infection control committee meeting minutes, Tab # 130	

Complete *Status: Completed - Updated as of 6/26/2009*

6 *Identify categories of data to be collected with initial focus on those data that relate to risks for this population.* — *CNE; Malcolm Cook*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a list of healthcare associated infections to track, which are relevant to our population	6/25/2009	IC monthly/quarterly reports, Tab # 131	

Complete *Status: The infection control coordinator has developed a list of healthcare associated infections, which are relevant to our population. 7/2/09 incidence rates for HAIs are being tracked monthly. - Updated as of 6/19/2009*

7 Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level and across the hospital. — Med; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	A supervisory review wiil be conducted to assess compliance with Infection Prevention standards. The frequency and type of review will be determined based on the scope of problems identified and the effectiveness of corrective measures.	6/25/2009	IC meeting minutes, Tab # 130	
	Complete *Status: on-going supervisory reveiws to assess compliance of infection prevention standards. - Updated as of 6/22/2009*			
2	Conduct compliance rounds for infection prevention activities such as, hand-washing	6/25/2009	Hand-hygiene data, Tab # 132	
	Complete *Status: on-going compliance rounds for hand-washing - Updated as of 6/25/2009*			

VIII.D.10.b

Compliance Status from DOJ Report: Partial

assess these data for trends;

Findings See VIII.D.10.a

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *See VIII.D.10.a* — ***- High Priority*** Med; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.D.10.a	6/1/2009		
	Complete *Status: healthcare associated infection rates are tracked and trended in monthly infection control report - Updated as of 6/30/2009*			

2 *The Infection Control Committee should review data/data analysis no less than quarterly.* — Med; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	The Infection Control Coordinator will track and trend healthcare associated infections/infection prevention activities and present data to the Infection Control Committee	6/25/2009	IC Monthly/Quarterly Reports, Tab # 131	
	Complete *Status: The infection control coordinator has presented infection control data to the infection control committee since April 2009 - Updated as of 6/19/2009*			

VIII.D.10.c

Compliance Status from DOJ Report: Partial

initiate inquiries regarding problematic trends;

Findings See VIII.D.10.a.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *See VIII.D.10.a.* — ***- High Priority*** Med; Malcolm Cook

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

1 Problematic trends to be identified and reviewed..	6/1/2009	Infection control committeemeeting minutes, Tab # 130	

Complete *Status: problematic trends and corrective actions are discussed at the monthly infection control meetings - Updated as of 6/30/2009*

***2** The Infection Control Committee should determine areas for further "drill down" based on trends in data.* *Med; Malcolm Cook*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 The ICC will review data from outcomes and process measures.	7/15/2009	ICC meeting minutes, Tab # 130	
Complete *Status: The ICC reviews outcomes and process measures data during monthly meetings - Updated as of 6/22/2009*			
2 Take corrective actions when areas of deficiency are noted.		ICC meeting minutes, Tab # 130	
Complete *Status: The ICC has taken corrective actions on several deficiencies - Updated as of 6/25/2009*			

VIII.D.10.d

Compliance Status from DOJ Report: Partial

identify necessary corrective action;

Findings See VIII.D.10.a

The Infection Control Committee reviewed the environmental survey and safety inspections, and has clarified the responsibilities. See Infection Control Committee minutes, tab # 130. Corrective action plans were developed to correct deficiencies identified in the environmental surveys.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1** See VIII.D.10.a.* ***- High Priority *Med; Malcolm Cook*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Corrective action plans to be developed for problematic trends.	6/1/2009		
Complete *Status: 7/10/09 please see previous response about corrective actions - Updated as of 6/30/2009*			

***2** Differentiate "monthly safety inspections" and "environmental survey", clarifying purpose, method, reporting routes, responsibility for taking and documenting actions as well as evaluating effectiveness of actions taken. Assure involvement of the ICC and the Infection Control Committee as applicable.* *Med; COO; Malcolm Cook, Robert Winfrey*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review findings infection control finding from the ES and monthly safety inspections with the ICC during monthly meetings	7/22/2009	Infection Control committee meeting minutes, Tab # 130.	
Complete *Status: in progress - Updated as of 6/22/2009*			
2 Take corrective actions on infection control findings when necessary	7/22/2009		
Complete *Status: in-progress 7/2/09 see above - Updated as of 6/25/2009*			

VIII.D.10.e

Compliance Status from DOJ Report: Partial

monitor to ensure that appropriate remedies are achieved;

Findings See VIII.D.10.a and d.

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
1 See VIII.D.10.a. - High Priority	Med; Trg; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See VIII.D.10.a.			

	DOJ Recommendations (Report 3)	Responsible Party
2	Include in the Infection Control Program/Policy/Procedures how actions will be monitored, and the effectiveness of actions evaluated.	Med; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Draft a Supervisory Review policy/procedure outlining process for detectiing and taking corrective action for non-compliance with infection control policies and procedures	7/22/2009	Infection control manual, Tab # 128	
	Complete Status: in progress 7/2/09 policy complete and awaiting review by icc 7/10/09 pending. 7/19/09 submitted for final edit. - Updated as of 6/22/2009			

	DOJ Recommendations (Report 3)	Responsible Party
3	Assure that the Infection Control Officer review Environmental Survey findings that relate to Infection Control.	Med; COO; Malcolm Cook, Robert Winfrey

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Review the Environmental Survey findings when they are published (quarterly) discuss finding with the ICC	7/22/2009		
	Complete Status: The ICP reviewed the infection control section in the 1st quarter 2009 Environmental Survey. 7/2/09 findings to be discussed with ICC during next meeting. 7/19/09 will be discussed during the next infection control meeting on 7/22/09. - Updated as of 6/22/2009			
2	ICC will make recommendations as necessary	7/22/2009		
	Complete Status: in progress 7/2/09 to be completed during next meeting - Updated as of 6/26/2009			

VIII.D.10.f

Compliance Status from DOJ Report: Noncompliance

integrate this information into SEH's quality assurance review; and

Findings See VIII.D.10.a

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
The Director of Performance Improvement and the Infection Control Chief should determine how to achieve integration. This should be described in Infection Control Program/Policies/Procedures.	Med; PID; Malcolm Cook

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Work with PI on monitoring processes such as, handwashing		Hand-hygiene data, Tab # 132	
	Complete Status: Hand-hygiene data is collected by the ICP and Quality Improvement Coordinator and is an example of integration between the two departments. - Updated as of 6/22/2009			
2	Draft policy/procedure describing PI/IC Integration	7/15/2009		
	Complete Status: in-progress. 7/19/09 in final edit. - Updated as of 6/25/2009			
3	Share process measurement data with PI Committee	7/15/2009		
	Complete			

VIII.D.10.g

Compliance Status from DOJ Report: Partial

ensure that nursing staff implement the infection control program.

Findings See VIII.D.10.a.

Nursing is implementing a new change of shift report process that includes environmental surveys as well as participating in the quarterly environmental surveys. The Infection control Manual includes specific procedures around precautions, and as reflected in the Infection Control Committee minutes, the infection control officer is working with nursing around implementation and supply issues.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *See VIII.D. 2 and VIII.D.10.a.* ***- High Priority*** *Med; Malcolm Cook*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, VIII.D.2 and VIII.D.10.a			

2 *Develop a policy that clearly defines precautions, directs steps to implement each type of precaution, and specifies documentation requirements.* ***- High Priority*** *Med; Malcolm Cook*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft a policy for isolation based on national guidelines such as, the CDC	7/15/2009	Infection Control Manual, Tab # 128	

Complete *Status: 7/10/09 isolation policy drafted and approved by committee. 7/19/09 in final edit. - Updated as of 6/22/2009*

3 *Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions.* *Med; CNE; PID; Malcolm Cook*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monitor compliance for adherence to the policies will be covered in the supervisory review mentioned earlier	7/15/2009	Infection control manual, Tab # 128	

Complete *Status: in progress 7/10/09. 7/19/09 in final edit - Updated as of 6/22/2009*

VIII.D.11

Compliance Status from DOJ Report: Noncompliance

Ensure sufficient nursing staff to provide nursing care and services.

Findings The Hospital hired a Chief Nurse Executive. Progress is being made in nurse staffing, although there are now four nurse manager vacancies. See VIII.D around nurse staffing and patient care hours. Effective August 15th, Staff have been redeployed to ensure RN coverage on each shift each ward. A standard for nursing care hours was set, and actual hours are being monitored against that standard. Data will be available during the site visit. In addition, the Hospital is now able to track those shifts or units who did not have an RN on duty. See Tab 107 for template, actual data will available during survey.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Evaluate the factors that have contributed to not having an RN on duty on each unit on all shifts. Address these factors in order to assure that an RN is on every unit, on every shift, at all times.* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 CNE to study how many shifts did not have RNs for the months of July and August, including access the Nursing Time Entry Database to develop a report that shows RN coverage. Program Analyst will also look at SAR usage to see if contract nurses were used to supplement RN coverage.	9/4/2009	Nursing care hours of patient care data, Tab # 108	Michael Spencer

Complete *Status: Meeting with Won-ok Kim on July 23, 2009 to learn how to access reports. Collected SAR data for June. - Updated as of 7/23/2009*

2	The CNE, ADONs, and other executive members will review the union contracts and relavant regulations to determine whether a flex scheduling plan can help the Hospital overcome the challenges of having an RN on every unit, on every shift, at all times. *Status: CNE has drafted a flexible staffing plan. - Updated as of 7/29/2009*	8/28/2009		Michael Hartley, George Tanyi and Martha Pontes
2	The CNE, ADONs, and other executive members continue to evaluate the number of RNs that work at Saint Elizabeths. ***Complete***	9/4/2009		Michael Hartley, George Tanyi and Martha Pontes
3	The CNE is considerin a change to the Hospital's approach to hiring supplement nurses, and focus on a contract that allows greater flexibility and a higher number of RNs instead of nursing asssitants.	9/4/2009		Michael Hartley

2 *Determine the targeted NCHPPD standards for each unit.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop a Plan for the Provision of Care for each unit. This plan will include a standard formula to determine the targeted NCHPPD standards for each unit.	8/14/2009	Nursing plan for provision of care (template), Tab # 107	Michael Hartley

3 *Report the actual NCHPPD delivered on a monthly basis by unit. Include in this report the number of shifts, by unit, that did not have at least one RN on duty.* ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	CNE or designee will use a standard formula to report the actual NCHPPD for July and August 2009.	9/4/2009	Nursing care hours of patient care data, Tab # 108	Michael Hartley and Michael Spencer

4 *Evaluate and adjust as necessary the mix of nursing personnel (RNs, LPNs, PTs) considering the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required number of RNs.* *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	The CNE will develop a Plan for the Provision of Care for each unit. This plan will address the nursing needs of every unit, and the action steps to meet those needs, including but not limited to, re-assigning staff to different units and/or shifts.	8/14/2009	Plan for provision of care (template), Tab # 107	Michael Hartley and Nurse Managers

5 *Revise a SEH Plan for Nursing Services that at a minimum: articulates the NCHPPD with rationale; establishes the mix of nursing personnel; describes scheduling models/policies; provides a guiding decision framework for alternatives when additional staffing is required.* *CNE; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	The CNE's Plan for the Provision of Care will articulate the NCHPPD with rationale as it has a unit-based approached based on each unit's level of stability. In conjunction with the CNE's Flexible Staffing Plan, the Plan for the Provision of Care will establish the ideal mix of nursing personnel for each unit, and provide guidance to nurse managers on staff allocation when additional staffing is required.	8/14/2009		Michael Hartley
2	The CNE's Flexible Staffing Plan will describe the Nursing Department's scheduling model(s) and policies.	8/14/2009		Michael Hartley

6 *If there are currently insufficient numbers of nursing positions to meet the targeted NCHPPD, develop an interim plan to assure the best use of resources, while long term planning is underway to secure the required positions.* *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 The CNE or designee will determine the NCHPPD for July and August 2009.	9/4/2009	Nursing care hours of patient care data, Tab # 108	Michael Harley and Michael Spencer
2 The CNE will continue to utilize contract nursing to assist the Hospital supply nursing services, and consider readjusting our approach to supplement nursing services in the near future.	9/4/2009		Michael Hartley

IX. Documentation

Summary of Progress See Sections V, VII, VIII, and X for progress summary.

IX. Documentation.

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

Findings See sections V, VI, VII, VIII and X concerning documentation issues.

Compliance Status: See related compliance findings.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications

Summary of Progress

1. The Hospital revised its Seclusion and Restraint for Behavioral Reasons policy, its Protective Measures policy and the Involuntary Administration of Medication policies to incorporate DOJ additional recommendations around the definition of drug used as a restraint.
.
2. An Unusual incident form is required by DMH policy each time seclusion or restraint is used. Hospital use of restraint or seclusion continues to decrease and in June, involved less than 1% of individuals, but the Hospital recognizes that in some incidents, use of the "quiet room" is in fact seclusion which is not being reported. Nurse managers continue to work with staff around these issues.

3. The Hospital still lacks the capacity to track incidents of emergency involuntary administration of medication. However, a report is available that tracks provision of STAT medication and method of administration. While this does not necessarily equate to emergency involuntary medication, it provides a source to try to identify those persons. The Hospital is able to track the non-emergency involuntary administration on medication.

4. Trauma informed care training is underway on RMB 3. Comfort items are now available on that unit.

5. The training around seclusion and restraint was significantly revised, with more emphasis on interventions to be used that may prevent the need for seclusion and restraint. The training includes vignettes (skits) were staff are able to see an issue and then discuss issues and alternative resolutions. Training is underway for all nursing staff.

6. The Performance Improvement Department continues to audit seclusion and restraint episodes using a modified tool. Further modifications are expected in order to improve inter-rater reliability.

X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications.

By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.

Findings See sub cells for findings.

Compliance Status: See sub cells for findings.

X.A.

By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:

Findings See sub-cells for status.

The Seclusion and Restraint for Behavioral Reasons policy was revised to clarify that the definition of "drug used as a restraint", by specifying that medication that is part of the individual's regular medication regimen, even if an extra dose and used to control the individual's behavior is not considered to be a drug used as a restraint, and that the use of drugs as a restraint are not permitted by policy. Seclusion and Restraint For Behavioral Reasons Policy, tab # 51. The policy was also substantially revised in the section involving termination of an episode of seclusion or restraint to require that the doctor's order include specific behavioral criteria for release, require the nurse to inform the individual every 15 minutes of the conditions for release, and describes the circumstances upon which the nurse should contact the physician to effect release prior to the specified release conditions are met. A new doctor's order form was developed, which removes any reference to drug as a restraint, prompts a specific review of what alternatives to the seclusion and restraint were tried, includes target symptoms, and identify specific criteria for release. Doctor's order for Restraint and Seclusion, tab # 138. Staff were provided with a list of examples of behavioral criteria for release, to assist in improving the quality and specificity of release criteria. Behavioral criteria release examples, tab # 139. Nursing developed and is implementing a nursing procedure that provides step by step instructions around use of seclusion and restraint. Nursing procedure re Restraint and Seclusion, tab # 113.

A new comfort plan form was developed, Advanced Instructions Comfort Plan, tab # 104, and nursing have updated comfort plans for almost ninety percent of individuals. An audit of comfort plans (54) was conducted in July, 2009. In general, four of the five sections of the comfort plan were adequately completed at least 85% of the time. Individuals signed the comfort plans 76% of the time, and in 62% of the cases where plans could not be completed, staff adequately documented the reasons. Comfort plan audit results, tab # 106.

The Hospital continued to conduct audits of seclusion and restraint incidents, with a modified tool and instructions were developed. (The tool went through a number of iterations.) Restraint and Seclusion Event Review tool/instructions, tab # 54. However, the tool is undergoing additional revisions and will be available during the site visit. Staff in PID audited 12 incidents of seclusion and restraint during February through June, 2009, which was 13% of the total incidents. The audit suggests improvement is needed in most aspects of restraint and seclusion, especially around whether alternatives used before restraint or seclusion was implemented. Restraint/Seclusion audit results, tab # 55.

Seclusion and restraint data continues to be reported and is now included in the PRISM (Performance Related Information for Staff and Managers) reports. PRISM, July, 2009, tab # 53. Data show that less than 1% of individuals are restrained, less than 1% are secluded, well below the national level of 4.1% for restraint, and 2.1% for seclusion and that these indicators have been below 1% since March, 2009. Restraint and seclusion hours are also well below national levels. Total number of restraint hours hospital wide in July, 2009 were 4 hours and 15 minutes; total hours of seclusion hospital wide in July were 3 hours. Data is also tracked by unit. However, managers believe there may be underreporting of seclusion hours, as there have been times when an individual is asked to go to the "quiet room" but may not understand he or she can leave at anytime. Managers continue to work with nursing staff on this issue, and it was specifically addressed in the recent seclusion training.

Compliance Status: Partial

X.A.1 ***Compliance Status from DOJ Report: Partial***

the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.

Findings See X. A.

The Policy includes a prohibition on use of prone restraint. Seclusion and Restraint For Behavioral Reasons Policy, tab # 51. In addition, the nursing procedures around seclusion and restraint make clear prone restraints are not permitted. Nursing procedure, seclusion and restraint, tab # 113 . Nursing staff are receiving training on use of seclusion and restraint, which specifically addressed the use of prone restraint.

The restraint and seclusion audit looked specifically at whether there was documented evidence of use of low or moderate level interventions, and whether there was evidence the interventions in the comfort plan was used. During the audit period, (February to June, 2009), staff used the comfort plan instructions in 27% of cases, and used low level and/or moderate level interventions in 75% of cases. Restraint and seclusion audit results, tab # 55. It should be noted that the initiative to update comfort plans occurred at the end of this review period, so the Hospital expects that use of the comfort plan interventions will increase.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Using the nursing p/p template, develop the nursing p/p for seclusion, restraint, and involuntary medication.* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise the p/p for seclusion, restraint and involuntary medication to include procedures for the assessment, triggers, use, individualized approaches, release criteria, etc.	8/5/2009	Nursing procedure on seclusion and restraint, Tab # 113	Lewis Mayo and Shirley Quarles
2 Train staff on nursing procedure	8/5/2009	Nursing training data, Tab # 120	Lewis Mayo and Michael Hartley

2 *See XIII.D.1 regarding training and competencies.* *- High Priority* *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See responses to XIII.D.1			

3 *Provide training to all nursing personnel on the new policy.* *- High Priority* *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Training Department will work with Nurse Managers to train all nursing personnel on the new S/R policy.	8/14/2009	Nursing training data, Tab # 120	Lewis Mayo and Nurse Managers

4 *Implement the nursing p/p.* *- High Priority* *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement seclusion and restraint nursing p/p *Status: Ongoing - Updated as of 7/23/2009*	8/31/2009		

5 *Continue monitoring. Involve clinical staff in analyzing findings, determining actions, and evaluating the effectiveness of actions taken.* *Med; CNE; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 PID to continue seclusion and restraint audits and will share findings with Executive and PIC *Status: Ongoing - Updated as of 6/25/2009*	6/1/2009 (Ongoing)	Seclusion and restraint audit results, Tab # 55	PID
2 Medical director (designee) to monitor use of r/s that meets Hospital policy triggers.	8/10/2009	Tracking report for high risk indicators, Tab # 56	Arons

X.A.2

Compliance Status from DOJ Report: Partial

training in the management of the individual crisis cycle and the use of restrictive procedures; and

Findings See VIII.D. and X.A.

Staff recently completed training on restraint and seclusion which included a component around de-escalation techniques and other interventions that should be implemented before seclusion or restraint is used. Nursing training data, tab # 120. Nonviolent crisis intervention training is still required of nursing staff, and the Chief Nurse Executive is reviewing this and other training options to strengthen identification of crisis intervention alternatives. Additionally, nursing have updated comfort plans on most individuals in the Hospital and it is to be reviewed each IRP conference. See IRP Manual at Tab 11 (checklists for IRP meetings).

The restraint and seclusion audit for the period of February to June, 2009, looked specifically at there was documented evidence of use of low or moderate level interventions, and whether there was evidence the interventions in the comfort plan was used. During the audit period, (February to June, 2009), staff used the comfort plan instructions in 27% of cases, and used low level and/or moderate level interventions in 75% of cases. Restraint and seclusion audit results, tab # 55. It should be noted that the initiative to update comfort plans occurred at the end of this review period, so the Hospital expects that use of the comfort plan interventions will increase.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

See VIII.D.1 and X.A.1 *- High Priority* *Med; CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See responses to VIIID.1 and X.A.1			

X.A.3

Compliance Status from DOJ Report: Partial

the use of side rails on beds, including a plan:

Findings Use of side rails continue to be governed by the Medical and Protective Devices Policy previously provided. Currently four individuals in RMB use some form of side rails each night, and seven individuals at JHP use them intermittently. A new nursing procedure is implemented around use of side rails and other protective equipment. Under the new nursing procedures, staff assess the need for side rails, and weigh the risks, including the condition of the individual. There are specific procedures for use of bed rails as a restraint, and use as a fall precaution and addressing their use in the IRP. It also requires a quarterly audit of side rails. Tab # 112.

Nursing and facilities conducted an assessment of type of side rails to determine if the Hospital is continuing to use those with winged or tapered ends, and to determine if new side rails need to be ordered. The seven side rails at JHP need to be replaced. The Hospital is identifying the appropriate replacement; the beds at JHP are an older vintage and it will take some investigation to determine which manufacturer's side rails can be fitted to these beds.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Using the nursing p/p template, revise the nursing policy that addresses side rails and medical protective devices so that it is aligned with the hospital policy and the terminology is consistent. Assure that assessment factors that influence, and risks associated with, full versus partial side rails are detailed. Clarify accountability for, and intervals of, checking the safety of the equipment.* ***- High Priority*** *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise p/p on siderails and protective measures.	8/5/2009	Nursing procedure on protective devices, Tab # 112	Shirley Quarles
2 Train nursing staff on p/p on use of siderails.	8/28/2009	Nursing training data, Tab # 120	Nurse Managers, Nurse Educators and Nurse Consultants

2 *Eliminate any remaining side rails with winged/tapered ends.* *CNE; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Nurse managers will conduct an inventory of side rails to identify those with winged and tapered ends. This assessment will particularly focus on RMB 1, RMB 2 and JHP 2.	8/10/2009		Nurse Managers
Status: Michael Spencer sent request for information to nurse managers on July 28th. - Updated as of 7/29/2009			
2 Remove side rails with winged and tapered ends, and replace with industry accepted side rails as soon as practical.	8/10/2009		Nurse Managers, Donna Moran
Status: Awaiting the list of rails that will need to be removed. - Updated as of 8/28/2009			

X.A.3.a

Compliance Status from DOJ Report: Partial

to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and

Findings See X.A.3 above.

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

Monitor for compliance. *CNE; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Once side rails with winged or tapered ends are removed, nurse managers and team leaders will monitor the remaining side rails for noticeable defects.	9/25/2009		Nurse managers
2	Nurse Managers and team leaders will inform Martha Pontes and George Tanyi of any defects in the remaining side rails.	10/30/2009		Nurse managers, team leaders

X.A.3.b

Compliance Status from DOJ Report: Partial

to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.

Findings The Hospital policy includes a requirement to include use of side rails into an individual's IRP. However, IRPs are not always including use of side rails or strategies to reduce reliance on them.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Monitor to assure compliance. *CNE; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Amend Protective Measures p/p or develop a side rails monitoring p/p that addresses monitoring requirements for side rails.	10/16/2009		Martha Pontes and George Tanyi
2	Implement the revised protective measures p/p or newly developed side rails monitoring p/p.	10/30/2009		Martha Pontes and George Tanyi

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.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

X.B.1

Compliance Status from DOJ Report: Partial

are used after a hierarchy of less restrictive measures has been considered and documented;

Findings Use of restraint and seclusion at the Hospital continues to decrease. Seclusion and restraint data continues to be reported and is now included in the PRISM (Performance related information for Staff and Managers) reports. PRISM, July, 2009, tab # 53. Data show that less than 1% of individuals are restrained, less than 1% are secluded, well below the national level of 4.1% for restraint, and 2.1% for seclusion and that these indicators have been below 1% since March, 2009. Restraint and seclusion hours are also well below national levels. The total number of restraint hours hospital wide in July, 2009 was 4 hours and 15 minutes; total hours of seclusion hospital wide in July were 3 hours. Data is also tracked by unit. However, managers believe there may be underreporting of seclusion hours, as there have been times when an individual is asked to go to the "quiet room" but may not understand he or she can leave at anytime. Managers continue to work with nursing staff on this issue, and it was specifically addressed in the recent seclusion training.

The Seclusion and Restraint for Behavioral Reasons policy was revised to clarify that the definition of "drug used as a restraint", by specifying that medication that is part of the individual's regular medication regimen, even if an extra dose and used to control the individual's behavior is not considered to be a drug used as a restraint, and that the use of drugs as a restraint are not permitted by policy. Seclusion and Restraint For Behavioral Reasons Policy, tab # 51. A new doctor's order form was developed, which removes any reference to drug as a restraint, prompts a specific review of what alternatives to the seclusion and restraint were tried, includes target symptoms, and identify specific criteria for release. Doctor's order for Restraint and Seclusion, tab # 138. Nursing developed and is implementing a nursing procedure that provides step by step instructions around use of seclusion and restraint. Nursing procedure re Restraint and Seclusion, tab # 113.

A new comfort plan form was developed, Advanced Instructions Comfort plan, tab # 104, and nursing have updated comfort plans for almost ninety percent of individuals. An audit of comfort plans (54) was conducted in July, 2009. In general, four of the five sections of the comfort plan were adequately completed at least 85% of the time. Individuals signed the comfort plans 76% of the time, and in 62% of the cases where plans could not be completed, staff adequately documented the reasons. Comfort plan audit results, tab # 106 . At each IRP review, the comfort plan is to be reviewed with the individual. IRP Manual at tab # 11.

The Hospital continued to conduct audits of seclusion and restraint incidents, with a modified tool and instructions were developed. (The tool went through a number of iterations.) Restraint and Seclusion Event Review tool/instructions, tab # 54. However, the tool and instructions were refined several times during this review period, and additional revisions are underway. Staff in PID audited 12 incidents of seclusion and restraint during February through June, 2009, which was 13% of the total incidents. The audit suggests improvement is needed in most aspects of restraint and seclusion, especially around whether alternatives used before restraint or seclusion was implemented. Restraint/Seclusion audit results, tab # 55. Data shows that low or moderate level interventions were tried in 75% of cases; comfort plans were only utilized in 40%.

Staff recently completed training on restraint and seclusion which included a component around de-escalation techniques and other interventions that should be implemented before seclusion or restraint is used. Nonviolent crisis intervention training is still required of nursing staff. Additionally, nursing have updated comfort plans on most individuals in the Hospital and it is to be reviewed each IRP conference. See IRP Manual at Tab 11 (checklists for IRP meetings).

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Implement all new forms and processes as planned.*		***- High Priority***	*Med; CNE; PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Implement new r/s policy after training of staff		Restraint or seclusion for behavioral reasons policy, Tab # 51; Nursing training data, Tab # 120	
2 Continue r/s audits by PID		Restraint and seclusion audit tool/instructions, Tab # 54	PID
Status: R/S audit tool revised several times as were instructions. Final revisions were made in August, and will be used in September audits. - Updated as of 7/27/2009			
2 *Continue IRP training and monitoring.*		***- High Priority***	*COS;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
Initiate training on all remaining units by July 15, 2009	7/15/2009		Gouse
Status: IRP training completed for 4 units, underway for 13 others. - Updated as of 6/18/2009			

2	Include in clinical chart audit tool provision assessing if IRP was updated based upon use of r/s and whether use is reflected in clinical formulation	Clinical chart audit tool/instructions, Tab # 10; Clinical chart audit results, Tab # 11

X.B.2

Compliance Status from DOJ Report: Partial

are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

Findings

Use of restraint and seclusion at the Hospital continues to decrease. Seclusion and restraint data continues to be reported and is now included in the PRISM (Performance related information for Staff and Managers) reports. PRISM, July, 2009, tab # 53. Data show that less than 1% of individuals are restrained, less than 1% are secluded, well below the national level of 4.1% for restraint, and 2.1% for seclusion and that these indicators have been below 1% since March, 2009. Restraint and seclusion hours are also well below national levels. The total number of restraint hours hospital wide in July, 2009 was 4 hours and 15 minutes; total hours of seclusion hospital wide in July were 3 hours. Data is also tracked by unit. However, managers believe there may be underreporting of seclusion hours, as there have been times when an individual is asked to go to the "quiet room" but may not understand he or she can leave at anytime. Managers continue to work with nursing staff on this issue, and it was specifically addressed in the recent seclusion training.

The Hospital continued with its restraint and seclusion audits; instructions were developed and the tool (and instructions) were refined several times over the review period. (Attached is a copy of the last version with instructions). Tab # 54. The audit results for the period of February, 2009 through June, 2009, show that in 0% of cases, was restraint or seclusion used as a convenience for staff or as a punishment; in 8% of cases there was evidence it was used as alternative to active treatment. Restraint and Seclusion audit results, tab # 55. This is an improvement over last reporting period.

The Hospital continues to improve treatment options; there are now four TLCs, serving 210 individuals in the civil side and JHP. There are more ward based activities for those who are not able to attend the treatment malls. TLC and ward schedules, tab # 69. Each unit now has a WII game, and other leisure activities are also available. RMB 3 was redesigned, and now serves individuals who need more intensive assessment and treatment as opposed to those with challenging behavioral issues. Programming at RMB 3 also changed, and there are more groups by each discipline. Further, some individuals on RMB 3 attend the treatment mall for all or some part of the day. See Letter from Ellen Efros to S. Cutler, tab # 98. Further information about the changes to RMB 3 will be available during the site visit.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Develop instructions to accompany the seclusion and restraint audit. Measure inter-rater reliability on a monthly basis.* — *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Conduct monthly audits using revised tool	6/15/2009		Hartley
Status: audits using prior tool were conducted and data is available. - Updated as of 6/18/2009			
Modify audit tool/instructions to incorporate DOJ recommendations	6/15/2009	Restraint and seclusion audit tool/instructions, Tab # 54	Hartley
Complete			

2 *Reconfigure RMB 3.* ***- High Priority*** *Civil; Med; CNE; COS; CEO*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Clinical leadership of hospital to meet to discuss DOJ recommendations and make decision around RMB 3..	5/1/2009	Letter to S. Cutler, DOJ, from E. Efros, outlining RMB-3 changes, Tab # 98	Vidoni-Clark
	Complete *Status: Several meetings held. Decision to reconfigure RMB 3 from behavior management unit to continuing care unit for persons who are not progressing as expected and need more in depth assessment and interventions. - Updated as of 8/27/2009*			
2	Identify and fill key clinical positions on unit	6/1/2009		CVC
	Complete *Status: Clinical administrator and Nurse manager hired 6/8/2009 - Updated as of 6/24/2009*			
3	Develop programming for newly configured RMB 3.	7/30/2009	TLC and civil side program schedules, Tab # 69	Vidoni-Clark
	Status: Unit is structured around small group programming & incorporates the full integration of all disciplines. Patients receive 5 group interventions per day & daily afternoon outdoor exercise. Program schedule implemented 6/01/2009. Clinical administrator to develop a system to monitor fidelity to RMB 3 program schedule and to monitor treatment hours provided to patients. - Updated as of 8/27/2009			
4	Reconfigure mix of patients assigned to RMB 3	7/31/2009	List of patients transferred off or discharged from RMB 3 since DOJ visit, tab #	CVC
	Status: Ten of the patients who were assigned to RMB 3 at time of DOJ visit have either been transferred to other units or discharged. - Updated as of 7/28/2009			
5	Clinical administrator to coordinate unit based work group to refine unit mission statement & identify and modify unit processes/practices that need to be changed	8/31/2009		CVC

X.B.3

Compliance Status from DOJ Report: Partial

are not used as part of a behavioral intervention; and

Findings The Hospital policy prohibits use of seclusion or restraint as part of a behavioral plan. There are no plans that include it.

Compliance Status: Substantial

DOJ Recommendations (Report 3) ***Responsible Party***

Monitor for compliance. *Med; CNE; Psychology*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Psychology will monitor behavioral plans and guidelines to assure they do not incorporate use of r/s as part of behavioral intervention.	8/31/2009		Gontang
	Status: Ongoing - Updated as of 7/23/2009			

X.B.4

Compliance Status from DOJ Report: Partial

are terminated as soon as the individual is no longer an imminent danger to self or others.

Findings The Hospital policy on Restraint and Seclusion was modified to clarify the standards around terminating use of restraint or seclusion. Restraint and Seclusion for Behavioral Reasons policy, tab # 51 . Among the changes are a specific requirement that nursing staff advise the individual every 15 minutes of the behavioral criteria for release as well as a provision that, after consultation with a physician, a nurse may terminate restraint or seclusion upon determining that the individual no longer is an imminent danger, even if the order has not expired or the specified behavioral criteria have not been met. A new doctor's order form for seclusion and restraint has been developed that incorporates some of the recommendations from

DOJ; the Medical Director determined that the Order should not include a list of behavioral criteria as it would likely lead to less individualized criteria. Doctor's order form for seclusion and restraint, tab # 138. Also, a list of examples of behavioral criteria for release from restraint or seclusion was provided to doctors. Tab # 139.

The seclusion and restraint audit establishes that there are still some issues around duration of a seclusion or restraint episode. The audit shows that in 75% of audited cases, restraint or seclusion terminated as soon as the individual was no longer an imminent danger. Restraint and Seclusion Audit results, tab # 55. The audit also found that in only 27% of cases was there documentation that the individual was reassessed for readiness for discontinuation of release from restraint or seclusion every fifteen minutes and in only 25% of cases was the individual informed of behavioral criteria for release every 30 minutes.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Implement the new doctor's order form with additional options for individualized release criteria.* — *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 New order form developed with more open options for individualized release criteria, supported by supplemental list of suggested formulation of individualized criteria for release.	6/1/2009	Doctor's order form for seclusion/restraint, Tab # 138; List examples of release criteria, Tab # 139	Arons

Complete *Status: Order form developed. - Updated as of 8/7/2009*

2 *Review and revise the nursing p/p for Physician Order Transcription to assure that the order that contains release criteria is transcribed exactly as written to the Levels of Observation Flowsheet form.* — *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure nursing procedure on seclusion and restraint includes direction on transcribing physician order to levels of observation flowsheet	7/31/2009	Nursing procedure on seclusion and restraint, Tab # 113	Hartley

Status: Nursing procedure developed - Updated as of 8/31/2009

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.

DOJ Recommendations (Report 3) — ***Responsible Party***

Please see sub-cells for findings and compliance. — *CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See actions steps in subcells			

X.C.1

Compliance Status from DOJ Report: Partial

the specific behaviors requiring the procedure;

Findings The doctor's order form for seclusion and restraint was revised, and after evaluating DOJ's recommendations, most were included. Doctor's order form for seclusion and restraint, tab # 138. Among the changes include removing "drug used as a restraint" as an option, and prompts for description of alternatives to restraint or seclusion that were tried, target symptoms for use of the intervention, tracking timeliness of response to the initiation of the episode, and notification of the attending physician of the use of restraint or seclusion. While DOJ also recommended that the order include sample behavioral criteria for release, the Medical Director elected not to include them on the order, in order to ensure criteria were

individualized to the patient. However, staff were given a list of examples of behavioral criteria for release.

The seclusion and restraint audit data suggests that in 82 % of cases audited, the specific behaviors requiring use of restraint or seclusion were appropriately documented in the order; however, only in 56% of the cases were the specific behaviors appropriately documented in the progress note. Finally, there was appropriate documentation that the individual posed an imminent risk in 92% of cases reviewed. Restraint and seclusion audit results, tab # 55.

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Implement the new order form.* — ***- High Priority*** *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Implement new order form.	6/1/2009	Doctor's order form for restraint and seclusion, Tab # 138	Arons

Complete *Status: New order form implemented and used. - Updated as of 6/29/2009*

2 *Continue monitoring.* — *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify r/s audit form and instructions per DOJ recommendations	7/31/2009	Restraint and seclusion audit tool and instructions, Tab # 54	PID
Complete			
2 Continue r/s audits	(Ongoing)	Restraint and seclusion audit results, Tab # 55	PID
Status: Ongoing - Updated as of 7/28/2009			

X.C.2

Compliance Status from DOJ Report: Partial

the maximum duration of the order;

Findings The Doctor's Order for restraint or seclusion includes a duration prompt, not to exceed one hour. However, the audit did not track this information so no data are available.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Monitor for compliance. — *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps to X.C.1			

X.C.3

Compliance Status from DOJ Report: Partial

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 The doctor's order form for seclusion and restraint was revised, and after evaluating DOJ's recommendations, most were included. Doctor's order form for seclusion and restraint, tab # 138. While DOJ also recommended that the order include sample behavioral criteria for release, the Medical Director elected not to include them on the order, in order to ensure criteria were individualized to the patient. However, staff were given a list of examples of behavioral criteria for release. Tab # 139.

The restraint and seclusion audit results show that in 75% of cases, the individual was released from restraint or seclusion as soon as he or she was no longer an imminent danger to self or others. Restraint and Seclusion audit results, tab # 55. However, in only 50% of cases were there

individualized behavioral criteria for release.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Revise the behavioral release criteria in the Doctor's Order for Restraint and Seclusion form (see above discussion). — *Med; COS;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
	Revise Doctor's order form around behavioral crteria for release	6/30/2009	Doctor's order form for seclusion and restraint, Tab # 138 ; List of examples of release criteria, Tab # 139	Arons
	Complete *Status: Revised Seclsion and restraint training developed - Updated as of 6/18/2009*			
2	Develop and conduct seclusion and restraint training to review policy as well as behavioral criteria for release	7/31/2009	Revised annual training, Tab # 119; Nursing training data, Tab # 120	
	Status: Training will be conducted for psychiatry and nursing staff on July 28, 2009 - Updated as of 7/26/2009			

X.C.4

Compliance Status from DOJ Report: Partial

ensure that the individual's physician be promptly consulted regarding the restrictive intervention;

Findings The restraint and seclusion audit tool results show that in only 50% of cases of restraint or seclusion was the individual's treating psychiatrist promptly consulted. However, the tool does not capture specifically in what percentage of cases was the ordering physician the treating psychiatrist - this will be fixed in the next iteration of the tool.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Continue monitoring for sustained compliance. — *PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See action steps X.C.2			

X.C.5

Compliance Status from DOJ Report: Partial

ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;

Findings According to the audit, in only 25% of cases is there evidence that the patient was notified of the behavioral criteria for release every thirty minutes. Seclusion/restraint audit data results, tab # 55 . The Levels of Observation Flow sheet includes prompts for assessing the individual for release every 15 minutes and for every thirty minutes, assessing whether the individual meets the behavioral criteria for release; it is at this point when staff are to inform the individual of the criteria for release. The revised audit tool expected to be completed by the site visit will include a check as to whether the criteria on the Levels of Observation Form is consistent with the release criteria on the doctor's order. Tab #113

Compliance Status: Partial.

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *See X.A.1.* — *CNE;*

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

1 See action steps X.A.1

2 Revise the Levels of Observation Flowsheet form to make explicit the requirement to notify the patient of release criteria every 30 minutes. — *CNE; PID; COS; Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Clarify instructions around levels of observation flowsheet	7/31/2009	Nursing procedure on seclusion and restraint, Tab # 113	CNE
Complete *Status: Levels of observation flowsheet cannot be revised at this time due to AVATAR build. However, nursing procedures will be modified to clarify which notation to reflect notifiying patient of release criteria. - Updated as of 7/26/2009*			
2 Train nursing on use of levels of observation		Nursing training data, Tab # 120	
Status: Ensure that this topic is covered in seclusion and restraint training on 7/28/09 - Updated as of 7/26/2009			

X.C.6

Compliance Status from DOJ Report: Noncompliance

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 met. The seclusion and restraint audit shows that in 17% of cases was there documented evidence of treatment team debriefing within 24 hours of the seclusion or restraint episode and in 9% of cases, the treatment team addressed the episode at the next IRP meeting . Seclusion/restraint audit data results, tab # 55. However, there have been a number of steps taken to improve compliance with this requirement. First, the Doctor's order now includes a specific prompt for the ordering physician to notify the attending doctor, which should prompt action by the treating psychiatrist. Second, the IRP manual, and training provided to clinical administrators, includes a tip sheet reminding the clinical administrator that a treatment team meeting (with the individual present) is required. IRP manual. Further, as each unit develops its unit specific plan for provision of care, they will include a section for unit level performance improvement activities. They will be asked to include review of their unit's performance to standard on restraint or seclusion.

Compliance Status: Noncompliance

DOJ Recommendations (Report 3) — ***Responsible Party***

Explore and resolve barriers to compliance. — *Civil; Forensic; Med; CNE; PID; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 R/S audits to monitor whether debriefing is occcuring and provide results to Civil and Forensic Directors	(Ongoing)	Restraint and seclusion audit results, Tab # 55	PID
Status: Ongoing - Updated as of 7/28/2009			
2 Civil and Forensic directors will review results of audits with clinical administrators on unit and identify and resolve barriers.			CVC, JH
Status: Ongoing - Updated as of 7/28/2009			

X.C.7

Compliance Status from DOJ Report: Partial

comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and

Findings There were no instances noted where a patient was secluded or restrained without a doctor's order. The Restraint and seclusion audit results also showed conducted a face to face assessment within one (1) hour of initiation in 70% of cases. Restraint and seclusion audit results, tab # 55.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Explore and resolve barriers to documenting the assessment. — *Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	R/S audits to monitor whether assessment is occcuring and provide results to Medical Director	(Ongoing)	Restraint and seclusion audit results, Tab # 55	Arons, PID
	Status: Ongoing - Updated as of 7/28/2009			
2	Medical Director to review results with psychiatric staff and Director of Residency program to ensure assessments are occurring and notes are written in record.			Arons
	Status: Ongoing - Updated as of 7/28/2009			

X.C.8

Compliance Status from DOJ Report: Partial

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. The training department is maintaining data with nursing around whether staff's seclusion and restraint training is current. That data, and revised training protocol, which includes video clips, will be available during the site visit.

Compliance Status: Partial

DOJ Recommendations (Report 3)			***Responsible Party***
See VIII.D.1.			*CNE;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See action steps, VIII.D. 1			

X.D.

Compliance Status from DOJ Report: Partial

By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.

Findings Seclusion and restraint data continues to be reported and is now included in the PRISM (Performance-related information for Staff and Managers) reports where the Hospital data is compared with the national public rate. PRISM, July, 2009, tab # 53. Data show that less than 1% of individuals are restrained, less than 1% are secluded, well below the national level of 4.1% for restraint, and 2.1% for seclusion and that these indicators have been below 1% since March, 2009. Restraint and seclusion hours are also well below national levels. Total number of restraint hours hospital wide in July, 2009 were 4 hours and 15 minutes; total hours of seclusion hospital wide in July were 3 hours. Data is also tracked by unit. The Hospital elected not to use run charts as recommended by DOJ due to the low incidence of restraint and seclusion (less than 1% of patients experience restraint or seclusion).

Consistent with DMH policy, seclusion and restraint must be reported as an unusual incident, as is also the case with emergency involuntary medication. This system has improved the data collection, but there remain some discrepancies. First, staff are still not reporting all use of emergency medication as a unusual incident, so that data is not accurate. Second, the Hospital believes there are incidents when staff use the "quiet room" but the individual does not know or understand that he or she is free to leave. Recent training on restraint and seclusion emphasized that use of the quiet room, if the individual is not free to leave, constitutes seclusion, and must be reported as such. A process to reconcile the seclusion and restraint data from the seclusion and restraint logs with the UI database is in place, so the Hospital believes that the number of seclusion and restraint incidents, with the exception of the use of the quiet room noted above, is accurate.

With respect to use of emergency involuntary medication, the Hospital continues to develop a methodology for tracking this while a long term solution is developed. Currently, the Hospital is monitoring "possible" cases of emergency involuntary medication, by tracking type of medication as well as whether the specific medications was given as a STAT and whether the method of administration was by injection. While it recognizes that not all injections are "involuntary" and not at oral medications are voluntary, given the current limitations the Hospital is using this report to monitor emergency involuntary medication. See Pharmacy and Medication Monthly Report, tab # 90, table 6.

Instructions were developed for use of the restraint and seclusion audit tool. Restraint and Seclusion audit tool, tab # 54. However, based upon continued issues around rater reliability, a new tool and set of instructions is being developed, and will be available during the site visit.

Finally, incidents of seclusion or restraint must now be reflected in the Psychiatric Update and clinical formulation update, and is expected to be discussed at the IRP conference. The pilot clinical chart audit results suggest that in 84% of cases, the use of Stat medication or seclusion or restraint was adequately reflected in the clinical formulation. Clinical chart audit results, tab # 11.

Compliance Status: Partial

DOJ Recommendations (Report 3)			*Responsible Party*
1 *Develop instructions to accompany the seclusion and restraint audit. Measure inter-rater reliability on a monthly basis.*		***- High Priority***	*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
Create instructions for use of r/s tool, and modify tool per DOJ recommendations	6/15/2009	Restraint and seclusion audit tool and instructions, Tab # 54	Hartley
Complete *Status: Audit tool has been modified several times; audits to occur for r/s in August (Sept audits) will use fully revised tool - Updated as of 8/31/2009*			
2 *Display data using run charts (see above discussion) where appropriate.*			*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Include charts with trends in report of results of r/s audits. *Status: Ongoing - Updated as of 7/28/2009*		Prism reports, Tab # 53	PID
3 *Involve clinical staff in analysis, identification of trends, formulating actions, and evaluating the effectiveness of actions taken. All of this should be clearly documented and tracked.*		***- High Priority***	*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Conduct meeting with clinical leadership group in September to review data to date	9/30/2009		PID

X.E.

Compliance Status from DOJ Report: Partial

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 includes a requirement that IRPs must be reviewed within three business days of where an individual has been in restraint or seclusion 3 or more times in a four week period or involuntarily medicated on an emergency basis three times in a four week period. Seclusion/restraint for behavioral reasons Policy, tab # 51. The issue is also addressed in the new IRP manual, and a tip sheet is included that reminds staff on the need for a special IRP conference. IRP Manual at tab # 8. In addition, the clinical formulation includes specific prompts about the use of seclusion and restraint. Clinical formulation and update, tab ## 6, 7.

Compliance Status: Partial.

DOJ Recommendations (Report 3)			*Responsible Party*
1 *Explore and resolve barriers to compliance.*			*Civil; Forensic; Med; CNE; PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 PID to track incidents of high use of r/s and notify Medical director of same	7/31/2009	Tracking report for high risk indicators, Tab # 56	PID

2	Medical directors Civil and Forensic to review cases involve high risk users and advise results of review, including changes to IRP	8/28/2009		Arons
3	Clinical chart audits to audit whether IRP was modified based upon use of s/r	9/30/2009	Clinical chart audit results, Tab # 11	Arons

Status: Ongoing - Updated as of 7/28/2009

2 *Establish levels of assistance that teams can access when faced with a patient whose behaviors are challenging and frequently require seclusion or restraint use.* *Civil; Forensic; Med; CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Complete and implement comfort plans for all patients	7/1/2009	Comfort plan form, Tab # 104; IRP Form and instructions, Tab # 5	Hartley
Complete *Status: Form has been developed. Staff will work with all 380 individuals in care to develop or update plans using new form. Full implementation by July 1, 2009. Additionally, IRP conferences will include discussion with patient of updating comfort plan - Updated as of 6/18/2009*			
Train nursing staff on crisis intervention techniques	8/30/2009	Revised annual training, Tab # 119, Nursing training data, Tab # 120	Hartley
Status: Other strategies are under consideration pending finalization of procedure and the action steps/dates may be revised to reflect new procedures. - Updated as of 6/18/2009			

3 *Conduct clinical case reviews on patients who have been high users of seclusion or restraint.* *Med; CNE;*

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

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.

DOJ Recommendations (Report 3) ***Responsible Party***

Please see sub-cells for findings and compliance.

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

X.F.1

Compliance Status from DOJ Report: Partial

such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;

Findings The Hospital revised its Involuntary Administration of Medication policy as well its Seclusion and Restraint for Behavioral Reasons policy to improve clarity around this requirement and eliminated the use of "drugs used as a restraint". Involuntary Administration of Medication Policy, tab # 140. It is now tracking "possible" emergency involuntary medications, by tracking use of STAT medication of parenteral tranquilizers and the data is provided to the Pharmacy and Therapeutics Committee. Pharmacy and Medication Monthly Report, tab # 93. The Medical Director also issued a clarifying email about the appropriate use of PRN and STAT medications; PRN is not to be used for psychiatric medications. Medical Director email, tab # 84. This is monitored through Pharmacy.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Review and evaluate the differences between PRN/STAT reports and audits.* — ***- High Priority*** *Med; CNE; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Clarify for staff difference between use of PRN and STAT medications		Medical director email to physicians regarding clarification of prn/stat, Tab # 84	Arons
2 Develop system to monitor frequent users of stat or prn medications that includes review by medical director (designee)		Tracking report for high risk indicators, Tab # 56	Arons, PID

2 *Determine a method to establish a database that will allow monitoring of emergency involuntary psychotropic medication administration.* — ***- High Priority*** *Med; CNE; PID; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Assess Avatar's capability to track emergency involuntary psychotropic medication administration.	6/1/2009		Seymour

Status: Analysis is being conduct to determine if Avatar can be enhanced to track this. - Updated as of 8/28/2009

3 *Involve the P&T Committee in reviewing findings.* — *Med; PID; Pharm;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Include topic in discussions of P& T Committee	6/1/2009	P and T Committee minutes, Tab # 90	BSA

Status: Data presented to P and T committee - Updated as of 6/29/2009

X.F.2

Compliance Status from DOJ Report: Partial

a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and

Findings Hospital policy provides that a prescriber must examine an individual prior to ordering medication, or in the case of verbal or telephone orders, must examine the individual within one hour of the verbal order. Medication Ordering and Administration policy, tab # 125. Data or other information on the status of meeting this requirement is not available. No tool has been developed to collect this data. However, 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: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

See X.F.1. — *Med;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Develop required policy.	6/1/2009	Involuntary administration of medication policy, Tab # 140	

Complete *Status: Policy developed. - Updated as of 8/27/2009*

X.F.3

Compliance Status from DOJ Report: Noncompliance

the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.

Findings See X.E

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

See X.F.1. — *Civil; Forensic; Med;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Develop mechanism for tracking use of seclusion and restraint and involuntary use of medication ***Complete***		Tracking report for high risk indicators, Tab # 56	CVC, JH, BA
1	Review Invol Medication policy to ensure that DOJ recommendations are reflected	6/1/2009	Involuntary administration of medication policy, Tab # 140	Jana Taylor

Status: Policy developed - Updated as of 6/29/2009

X.G.

Compliance Status from DOJ Report: Partial

By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based

Findings See VIII.D. The training curricula for restraint and seclusion and emergency medication was revised. The curricula includes vignettes in which staff "acted" various roles and that are designed to prompt discussion. The revised curricula and data will be available during the site visit.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

See VIII.D.1 and X.C.8 — *Med; CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct annual training on seclusion, restraints and involuntary medication use.	6/1/2009	Revised annual training, Tab # 119	BSA

Status: Annual training conducted and information discussed at monthly psychiatry meetings. - Updated as of 6/29/2009

XI. Protection from Harm

Summary of Progress

1. The Hospital revised its training of "Reporting of Suspected Abuse or Neglect" to clarify that only individuals in care can be subject to abuse or neglect and to emphasize that retaliation for reporting abuse and neglect will not be tolerated. Further, the Policy was also revised to specify potential disciplinary actions for staff who are found to have abused, neglected or exploited an individual in care.

2. The Hospital revised its unusual incident reporting policy and UI form. Training was provided to nurse managers in an effort to improve accuracy, and the Risk Manager is regularly checking the forms and database to improve data accuracy.

4. The Hospital has fully implemented criminal background checks for unlicensed direct care staff employed after 2001 and new employees, the full extent permitted by DC Law. The law excludes criminal checks of licensed employees, and it does not appear that DC licensing boards routinely complete criminal background checks prior to issuing licenses.

5. The Hospital conducted environmental surveys that showed improvement compared with the previous survey.

6. The Hospital has filled the position of Director of Consumer Affairs. A patient handbook is finalized, a consumer satisfaction survey was completed, and written information about medications is now available for consumers.

7. The Hospital is recruiting for a new Risk Manager, as the prior one was promoted to Assistant Chief Nurse. She continues to act as Risk Manager at this time. An investigator to assist her was hired and is on staff.

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

XII. Incident Management

Summary of Progress

1. The Hospital revised its UI policy to incorporate additional recommendations by DOJ. An unusual incident form is to be submitted for all UIs. Further, the Hospital has now fully switched to the new UI form and the data base revised so that data is collected by patient and by staff, inter alia.

2. The Hospital is recruiting for a new Risk Manager, as the current one was promoted to Assistant Chief Nurse. An investigator has been hired to assist her.

3. The Hospital is conducting investigations into all reported allegations of abuse or neglect, suicide or suicide attempts, and elopements of dangerous patients.

4.. The Hospital has developed and implemented a training program governing suspected abuse and neglect. Over 700 staff have been trained.

5. The UI data is reported monthly. Back up data is made available to managers. Specific data around elopements and patient injury is also highlighted in the monthly PRISM reports.

6. New patient death review and sentinel events policies have been implemented. .

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.

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall requir

Findings The Hospital revised its UI policy and made slight modifications to the UI form based upon DOJ recommendations and feedback from staff. Unusual Incident Policy, tab # 134; UI form, tab # 141. Modifications were made to the policy Reporting Suspected Patient Abuse and Neglect to clarify the administrative actions involving staff that are required to be taken during an investigation. Reporting Abuse and Neglect Policy, tab # 133. The definition of abuse or neglect was clarified to only include abuse or neglect of a person in care.

In addition, the Hospital developed an Unusual Incident Investigation Policy to formalize the content and process of investigations. UI Investigation policy, tab # 136.

Compliance Status: Partial

DOJ Recommendations (Report 3)	*Responsible Party*
1 Make the changes cited above to policies 301-01 and 302.1-03.	*- High Priority PID; Jana Taylor*

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

1 Make revisions to Policies 301-01 and 302.1-03.		Reporting patient abuse and neglect policy 301-01, Tab # 133; Unusual incident reporting and documentation policy 302-03, Tab # 134	Jana Taylor

Complete *Status: Policy revisions completed. - Updated as of 6/22/2009*

2** Ensure consistency between all relevant policies and PID procedures.* ***- High Priority *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ensure that the language in the policy is consistent with actual PID practices.	7/15/2009	Unusual incident reporting and documentation policy, Tab # 134	Jana Taylor

Complete *Status: The language of the UI Reporting policy accurately reflects the procedures used in PID. - Updated as of 7/28/2009*

XII.A.1

Compliance Status from DOJ Report: Partial

identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;

Findings The Risk Manager developed procedures to improve accuracy of the UI reports and UI database. First, she has limited who is doing data entry into the database, and reviews all Unusual incidents before they are entered into database. Next, all nurse managers were trained regarding the appropriate and accurate submission of UIs and a poster was made for each unit. That has helped with the accuracy - and a bit with the timeliness. However, the Hospital is aware that UIs are not completed for every incident of seclusion, restraint or emergency involuntary medication, as required by policy. Since the training around reporting abuse and neglect was completed, there has been a slight increase in this type of reports - from an average of 6 per month in the first four months of FY09 to an average of 8 per month since training was initiated.

Unusual incident data is reported monthly. See Unusual Incident Monthly Report, tab # 142 (covers October 2008 to July, 2009). In addition, the elopement rate, patient injury rate and medication variance rates are included in the monthly PRISM report. PRISM report, tab # 53. The UI report tracks volume of UIs, the timeliness of UI reporting (recent trend shows more than half are reported within 1 day); number and percent by type of incident; and number of incidents by unit. Since unusual incident data is tracked by unit, it is available to each unit as well.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

***1** Continue monitoring each use of restraint and seclusion and take measures to ensure that each is recorded on a UI reporting form.* *CNE; PID; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Conduct monthly audits using revised tool	8/7/2009	Restraint and seclusion audit tool/instructions, Tab # 54; Restraint and seclusion audit results, Tab # 55	PID

Status: Audits using prior tool were conducted and data is available. Tool will be modified again to reflect changes, and will be used for August audits (done in Sept) after training on revised r/s policy - Updated as of 6/18/2009

***2** Determine and correct the cause of the discrepancy in the R&S data between the Trend Analysis and the Risk Management Incident tracking form.* *PID; Risk Manager*

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

3 *Review and make corrections to UI reports.* *CNE; PID; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Policy revisions to be posted on Intranet with changes hightlighted	5/22/2009	Revised UI investigations policy, Tab # 136.	PID
2 Develop a system to review and provide feedback on Uis received.	5/22/2009		PID
3 Education and explanation of importance of UI accuracy to be presented at Senior Staff and all hands meetings in May.	5/22/2009		PID

Complete

4 *Correct errors in the incident database.* ***- High Priority*** *PID;*

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

Not Identified

5 *Provide training or take any other measures the hospital believes will improve the accuracy of the UI reports.* ***- High Priority*** *PID; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Provide training to Senior staff on importance of UI accuracy.		Abuse and Neglect training data,Tab # 135	

XII.A.2

Compliance Status from DOJ Report: Partial

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 "Reporting Patient Abuse or Neglect" policy was modified to include specific disciplinary actions for failure to report suspected abuse or neglect. Reporting abuse and neglect is part of new employee orientation using the curriculum developed in Winter, 2009 (and modified per DOJ recommendation)

The Risk Manager assigns severity level at this time and completes the Administrative part of the UI form.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Develop written guidelines on disciplinary actions for failure to report allegations of staff misconduct in the manner prescribed in policy.* ***- High Priority*** *COO; Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Draft Policy	4/22/2009	Reporting Abuse and Neglect Policy, Tab # 133	Seymour

Complete *Status: Status 05/19/09: Initial policy to be drafted for review. The initial draft needs to be completed by CNE. Then HR will rpovide input from Table of Penalties. Policy to CEO for review. A table of changes will be developed for posting on the Intranet and to be presented at Senior Staff meeting.*

The disciplinary action including the failure to report and the table of penalty was completed. - Updated as of 8/4/2009

2 Insert DC-DPM disciplinary requirements into UI Rpt and Doc policy	7/15/2009	Unusual incident reporting and documentation policy, Tab # 134	Jana Taylor

Complete *Status: Language of DC DPM disciplinary requirements was written into the Unusual Incident Reporting policy - Updated as of 7/30/2009*

2 Ensure that the portion of the UIR reserved for the Risk Manager is completed. — PID; Risk Manager

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager to complete section	(Ongoing)		PID
Complete Status: Ongoing - Updated as of 7/28/2009			

XII.A.3

Compliance Status from DOJ Report: Partial

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 # 133. It is the routine practice of the Hospital to do so when an allegation of abuse of neglect has been made. Data around disciplinary action will be available during the site visit.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Document decisions and rationales for removing and returning staff members who allegedly engaged in misconduct while the investigation is in process. — ***- High Priority*** COO;

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Policy and Procedure will include guidelines for the scope of recommended actions; placing increased focus on unit/staff action vs. hospital wide follow up action; consistent guidelines and procedures for staff suspension and/or reassignment pending investigation of Patient Abuse, Neglect or Exploitation or other staff misconduct	4/22/2009	Reporting abuse and neglect policy, Tab #133	Seymour; Gallo
Complete			

XII.A.4

Compliance Status from DOJ Report: Substantial

adequate training for all staff on recognizing and reporting incidents;

Findings Competency based training on reporting suspected abuse and neglect is well underway. This revised training module was incorporated into new employee orientation. This information is included in the Advanced Document request for Ms. Chura.

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

Continue current practice. — PID; Trg; Risk Manager

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 N/a			

XII.A.5

Compliance Status from DOJ Report: Partial

notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;

Findings See XII.A, A.2. A.4. The Policy was revised to specifically require notification of suspected abuse and neglect. Training using a new curricula of reporting suspected abuse and neglect is well underway.

Compliance Status: Substantial

DOJ Recommendations (Report 3)	Responsible Party
Write specific guidelines for disciplining staff members who fail to report allegations of staff misconduct as required in policy.	COO; Jana Taylor

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
H.R. will provide input from Table of Penalties	6/12/2009		seymour
Complete Status: The disciplinary action including the failure to report and the table of penalty was completed - Updated as of 8/4/2009			
Develop policy and procedure		Reporting abuse and neglect policy, Tab #133	hartley Jana Taylor
Complete Status: DPM Table of Penalties inserted as an exhibit into Abuse/Neglect/Exploitation policy along with a standard requiring disciplinary action for failure to report. - Updated as of 6/22/2009			

XII.A.6

Compliance Status from DOJ Report: Substantial

posting in each unit a brief and easily understood statement of how to report incidents;

Findings Posters continue to be maintained on each unit.

Compliance Status: Substantial

DOJ Recommendations (Report 3)	Responsible Party
Continue current practice.	CNE;

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 N/A			

XII.A.7

Compliance Status from DOJ Report: Partial

procedures for referring incidents, as appropriate, to law enforcement; and

Findings The UI policy was revised to include a specific requirement that all cases involving potential criminal action shall be reported to MPD, regardless of the wishes of the individuals involved. It also includes a provision that makes a security official subject to discipline for failure to report to MPD. The reporting of incidents to the Police is also covered in the reporting abuse and neglect training.

Compliance Status: Substantial

DOJ Recommendations (Report 3)	Responsible Party
Clarify policy 302.1-03 to direct that in "all cases involving potential criminal action," Security shall notify MPD.	PID; COO; Jana Taylor

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Clarify the standard.		Reporting Abuse and Neglect policy, Tab #133	Jana Taylor
Complete Status: Clarified standard in the revised policy. - Updated as of 6/22/2009			
2 Train security staff		Abuse and neglect training data, Tab #135	Seymour
Complete Status: Training was conducted during the month of March, 2009 on Policy 107-02 Patient Searches and Policy 108-09 Control of Contraband. - Updated as of 8/13/2009			

XII.A.8

Compliance Status from DOJ Report: Partial

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. Reporting abuse and neglect policy, tab # 133. Language in DC regulations governing consumer rights similarly protects patients who may seek to file a grievance. The issue of the right to be free from retaliation for reporting an incident continues to be covered in the reporting abuse and neglect training. Reporting Abuse and Neglect training, tab # 135.

As noted, timeliness of reports of UIs generally has improved; In July, 2009, unusual incidents were reported within one day in 54% of cases, the highest level since October, 2008. Unusual Incident Monthly Report, tab # 142.

Compliance Status: Substantial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Include the right of staff members and individuals in care to be free of retaliation for reporting A/N/E and how to report threats or retaliatory actions in all training provided on the subject.* ***- High Priority*** *Trg;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify training curricula to note free of retaliation	(Ongoing)	Revised annual training, Tab # 119	Snyder
Status: A review of the curricula shows that was in prior training materials, and it will continue to be emphazied in ongoing training - Updated as of 7/28/2009			

2 *Address in investigations the reason for delays in reporting, as the delay may be related to fear of retaliation.* *PID; Risk Manager Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Insert as standard into the new UI Investigations policy		UI Investigations Policy, Tab # 136	Jana Taylor
Complete *Status: Inserted into the new policy as a standard - Updated as of 6/18/2009*			
2 Risk manager to address delay in reporting as applicable in investigation reports			Risk Manager

XII.B. ***Compliance Status from DOJ Report: Noncompliance***

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 developed and is implementing a new policy, titled Unusual Incident Investigations, tab # 136. The policy sets forth standards for investigations into all major unusual incidents and includes standard of proof to be used in all investigations (preponderance of the evidence), actions to be taken by the employee's manager in cases of alleged abuse, neglect or exploitation, requires the involved employee to participate in the investigation, process for review of the investigation by the Director of Performance Improvement and requirements to interview the individual/victim, staff, other individuals in care, and other witnesses. The policy also requires the Risk Manager to address in interviews reasons for any delay in reporting to assess if the delay was due to fear of retaliation. The Policy includes a step-by-step description of key steps to be taken as part of the investigation process. The policy requires that the investigator prepare a written summary of each interview that includes the date and time of the interview and who was present at the interview. Finally, the policy specifies the standards for the written report, which is to include standard of proof used, the findings, conclusions and recommendations; each investigation is to include a face sheet that includes the type of incident, date of incident and date received in Risk management, synopsis of the investigation, names of alleged victim, staff or witnesses and the determination. It provides that the report shall include decisions or rationales for removing staff, or returning staff to work, in the event the matter involves alleged abuse, neglect or exploitation. The policy provides specific standards for implementing recommendations of the Risk Manager. Investigations are being conducted according to these standards. It should be noted, however, that the Risk Manager was promoted to Assistant Chief Nurse, and to date

the Hospital has not been successful in finding a qualified candidate to fill her position. The Hospital hired an additional staff member to assist with investigations and tracking recommendations.

The Risk Manager also developed protocols for the review of UI forms to ensure all information is reported and is accurate. Data entry is now done by only two individuals and each month the data is reviewed for accuracy. The risk manager is tracking of recommendations to ensure that recommendations are considered by Executive staff, approved and implemented.

Compliance Status: Substantial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Include the use of the preponderance of the evidence standard in the policies and procedures being written for the Performance Improvement Department.* — ***- High Priority*** — *PID; Risk Manager Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Insert as a standard into the new UI Investigation policy.		UI Investigations policy, Tab # 136	Jana Taylor

Complete *Status: Inserted as a standard into the new UI Investigation policy. - Updated as of 6/22/2009*

2 *Reference the standard in making determinations (substantiated or not substantiated).* — ***- High Priority*** — *PID; Risk Manager Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Insert the standard into the new UI Investigations policy		UI investigations policy, Tab # 136	Jana Taylor

Complete *Status: Inserted the standard into the new UI Investigations policy. - Updated as of 6/22/2009*

2 Risk Manager to include standard in investigation reports.

Status: Ongoing - Updated as of 7/28/2009

XII.B.1

Compliance Status from DOJ Report: Noncompliance

require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;

Findings The Hospital developed and is implementing a new policy, titled Unusual Incident Investigations, tab # 136, which addresses the issues around quality and standards of investigations . The policy sets forth standards for investigations into all major unusual incidents and includes standard of proof to be used in all investigations (preponderance of the evidence), actions to be taken by the employee's manager in cases of alleged abuse, neglect or exploitation, obligation of the involved employee to participate in the investigation, process for review of the investigation by the Director of Performance Improvement and requirements to interview the individual/victim, staff, other individuals in care, and other witnesses. The policy also requires the Risk manager to address in interviews reasons for any delay in reporting to assess if the delay was due to fear of retaliation. The Policy includes a step by step description of key steps to be taken as part of the investigation process. The policy requires that the investigator prepare a written summary of each interview that includes the date and time of the interview and who was present at the interview. Finally, the policy specifies the standards for the written report, which is to include standard of proof used, the findings, conclusions and recommendations; each investigation is to include a face sheet that includes the type of incident, date of incident and date received in Risk management, synopsis of the investigation, names of alleged victim, staff or witnesses and the determination. The report shall include decisions or rationales for removing staff, or returning staff to work, in the event the matter involves alleged abuse, neglect or exploitation. The policy provides specific standards for implementing recommendations of the Risk Manager. Investigations are being conducted according to these standards. It should be noted, however, that the Risk Manager was promoted to Assistant Chief Nurse, and to date the Hospital has not been successful in finding a qualified candidate to fill her position. The Hospital hired an additional staff member to assist with investigations and tracking recommendations.

The Risk Manager also has a "manual" to assist in investigations, which will be made available during the site visit. The Risk Manager implemented the recommendations made by DOJ - - the preponderance of evidence standard is being used in investigations, a face sheet is included with each investigation report, and all interviews are dated.

Compliance Status: Substantial

DOJ Recommendations (Report 3)		Responsible Party
1 *Adopt a standard face sheet for A/N/E investigations that states the type of incident, date of the incident, date received in Risk Management, synopsis of the allegation, names of the alleged victim, named staff member and witnesses, and the determination.*	*- High Priority*	*PID; Risk Manager Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Insert as a standard into the new UI Investigations policy.		UI Investigations Policy, Tab # 136	Jana Taylor

Status: Inserted as a standard into the new UI Investigations policy. - Updated as of 6/22/2009

2 *Follow standard investigation procedures, including the dating of all interviews and a summary of the contents. Do not accept only written statements from persons critical to an investigation unless there is no alternative.*	*- High Priority*	*PID; Risk Manager Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Insert as standards into the new UI Investigation policy.		UI Investigations policy, Tab # 136	Jana Taylor

Complete *Status: Inserted as standards into the new UI Investigation policy - Updated as of 6/22/2009*

3 *Make determinations based on preponderance of the evidence.*		*PID; Risk Manager Jana Taylor*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Insert as standard into new UI Investigations policy.		UI investigations policy, Tab # 136	Jana Taylor

Complete *Status: Inserted as standard into new UI Investigations policy. - Updated as of 6/22/2009*

4 *Take measures to ensure that reports of incidents reach the Risk Manager in the timeframes required by policy through training and feedback to units submitting late reports.*		*Civil; Forensic; CNE; PID;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Monitor timing of UI Reports	6/1/2009		Risk manager
2	Regularly remind staff of time frames for submission of UI reports			CNE

Status: Ongoing - Updated as of 7/28/2009

XII.B.2

Compliance Status from DOJ Report: Presently in partial compliance with the hiring of the current Risk Manager

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 The Risk Manager has completed training on investigations. It should be noted, however, that the Risk Manager was promoted to Assistant Chief Nurse, and to date the Hospital has not been successful in finding a qualified candidate to fill her position, so she is performing both responsibilities at this time. The Hospital hired an additional staff member to assist with investigations and tracking recommendations. That individual is trained in investigating critical incidents.

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
1 *Continue to implement current procedures wherein the Risk Manager investigates or supervises the*	*PID; Risk Manager*

investigation of incidents specified in the Settlement Agreement.

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Increase capacity to conduct and complete timely investigations			Gouse, Hartley
Status: Successfully completed hiring of second investigator. Began work, 7/27. Training underway - Updated as of 6/18/2009			

2 *Continue the procedure of having the PID Director review and approve all investigation reports.* *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Continue approval process			PID
Status: Ongoing - Updated as of 7/28/2009			

XII.B.3

Compliance Status from DOJ Report: Partial

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 See XII.B.

The Risk Manager's reports are reviewed and approved by Director, Performance Improvement Division. Mortality reports are provided to the Executive staff of the Hospital, including the Medical Director, as well as to the Medical Staff Executive Committee. Patient Death review policy, tab # 95; Sentinel Event Policy, tab # 143. The Director, PID is working with the Performance Improvement Committee to implement a feedback loop. Presently, findings are presented to the CEO and the Performance Improvement Committee, of which both the Risk Manager and Director, Performance Improvement Department, are members.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

1 *Implement plan to have all investigations reviewed and signed by the PID Director. Any investigations that do not meet practice standards should be returned for additional work.* ***- High Priority*** *PID; Risk Manager Jana Taylor*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop Policy and Procedure on Investigations	5/12/2009	UI Investigations policy, Tab # 136	Hartley
2 Draft SEH policy on UI Investigations developed to provide practice standards and requirements for UI investigations and report contents.		UI Investigations policy, Tab # 136	Jana Taylor
Complete *Status: Policy draft forwarded for final review and approval. - Updated as of 6/22/2009*			
3 Continue with current approval process			

2 *Implement plans to hire another investigator so that investigations are completed in a timely manner and other Risk Management monitoring can proceed.* ***- High Priority*** *PID; COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Increase capacity to conduct and complete timely investigations			Gouse, Hartley
Status: A second investigator hired, began work 7/27/09. Being trained. - Updated as of 6/18/2009			

XII.B.4

Compliance Status from DOJ Report: Noncompliance

include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as s result of investigations.

Findings See XII.B.3.

Under the process in place, recommendations are transmitted to the CEO and ultimately to the Performance Improvement Committee, who will identify indicators relating to the recommendations and track their implementation. The Office of Quality Improvement within the Performance Improvement Division supports the Performance Improvement Committee by tracking the information and submitting it to PIC regularly. A serious incident investigation grid is maintained

The Quality Improvement Division also makes recommendations to Performance Improvement Committee based upon the various audit results. Recommendations for PIC, tab # 144, which is discussed in more detail in Chapter XIII.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

Implement the PID procedures for the Investigation and Review of Incidents as planned. Document the monitoring of implementation of the approved recommendations. — ***- High Priority*** *PID; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Communicate results of audits in timely fashion to improve practice *Status: Within 30 days of audit data being submitted, provide analysis to staff. - Updated as of 6/18/2009*			
2 Develop and maintain tracking system **Complete** *Status: Committee reports and investigations will be forwarded to PIC each month, beginning June 2009. Recommendations are being tracked to assess implementation. - Updated as of 6/18/2009*	6/1/2009 (Ongoing)		Hartley
3 Implement PRISM system of reporting on key indicators. **Complete**	(Ongoing)	PRISM Reports, Tab # 53	

XII.C.

Compliance Status from DOJ Report: Noncompliance

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

The Sentinel Event policy was provided prior to the last review and no changes have been made. The Patient Death review policy establishes a review process that includes investigation by the Risk Manager or Office of Accountability, review by the Hospital's Mortality Review Committee, and a review by the Sentinel Event Review Committee. Patient Death Review, tab # 95. The policy was modified to include a requirement that abuse, neglect or exploitation be considered in every death review investigation. Further, the policy specifically provides that the Medical Director is a member of the Sentinel Review Committee, which reviews not only deaths but other serious incidents at the Hospital.

PID is implementing a system for identifying and monitoring recommendations from investigations.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Ensure that the Sentinel Event Committee includes a senior psychiatrist when the case under review raises issues in his/her domain.* — ***- High Priority*** *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Dr. Arons to attend Sentinel Event Committee meetings as senior psychiatrist. *Status: Dr. Arons attending meetings as they are called. Ongoing - Updated as of 6/29/2009*	6/1/2009 (Ongoing)		Arons

2 Implement the policies and procedures of the PID for identifying and monitoring recommendations from investigations. *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Within 30 days of audit data being submitted, provide analysis to staff			Hartley
Implement PRISM system or reportign on key indicators		PRISM documents, Tab # 53	Hartley
Develop and maintain tracking system	6/1/2009		Hartley

Status: Committee reports and investigations will be forwarded to PIC each month, beginning June 2009. Recommendations are being tracked to assess implementation - Updated as of 6/18/2009

XII.D.

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigatio

Findings The UI form has been revised to capture information about patients, staff involved, and witnesses. The form is now in use hospital wide, and data is available that reflects staff and patient involvement. There are still some cases in which key data is omitted in the form; the Risk Manager has developed a process to ensure UI reports contain all mandated data. Each UI now has a specific number which allows tracking.

Compliance Status: Substantial

DOJ Recommendations (Report 3) ***Responsible Party***

Assign a discrete number to each UIR. *PID; Risk Manager*

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

XII.E.

Compliance Status from DOJ Report: Partial

By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:

Findings See XII.D. See also UI form Tab # 141.

The database permits tracking and trending of each field of the UI form, including individual in care, date, type of incident, unit, time, location, role in incident and action taken . A summary report is prepared each month reflecting trends in UIs; information is available by ward as well as shift although that information is not published each month. Unusual Incident Monthly Report, Tab # 142. Recent data shows that since October, 2008, there has been improvement in the timeliness of reporting UIs. The Number of UIs reported decreased (census has also decreased), and in recent months, the number of patient assaults/altercations decreased as did falls, medical emergencies and unauthorized leaves compared with levels in Spring, 2009.

Receipt of the UI will generate some type of action. All UIs are reviewed by the Risk Manager, numbered and coded, and information checked for accuracy. If information is missing, the UI is returned to the unit for completion or correction. Monthly, the Risk Manager and the Director, Office of Monitoring Systems, review the incident management database to identify errors or discrepancies that need correction or follow up, and is working closely with Nurse Managers on improving the accuracy and completeness of the UI forms . The Risk Manager also initiates investigations of major incidents, and ensures, if appropriate, staff are placed on administrative leave. Once completed, her findings (including cause and/or contributing factors) and recommendations will be forward to the Division director and to PIC for review. The Office of Quality Improvement also tracks the implementation of recommendations made during investigations.

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
Implement PID policies and procedures that direct the approval, implementation, and monitoring of recommendations emerging from incident investigations.	*- High Priority* PID;

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Within 30 days of audit data being submitted, provide analysis to staff			
Implement PRISM system of reporting on key indicators			
Develop and maintain tracking system	6/1/2009		Hartley

XII.E.1

Track trends by at least the following categories:

Findings See XII.E

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
Please see sub-cells for findings and compliance:	

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

XII.E.1.a

Compliance Status from DOJ Report: Partial

type of incident;

Findings See XII.E

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
Take measures to bring the problem of under-reporting to the attention of unit and discipline leadership. PID should undertake a review of communication and transportation logs to identify events that should have been reported on UIRs and were not. Social workers and others reviewing clinical records should be alerted to the need to identify events that should have been reported as incidents and ensure a UIR is completed.	*Civil; Forensic; Med; CNE; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Risk Manager/PID to construct report documenting ANE reporting and detection by ward\department and provide this data to individual unit leadership. In addition these occurrences will also be addressed in feedback communication. *Status: Information is available in UI database - Updated as of 6/18/2009*	5/15/2009		
Risk Manager and staff to review all UIs and Daily Nursing reports for an implication of ANE. If we suspect ANE, via this daily concurrent review, then we will capture it in a UI and conduct an investigation *Status: Ongoing - Updated as of 6/18/2009*	4/10/2009 (Ongoing)		

PID to research availability of ANE incidence frequency for public data sources (if available) to help determine benchmarking source	4/23/2009	Hartley
Complete *Status: No data is kept of what is expected level of reporting for institution this size, so there is no objective standard to be measured against - Updated as of 6/18/2009*		
Research UI data re: ANE for past 12 months depending on available data sources to establish trend line and compre pre and post training reporting incidences	4/28/2009	Hartley

XII.E.1.b

Compliance Status from DOJ Report: Partial

staff involved and staff present;

Findings See XII.E

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Monitor UIR forms for accuracy and provide any necessary training. Make the necessary changes in the database to improve its accuracy.* — *Civil; Forensic; CNE; PID; Risk manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Monitor UI Forms.	6/1/2009		Risk Manager
2 Work with staff entering data to improve accuracy and train them to follow up if key data is missing			Risk manager

2 *Train staff completing UIRs to list individuals who saw or heard the incident on the reporting form.* — *PID; Trg; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Ongoing training of staff to complete forms fully			Snyder, Risk Manager

XII.E.1.c

Compliance Status from DOJ Report: Partial

individuals involved and witnesses identified;

Findings See XII.E

The Hospital is now tracking individuals in care who have been involved in three or more UIs (any type) in a thirty day period. The Risk Manager alerts the Medical Director of Civil or Forensic Services of the three incidents, and he then reviews the case with the treatment teams. A tracking system was recently developed to track notifications and responses. See tracking form of high risk cases, tab # 56.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Setting inclusion criteria, expand the list of repeat victims and repeat aggressors to cover all units of the hospital. Alert units/teams when an individual is added to the list.* — ***- High Priority*** *Med; PID; Risk manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk manager to monitor and notify Medical directors of any case in which single patient has 3 or more UIS in 30 day period.		Tracking report for high risk indicators, Tab # 56	Risk Manager, Arons

Status: Tracking data base developed for notification and response. - Updated as of 7/28/2009

2 Establish a protocol whereby the IRP team will respond by identifying interventions it has/will undertake in response to the alert. - ***High Priority*** *PID; COS; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Review with clinical administrators the high risk indicators which would trigger an IRP review			Gouse
Status: Reviewed in meeting on August 13, 2009 - Updated as of 8/31/2009			

3 Monitor the implementation of the interventions on at least a sample basis. *PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 OngoingMonitor interventions in IRP	9/30/2009	Clinical chart audit results, tab # 11	PID

XII.E.1.d

Compliance Status from DOJ Report: Partial

location of incident;

Findings See XII.E. The Hospital continues to track incidents by unit.

The Hospital implemented recommendations around the reconfiguration of RMB 3. It is no longer a behavior management unit. It is now a unit for more intensive assessment and treatment for individuals who have not stabilized on other units; individuals assigned to the units do not necessarily exhibit serious behavioral issues. See letter from Ellen Efros to Shanetta Cutler, August 14, 2009, tab # 98. The Hospital changed the individual profile on RMB 3, integrating individuals on RMB 3 with more acute behavioral issues to other units. Almost fifty percent of patients on the unit at the time of the DOJ visit have been transferred to other units or discharged. There are currently six patients on RMB 3 for whom PBS plans are needed; it is expected that 3 PBS plans will be completed by the time of the DOJ visit. A full time clinical administrator and nurse manager were assigned, and a number of patients attend the TLCs at least part-time or are attending DD programs in the community. Pharmacy makes regular rounds to provide consultation services. A full array of groups led by all disciplines are available on the unit for those who cannot attend the TLC for all or part of a day. It is also implementing a new initiative, (EARN - engage, assess, reassure/reorient, meet needs) and training of staff began in late July, 2009. A psychologist is assigned to the unit, while the other psychologist has been detailed to the PBS team leader position pending a selection. Finally, the Hospital is entering into a contract with a consultant to provide support around the program on RMB 3. UI data show that incidents have decreased on RMB 3 since the changes began in May, 2009.

With respect to RMB 6, it is an admission unit, and therefore, a higher level of incidents is not unexpected, as individuals on that unit are more unstable, and more prone to be involved in unusual incidents due to the level of psychosis. UIs have decreased on RMB 6 as well, however, since the March, 2009 high.

Compliance Status: Partial

DOJ Recommendations (Report 3) ***Responsible Party***

Take appropriate measures to reduce the incidents on RMB-3 and RMB-6. - ***High Priority*** *Civil; Med; CNE;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See action steps, X.B.2 recommendation #2			
2 See action steps XII.E.1.c recommendation 1.			

XII.E.1.e

Compliance Status from DOJ Report: Partial

date and time of incident;

Findings See XII.E.

See Risk Management and Safety committee minutes, tab # 145.

Compliance Status: Partial

DOJ Recommendations (Report 3)		Responsible Party
1 *Implement plans to discuss the unit-specific incident data with the unit staff and leadership. Briefly document the outcomes of these discussions.*	- High Priority	Civil; Forensic; CNE; PID;

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

2 *Identify in writing the purpose and responsibilities of the Risk Management & Safety Committee meetings.*	- High Priority	PID;	

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Draft responsibilities of risk management committee		Description of monitoring systems, Tab # 62, Risk management meetings, Tab # 145	

XII.E.1.f

Compliance Status from DOJ Report: Noncompliance

cause(s) of incident; and

Findings See XII.E

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
1 *Focus the work of the Risk Management & Safety Committee by writing guidelines describing its function, composition, responsibilities, etc.*	PID;

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

2 *Identify contributing factors when investigating incidents. Bring these to the attention of the Risk Management & Safety Committee or other relevant committees when incidents are reviewed.*	PID; Risk Manager

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Risk Manager to include contributing factors in reports *Status: Ongoing - Updated as of 7/28/2009*	(Ongoing)		Risk manager
2 Risk Management and Safety committee to be briefed by Risk Manager on contributing factors as needed. *Status: Ongoing - Updated as of 7/28/2009*	(Ongoing)	Risk management and safety committee meeting minutes, Tab # 145	

XII.E.1.g

Compliance Status from DOJ Report: Noncompliance

actions taken.

Findings See XII.E

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
Implement plans for the review, approval, and monitoring of recommendations resulting from incident investigations. Document monitoring findings.	PID; Risk manager

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Develop and maintain tracking system	6/1/2009	PIC Committee minutes, Tab # 137	Hartley
Status: Committee reports and investigations will be forwarded to PIC each month, beginning June 2009. Recommendations are being tracked to assess implementation. - Updated as of 6/18/2009			

XII.E.2

Compliance Status from DOJ Report: Noncompliance

Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.

Findings The Hospital is implementing this recommendation, in a phased approach. Three indicators have been identified to date (Persons with 3 or more incidents of STAT medications in a 24 hour period, 3 or more UIs (any type) in 30 day rolling period, and restraint or seclusion - 2 or more episodes in a 24 hour period or 3 or more in a 30 day period or episodes on two consecutive days or any episode over 12 hours) . Notifications will be made to the Risk Manager, clinical administrator and treatment team, Psychology department for behavioral referral (if appropriate) and Medical Director of Civil or Forensic. Within 3 days information must be provided about actions taken, which will be tracked. High Risk Indicator Tracking Log, tab # 56.

Compliance Status: Partial

DOJ Recommendations (Report 3)	Responsible Party
1 *Implement plans to identify medical and behavioral high-risk indicators.*	*- High Priority PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1.c Also, additional indicators include repeated use of r/s and Stat/prn medications.		Tracking report for high risk indicators, Tab # 56	
2 Executive staff to meet with PIC chair to agree upon PI initiatives for year ***Complete***		Presentation to Executive Committee by PIC, Tabs # 121 and 122	
3 PRISM reports monthly to staff	(Ongoing)	PRISM reports, Tab # 53	
Status: Ongoing - Updated as of 7/28/2009			

2 *See also recommendation in XII.E.1.C.*	*PID;*

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

XII.E.3

Compliance Status from DOJ Report: Noncompliance

Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.

Findings Risk assessment for suicide is included in psychiatric, nursing and psychological assessments and their updates. Comprehensive Initial Psychiatric Assessment, tab # 14 ; Psychiatric Update, tab # 17; Initial Nursing Assessment, tab # 26; Nursing Assessment Update, tab # 28; Initial Psychological Assessment, Part A, tab # 19. Audits of the forms completed by the disciplines show that in the Psychological Assessments, suicide risk was assessed in 100% of cases, tab # 21; and in 87% of cases in the Comprehensive Initial Psychiatric Assessment, tab # 16. The instructions

with the Initial Psychiatric Assessment make clear physicians are expected to identify precautions for those at risk of suicide; data from the CIPA audits show that precautions were identified in 77% of cases. CIPA audit results, tab # 16.

See also XII.E.2

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Identify a number of behavioral and medical high-risk indicators and begin to identify those individuals who meet the criteria.* — ***- High Priority*** — *Med; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1.c and XII.E.2.	6/1/2009		BSA
Status: Indicators identified. - Updated as of 6/29/2009			

2 *Alert the IRP teams as individuals meet an indicator and request a response from the team indicating the interventions in place or planned to address the risk.* — *PID; COS; Risk Manager*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1.c			

3 *Identify criteria for when a review of an individual treatment should move beyond the team to receive attention from senior clinicians.* — *Civil; Forensic; Med; CNE; PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Criteria have been developed that indicate review by psychiatric director of program, whether civil or forensic. The criteria will be continually updated as new indicators become apparent.	6/1/2009 (Ongoing)	Tracking report for high risk indicators, Tab # 56	
Status: Ongoing - Updated as of 6/25/2009			

XIII. Quality Improvement

Summary of Progress

1. The Hospital developed a new system, PRISM (Performance-Related Information for Staff and Managers), which tracks its performance on 11 indicators, comparing performance to the national public rate. In addition, twice each year, a comprehensive trend analysis will be completed.

2. The Hospital is conducting IRP observations of 10-15% of scheduled IRPs and is reporting the results. Specific results are embedded in the related sub-cells of this report. A clinical chart audit was piloted, and the tool, instructions, and training are under review.

3. The Hospital is reviewing 20% of closed records to evaluate discharge planning, and is reporting the results. Specific results are embedded in the related sub-cells of this report.

4. The Hospital conducted a medication review of 170 charts and is reporting the results.

5. The Hospital conducted an audit of inter-unit and inter- hospital transfers and is reporting the results. Audits on individuals with tardive dyskinesia and those who were secluded and restrained were conducted and the results reported.

6. All disciplines have begun to conduct audits of their assessments and are reporting the results.

7. The Hospital completed two Environmental Surveys of all patient care areas.

8. The Hospital's Performance Improvement Department has identified three high risk indicators that were approved by the Performance Improvement Committee. PIC also identified several initiatives around continuity of care and communication, and is tracking other data as well. Two new policies have been completed, one of hand-off communication and one on Medical Response, that are designed to improve outcomes.

9. The Hospital implemented the new patient death review policy and a sentinel event policy.

XIII. Quality Improvement.

By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.

Findings See sub-cells for findings.

Compliance Status: See sub cells for findings

XIII.A.

Compliance Status from DOJ Report: Partial

Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.

Findings Saint Elizabeths Hospital (SEH) is implementing a comprehensive quality assessment and performance improvement system that evaluates the provision of care, processes, and outcomes using a variety of methods, including process and clinical audits, data collection and analysis, case reviews, and unusual incident reporting. Led by the Hospital's Executive staff and Medical Staff Executive Committee (with other committees in support), priorities are set and high risk indicators are identified at least annually. The Hospital Policy #312-07 describes the process overall. Tab # 146.

The Hospital's Performance Improvement Department (PID) coordinates quality improvement activities through the offices of Quality Improvement, Monitoring Systems, Policy and Procedures, and Risk Management. Quantitative data on a host of indicators are collected and analyzed regularly. Some data are produced monthly, and some bi-monthly. In addition, PID produces a monthly report on key indicators known as PRISM (Performance Related Information for Staff and Managers). PRISM reviews 11 indicators and, where applicable, compares the Hospital's performance against national data. Indicators include rates of readmission, elopement, patient injury, medication variance, and restraint and

seclusion. Data are trended and published to all Hospital staff, as well as the D.C. Mental Health Authority. PRISM data are also presented by unit and they are shared with leaders of each unit, including clinical administrator, attending physician, and nurse manager. Twice yearly, PID also issues a trend analysis of Hospital-wide statistics in order to provide clinical and management staff with critical information regarding patients and the Hospital's performance in delivering timely and effective services. Results are widely circulated throughout the Hospital, posted on the SEH intranet, and reviewed by relevant Hospital committees.

SEH's Performance Improvement Committee, described below, is seeking to establish a formalized communication model for information dissemination and education. Possible strategies include developing and institutionalizing a feedback structure for quality improvement functions to continually feed information and lessons learned to staff; developing protocols for explication of and response to corrective action plans and solution based recommendations; and coordinating development of user-friendly and meaningful reports and fact sheets on outcomes (relating to patient care and mental health service integration) to present to all levels of staff. In the interim, to ensure that data and findings influence patient care, clinical practice, service delivery, and internal operations, the Hospital's various quality improvement functions work with the Hospital's policy office to enhance or develop standards of practice and service delivery and with the Hospital's training and continuing education functions to develop curricula for staff.

Described in detail below are three distinctive elements of the Hospital's monitoring and performance improvement system: 1) the other Hospital based entities responsible for quality improvement activities, 2) the Hospital's additional evaluation and auditing functions; and 3) investigation and analysis of unusual incidents.

I. Hospital Committees: Several key Hospital committees identify quality improvement priorities, review the results of evaluation and monitoring efforts, and make recommendations for improvement. They include:

A. Executive Staff Committee – Comprised of the Chief Executive Officer, the Medical Director, Director Forensic Services, Director Civil Services, Chief Nursing Executive, Chief of Staff, Chief Administrative Officer, Chief Operating Officer, Director of Training, Director of Performance Improvement, and DOJ Compliance Officer. Among other tasks, the committee reviews key performance indicators, makes policy decisions, and approves recommendations made by other committees or individuals that affect quality of care and service delivery.

B. Medical Staff Executive Committee (MEDSEC) – Comprised of the President of the Medical Staff, Past President, President-elect, Vice-President, Secretary, Treasurer, and two Members at Large, each of whom is elected. The committee recommends and reviews policies related to patient care, receives and acts upon reports and recommendations of Medical Staff committees, and recommends policies and procedures for maintaining and improving the overall quality and efficiency of care rendered to patients. MEDSEC also reviews reports generated by disciplines and PID around quality of care issues and annually identifies quality improvement initiatives. The Hospital bylaws specifically provide that all members of the Organized Medical Staff have a responsibility to work with the SEH quality assurance (QA) and performance improvement (PI) program by serving on committees and by providing requested consultation, raising individual concerns, and suggesting topics for QA/PI activities.

CoMorbidity and Mortality Review Committee – A Medical Staff Committee, this committee is comprised of two physicians from the Department of Medical Services, one psychiatrist, one psychologist, the head of Risk Management, the PID director, the Director of Nursing or designee, and the Associate Director of Medical Services, who is the committee's designated coordinator. The Committee reviews all deaths, near deaths, or other life threatening medical incidents that occur in the SEH patient population. It provides a written report of its evaluation and findings regarding each incident and of any recommendations to the MEDSEC and the CEO.

D. Pharmacy and Therapeutics Committee – Comprised of Medical Staff. This committee oversees pharmacy and prescribing practices. It conducts drug utilization reviews and other PI activities, such as monitoring/investigation of medication errors, dissemination of manufacturer, Med Watch, and drug interaction alerts, and monitoring/investigation of adverse drug events. It also makes recommendations to medical staff around quality of care and prescribing practices.

E. Performance Improvement Committee (PIC) – Comprised of medical, clinical, and other administrative staff. This interdisciplinary committee develops yearly quality improvement priorities and high risk indicators, such as medication error/variance rates and hours of restraint and seclusion use. It works closely with the above described medical staff committees on their respective initiatives and conducts work through work groups. It collects and analyzes data, reviews findings from the collected data, and receives monitoring recommendations from PID based on results from its

evaluation and auditing activities. PIC develops recommendations that are presented to the Executive Staff Committee, which approves or disapproves them. PIC also monitors and tracks implementation of recommendations approved by the Executive Committee.

F. Risk Management and Safety Committee – Comprised of the Risk Manager, Safety Officer, and staff from other disciplines. This committee provides oversight, coordination, and referral for SEH-based risk management and safety programs that are primarily limited to human and environmental safety issues. The committee is composed of two distinct cohorts: 1) human safety—led by the Risk Manager, this cohort identifies and evaluates areas of risk in clinical care and safety that were identified through case reviews; and 2) environmental safety—led by the Safety Officer, this cohort identifies and evaluates areas of risk in the environmental and security aspects of care and safety that were identified through case reviews. Committee functions include trend analysis and unusual incident monitoring around risk reduction activities. The Committee also provides recommendations and reports on risk exposure and risk reduction to PIC and other hospital entities.

II. Description of Audits: SEH regularly conducts audits, using data collection tools and operational instructions, to measure performance on key indicators and inform the Committees and direct care staff of areas needing improvement. Audit results also form the basis for identifying quality improvement priorities.

A. IRP Audit – The Hospital conducts monthly process audits of randomly selected IRP meetings. The goal is to audit 20% of the IRP meetings held each month, but that goal has not been consistently reached. Auditors are trained on the IRP data collection tool and instructions. The tool includes a chart review to determine timeliness of IRPs, discipline assessments/updates, and clinical formulations/updates that are to be completed prior to the IRP meeting; however, the audit's focus is on the actual conduct and content of the IRP meeting. The tool assesses 10 indicators using various measures. Tools are scored and data are analyzed and reported monthly. Data on key measures are presented to reflect trends, and recommendations for improvement may be made. In addition, each auditor provides immediate feedback to the treatment teams, and data are distributed on a unit by unit basis. Results are shared with all Hospital Senior Managers and the MEDSEC, and will be posted on the SEH intranet.

B. Clinical Chart Audit – This audit, which was piloted in July 2009, evaluates the quality of the IRP and clinical formulation/updates. Clinical administrators and discipline chiefs conduct the audits. The goal is review a 20% sample, although that target has not yet been reached. The audit assesses the content of the clinical formulation/update, the quality of the IRP focus area and need lists, the quality of specific objectives and interventions, and the status of referrals made. Results are provided monthly, and will be trended to measure progress or lack thereof. Results will be shared with all Hospital Senior Managers and the MEDSEC, and will be posted on the SEH intranet.

C. Discipline specific audits – Each of the five major disciplines—psychiatry, psychology, social work, rehabilitation services, nursing—conducts audits of its relevant initial assessment and assessment updates. The disciplines are reviewing 20% of the initial assessments completed the prior month but are not yet reaching the 20% threshold in monthly notes. Each tool focuses on indicators identified by the discipline as key to quality, thus the indicators differ from discipline to discipline; in some cases, however, there is overlap. For example, both psychiatry and psychology review accuracy of diagnosis and both psychiatry and social work evaluate aspects of discharge planning. In addition, the psychiatry audits assess substance abuse screening. PID analyzes data from the audits and produces monthly reports. Data are trended to show improvement or lack thereof. Results are provided to the Discipline Chiefs, the Executive staff and the MEDSEC.

D. Restraint and Seclusion Audit – The Hospital conducts monthly audits of at least 20% of the incidents of restraint and seclusion. The tool incorporates indicators reflecting SEH's restraint/seclusion policy and assesses the use of less restrictive interventions before use of restraint/seclusion, release criteria, and documentation quality. Monthly data are analyzed, trended in aggregate, and provided to the Discipline Chiefs, Executive staff, MEDSEC, and the units.

E. Discharge Audit – The Hospital, through its Quality Improvement Office, conducts monthly audits of the charts of persons discharged in the prior month, at a 20% sample. The audit reviews key questions around discharge planning and transition, such as: 1) did discharge planning begin upon admission?; 2) was the patient aided in transitioning to the community?; 3) was there involvement of a community case manager?; and 4) were written discharge instructions provided? Monthly reports are circulated to senior staff and posted on the SEH intranet.

F. Transfer Audit – The Hospital, through its Quality Improvement Office, conducts monthly audits of 20% of cases involving the transfer of patients within the Hospital and to other medical facilities. Indicators include compliance with Hospital policy around the content of transfer documentation by discipline and whether the IRP was timely completed on the new unit, if applicable. Results are provided to the Discipline Chiefs, Executive staff,

MEDSEC, and the units.

G. Infection Control Surveillance – The Infection Control Coordinator regularly conducts on unit surveillance activities, including observation of hand hygiene practices and other infection control activities. Statistics on these activities, as well as those related to certain medical conditions, are collected, analyzed, and presented to the Infection Control Committee.

H. Medication Audit – Pharmacy staff conduct monthly reviews of all patients' medication regimens and in-depth audits on an average of 50 cases per month. The audits review practices around use of high risk medications. Data are shared with the Pharmacy and Therapeutics Committee.

I. Therapeutic Monthly Note Audit – The Hospital reviews a monthly sample of therapeutic monthly notes completed by group and individual therapy providers. The audit reviews the timeliness of the note and whether its addresses the progress toward meeting the IRP objective that the intervention is targeting. Results are provided to the Discipline Chiefs, the Executive staff, MEDSEC, and the units. This Audit will begin in September, 2009.

J. Tardive Dyskinesia Audit – The Hospital reviews a sample of cases each month (scheduled so that each individual's case is reviewed four times per year) involving individuals with a diagnosis of tardive dsykinesia. The audits focus on ensuring a current AIMS test and monitoring the medical condition. Results are provided to the Medical Director, the Executive staff and the MEDSEC.

K. Treatment Mall Audit – The Hospital is conducting quarterly audits of the treatment mall programs (TLC I, II, and III, with audits of TLC IV expected in fall 2009) to assess fidelity to the curricula. Results are provided to the TLC leadership, Discipline Chiefs, the Executive staff, MEDSEC, and the units.

L. Post Discharge Audit – The Integrated Care Division (ICD) will conduct regular post-discharge audits to determine whether individuals released from Saint Elizabeths were seen within 7, 14 or 30 days of discharge (or not at all), and will also monitor to determine if services prescribed upon discharge have been provided.

M. Co-morbidity Audits – These audits are part of the effort to achieve the highest quality of care possible for SEH patients by ensuring that medical/physical and psychiatric needs are fully integrated and documented. The D.C. Department of Mental Health's QI office initiated the audits in April 2008 with the intention of reviewing at least one ward in the Civil and Forensic Programs per quarter. Approximately 14 records are reviewed each quarter.

III. Unusual Incident (UI) Investigations and Analysis – The Risk Manager monitors UI reports on a daily and monthly basis. UI data are collected and a report is published monthly. In addition, the Risk Manager monitors data for trends and notifies the program medical directors when any patient is involved in three or more UIs of any kind in a 30-day period. Those personnel are charged with informing the Risk Manager of follow-up actions taken, such as chart reviews or consultation with treatment teams.

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

DOJ Recommendations (Report 3)	***Responsible Party***
Identify additional high-risk indicators, continue tracking and trending. Develop policies around expectations for the response of IRP teams and other clinicians/disciplines to individuals who reach triggers. See cell below.	*PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1.c. and XII.E.2-3			

XIII.B. ***Compliance Status from DOJ Report: Noncompliance***

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

The Performance Improvement Department is making recommendations to Performance Improvement Committee about issues to track and recommendations to implement based upon the results of the audits being conducted. In addition, information about high risk indicators is being directly provided to treatment teams as they occur and are identified. The respective medical directors are also informed, and teams have three days to provide details on steps taken to address the high risk issues. Tracking high risk indicators template, tab # 56.

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

DOJ Recommendations (Report 3)			***Responsible Party***
1 *Implement the PID procedures as planned.*			*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See action steps above			
2 *Develop policies necessary for the implementation of a quality management system for addressing the treatment needs of high risk individuals.*		***- High Priority***	*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See action steps above ***Complete***		Presentation of PIC to Executive committee, Tabs # 121 and 122	
2 Implement PRISM system *Status: Ongoing - Updated as of 7/28/2009*	(Ongoing)	PRISM reports, Tab # 53	
3 Revise QI policy ***Complete***		QA policy, Tab # 146	JanA Taylor

XIII.B.1

Compliance Status from DOJ Report: Noncompliance

the action steps recommended to remedy and/or prevent the reoccurrence of problems;

Findings See XIII. A. and B.

Compliance Status: See XIII.A and B

DOJ Recommendations (Report 3)			***Responsible Party***
Implement the procedures prescribed by the PID policies and begin work on drafting policies/procedures addressing the treatment needs of individuals reaching high-risk indicators.			*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Same as above			

XIII.B.2

the anticipated outcome of each step; and

Findings See XIII. A. and B

Compliance Status: See XIII.A and B

DOJ Recommendations (Report 3)	Responsible Party
[The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.]	*PID;*

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

DOJ Recommendations (Report 3)	Responsible Party
The hospital will not be able to meet this requirement of the Settlement Agreement until it has identified additional high-risk indicators, has identified individuals reaching these indicators and has policies and procedures for responding to the treatment needs of individuals who reach the indicator criteria. It will likewise be essential to implement the PID policies and procedures for approving, implementing, and monitoring recommendations emerging from incident investigations.	*PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
PID will conduct focused reviews of the patients identified on AVATAR PRN and STAT report	4/21/2009		Hartley; Pontes
PID staff developing system to flag PID audits for IRP and S/R to detect and collect data re: evidence of follow up to high risk patiens as identified in the tracking process	4/21/2009	Tracking report for high risk indicators, Tab # 56	Hartley; Pontes
Status: Clinical chart audits, psychiatry audits and IRP process audits, as well as s/r audits, all review for use of PRN/Stat or R/s. - Updated as of 6/18/2009			
PID will develop monitoring and notification systems to support clinical staff in their efforts to intervene with patients at risk.		Tracking report for high risk indicators, Tab # 56	Hartley; Pontes
Status: Department Policy 01 - Risk Management Trigger and Intervention Tracking was developed on 03/23/09. Policy was reviewed and approved by Doj surveyor, Chura on 3/30/09. Policy partially implemented. - Updated as of 6/18/2009			
Implement System to flag and report patients in high risk situations to appropriate managers	(Ongoing)	Tracking report for high risk indicators, Tab # 56	Hartley; Pontes
Status: ongoing - Updated as of 6/18/2009			

XIII.B.3

the person(s) responsible and the time frame anticipated for each action step.

Findings See XIII. A. and B

Compliance Status: See XIII. A. and B

DOJ Recommendations (Report 3)	Responsible Party
[The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.]	*PID;*

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

See cell above.

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

XIII.C.

Compliance Status from DOJ Report: Noncompliance

Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:

Findings See XIII.A and XIII.B

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

DOJ Recommendations (Report 3)			*Responsible Party*
1 *Ensure that recovery teams are aware of their responsibility to review incidents and high-risk indicators, including restraint and seclusion episodes, when they convene.*			***- High Priority*** *PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 Educate treatment teams of need to consider incidents of UI, r/s and stat/prn medication when reviewing IRPs ***Complete*** *Status: ongoing - Updated as of 7/28/2009*	(Ongoing)		
2 Audit through IRP process and Clinical chart audits *Status: Ongoing - Updated as of 7/28/2009*	(Ongoing)	IRP process audit results, Tab # 9 ; Clinical chart audit results, Tab # 11	
2 *See also XIII.B*			*PID;*
Action Step and Status	**Target Date**	**Relevant Document(s)**	**Responsible Staff**
1 See related action steps			

XIII.C.1

disseminating corrective action plans to all persons responsible for their implementation;

Findings See XIII.A. and B..

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

XIII.C.2

monitoring and documenting the outcomes achieved; and

Findings See XIII.A and B.

Compliance Status: Progress toward compliance date of June, 2010.

XIII.C.3

modifying corrective action plans, as necessary.

Findings See XIII.A. B and C.

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

XIII.D.

Compliance Status from DOJ Report: Noncompliance

Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.

Findings See XIII.A. and B. The Performance Improvement Committee proffered goals to the Hospital's Executive Committee for 2009, which were approved. These can be found at tab # 121 and 122. The Hospital is collecting data on a number of indicators and measuring progress against the national public rate (PRISM reports, tab # 53), and also is tracking other key trends. Three high risk indicators are also tracked - 3 or more Unusual incidents

in a rolling 30 day period, high use of seclusion or restraint pursuant to policy (12 hours or more, 2 or more incidents in a 24 hour period, or three or more in a 30 day period), and use of 3 or more STAT medications during a 24 hour period.

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

DOJ Recommendations (Report 3)	***Responsible Party***
1 *Identify, as planned, additional medical and behavioral indicators.*	*PID;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XII.E.1.c			

2 *Adopt procedures to ensure that IRP teams address the treatment needs of individuals involved in incidents and who have reached triggers. See XIII.B.*	*PID; COS;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 See XIII.C recommendation #1			

XIV. Environmental Conditions

Summary of Progress

1. The Hospital's Safety Officer led two environmental surveys for second and third quarters, 2009. Improvement was noted, and the Safety Officer and Infection Control officer are working together to improve environmental conditions.

2. The Hospital is repairing air vents as well as showers to address suicide or other safety issues.

3. The Hospital is on target to move most patients into the new Hospital by Spring, 2010.

4. DCFD approved the fire plan. However, water pressure issues at JHP require that a fire watch continue.

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.

Compliance Status from DOJ Report: Partial

By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.

Findings The Hospital's Safety Officer and Infection Control Officer are charged with assessing the environment of care and patient and employee safety. The Safety Officer conducts a monthly walk-through of the hospital to look for potential hazards and continues to work to refine the environmental checklist. Environmental checklist, tab # 147. The Infection Control Coordinator also conducts reviews of the wards and patient areas to identify potential infection control issues.

In addition, the Hospital continues to conduct a periodic environmental surveys using staff and outsiders as review teams. See Environmental Surveys, tab # 148. The March 2009 survey showed improvements in the percentage of units rated as acceptable, form 79% in first quarter, FY09 to 93% in the second quarter, 2009.

The air vents were ordered on 8/17/09. Sixty six (66) vents will be replaced in JHP during the next couple of weeks on the following wards, 1, 2, 3, 6, 7, 8, 9, 10, 11, and 12. As of 8/24, the vendor has indicated that they will contact the manufacturer to confirm the exact date when the vents will be shipped. The vendor estimates that they will complete two ward per day after they receive the materials. Work is underway on repair of leaking shower heads in patient areas.

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

DOJ Recommendations (Report 3)		***Responsible Party***
1 *Assess the environment to determine areas where individuals are likely to have privacy and where the air vents can present a suicide hazard.*	***- High Priority***	*COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Conduct survey of JHP and RMB including bathrooms to search for suicide hazards			Seymour
	Complete *Status: Survy has been conducted and vents identified. Vendor has been selected. - Updated as of 8/28/2009*			

2	Develop plan to minimize suicide risk		Seymour

Status: Vendor has been selected to do this work. A determination is being made between the two alternates – utilizing breakaway screws and or installation of screens on vents to determine the most effective method to prevent potential suicide and completion date. There could be a gap of about $30,000 for this work to be completed. A follow up discussion will need to occur. - Updated as of 8/10/2009

3	Repair or modify identified risks as needed	Contract for air vent repairs	Seymour

Status: Vendor has been selected to do this work. A determination is being made between the two alternates – utilizing breakaway screws and or installation of screens on vents to determine the most effective method to prevent potential suicide and completion date. There could be a gap of about $30,000 for this work to be completed. A follow up discussion will need to occur. The vents were recently ordered on 8/17/09. Sixty six (66) vents will be replaced in JHP during the next couple of weeks on the following wards, 1, 2, 3, 6, 7, 8, 9, 10, 11, and 12. As of 8/24, the vendor has indicated that they will contact the manufacturer to confirm the exact date when the vents will be shipped. The vendor estimates that they will complete two ward per day after they receive the materials. - Updated as of 8/25/2009

2 *If not already done, alert all units to the hazard presented by the air vents.* ***- High Priority*** *COO; Psy;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Alert units of Potential Hazards			HenneberrySeymour

Complete *Status: The survey has been completed and Director of Forensic notified of results - Updated as of 8/28/2009*

3 *Identify ways to minimize the hazard presented by the vents. This might include bolting furniture to wall/floor away from vents, replacing the vents with a finer screen that still permits adequate airflow.* ***- High Priority*** *COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	See XIV.A recommendation #1			

Status: The vents were recently ordered on 8/17/09. Sixty six (66) vents will be replaced in JHP during the next couple of weeks on the following wards, 1, 2, 3, 6, 7, 8, 9, 10, 11, and 12. As of 8/24, the vendor has indicated that they will contact the manufacturer to confirm the exact date when the vents will be shipped. The vendor estimates that they will complete two ward per day after they receive the materials. Based upon the survey, RMB does need vents at this time. - Updated as of 8/26/2009

XIV.B.

Compliance Status from DOJ Report: Partial

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 A contraband policy was finalized. Tab # 149 . In addition, contraband is tracked through the completion of a UI. Data from the period of October, 2008 to July, 2009 shows incidence of contraband make up 4.2% of all UIs. Confiscation of contraband was highest in October, 2008 at 11, and lowest in July at 1. Tab # 150.

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

DOJ Recommendations (Report 3) ***Responsible Party***

Provide information in the next progress report on incidents involving contraband. *PID; COO;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Provide report on contraband based upon Uis and security reports		Report on contraband, Tab #150	Seymour, Risk manager

Status: In the last 8 months there have been 5 contraband incidents reported by Security. - Updated as of 8/25/2009

XIV.C.

Compliance Status from DOJ Report: Partial

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 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. Specific information about the investigations is include in the Advanced Document request for Ms. Chura; investigative reports will be provided at the site visit as they were too voluminous to copy.

Data is also available around elopements and patient on patient assaults or altercations. The Hospital's elopement rate continues above the national public rate at about .36 per 1000 patient days as of July 2009 (National Public rate is .21). Its patient injury rate is also higher than the public rate, at .80 in July, 2009 (national public rate is .43); it was at its highest in March and April, 2009 but has decreased in recent months. PRISM report, July, 2009 tab # 53 . According to UI data, to date in FY2009, assaults and altercations remain the category with highest percentage of incidents, (33%) while elopements are at 8.8%.

There continue to be issues around adequate supervision of individuals in care as evidenced by a serious sexual assault on one unit, consensual sex on another, and several instances of fire setting. The Chief Nurse continues to work with nurse managers and staff around positioning staff on units to ensure individuals are properly supervised. In addition to staff deployment to areas on the units with low visibility, the Hospital initiated an increased level of observation on RMB 3 (q 15 and 30 minute checks). The introduction of the EARN program ((tab # 117) is expected to enhance engagement with individuals in care and will be effective in early identification of clinical issues and concerns. As stated in the EARN overview, the proactive engagement of individuals will identify basic individual needs before they become urgent needs or concerns.

Compliance Status: Partial

DOJ Recommendations (Report 3) — ***Responsible Party***

1 *Determine if there is a problem staffing the evening shift and take appropriate measures to address the issue.* — ***- High Priority*** *CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	CNE Michael Hartley along with ADONs Martha Pontes and George Tanyi are creating a flexible staffing plan that will address this recommendation. The Flex Staffing plan will attempt to reassign nursing personnel to units and shifts, if necessary, in order to provide adequate coverage.	8/31/2009		CNE, Martha Pontes, and George Tanyi

2 *Take any other steps necessary to staff units commensurate with the needs of the individuals.* — ***- High Priority*** *Civil; Forensic; Med; CNE;*

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	Staff units commensurate with needs.	6/1/2009		BSA
	Status: Psychiatrists are assigned according to needs of units. - Updated as of 6/29/2009			

XIV.D.

Compliance Status from DOJ Report: Substantial—with recognition that some individuals using wheelchairs are not housed on the first floor

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. Trouble desk reports, tab # 151.

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

DOJ Recommendations (Report 3) — ***Responsible Party***

Continue current practice.

	Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1	N/A			

XIV.E.

Compliance Status from DOJ Report: Substantial

By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.

Findings DCFD approved the fire plan. Fire inspections continue to occur throughout the Hospital.

Compliance Status: Substantial

DOJ Recommendations (Report 3)		*Responsible Party*
Continue current practice.		*Civil;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 N/A			

XIV.F.

Compliance Status from DOJ Report: Partial

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 Environmental surveys continue to be completed each quarter. See Environmental Surveys for second and third quarter, FY 2009, tab # 148. In general, improvement is noted over most assessed areas. In July, 2008 due to issues with the fire hydrants experienced city wide, the Hospital began a fire watch for JHP, which continues.

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

DOJ Recommendations (Report 3)		*Responsible Party*
1 *Consider revising the protocol for the quarterly surveys from a blitz style to avoid alerting the units that the inspections are underway.*	***- High Priority***	*COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Revise Blitz Style for survey			Seymour
Complete *Status: Surveys were conducted at different times and days/ weeks apart. - Updated as of 8/28/2009*			

2 *During the hospital quarterly surveys, ask a sample of individuals to show how they store their clothing and personal hygiene supplies.*	***- High Priority***	*COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
1 Modify environmental survey tool to add this question		Environmental surveys, Tab # 148	Seymour
Complete *Status: Surveys are now being conducted at different times and days/ weeks apart. - Updated as of 8/28/2009*			
2 Report results		Environmental surveys, Tab # 148	Seymour
Complete *Status: Iindividuals were interviewed and result reported in the Qtrly report - Updated as of 8/28/2009*			

3 *Address the standing water issue in the showers with expertise from the maintenance department and infection control, if necessary.*	***- High Priority***	*COO;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Identify funding to remove all unused plumbing fixtures.			Seymour
Complete *Status: Completion date to be determined based upon the availability of funds. - Updated as of 8/28/2009*			

Contractor to provide proposal to remove all unused plumbing fixtures in shower rooms in RMB building.		Seymour
Complete	*Status: 5/21/09: proposal for approximately 45K has been received for this project. However, funding has yet to be identified. - Updated as of 8/28/2009*	
Remove all unused plumbing fixtures in shower rooms in RMB building as cited by DOJ inspector on 4/1/09.		Seymour
	Status: Leaking shower heads -- the Vendor will be at the hospital 8/25, for a pre-contruction meeting. The purchase order was received 8/24/09. anticipated completion date 9/11/09 - Updated as of 8/25/2009	

4 *Adopt a weekly review of the environment by unit leadership that includes a review of personal clothing care and storage.* ***- High Priority*** *COO; Psy;*

Action Step and Status	Target Date	Relevant Document(s)	Responsible Staff
Materials Management will identify type of shower shoe that can be purchased from vendor for patients to wer and show product to Safety Officer, Clinical Administrators, Director, JHP, Foresnics to authoize purchase. Clinical Administratrors will determine sizes and quantity and submit list to Material Management. Management will place order and put in stock. Materials Management will inform programs when items arrive. Programs will submit 1509s to obtain shower shoes for their patients. Materials Management will determine par level rate.			Seymour
Complete	*Status: 5/21 Shower shoes were delivered to JHP on 5/12/09. All requested sizes were delivered excep XX-large that were recently requested by JHP. These are on order. Civil also submitted their order and these items have been delivered as well. Par levels have determined by Materials Management. - Updated as of 6/18/2009*		
Survey JHP units to determine storage needs and to identify solutions	5/15/2009		seymour; henneberry
Complete	*Status: Status 05/21/09 Forensics AO purchased 75 bins to be used throughout JHP units to store patient clothing. 59 laundry bags were issued to Nursing to be distributed Civil units for the same purpose - Updated as of 6/18/2009*		