# United States of America v. District of Columbia

## An Assessment of Saint Elizabeths Hospital's Progress as of October 31, 2007 In Meeting the Requirements for Reform

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# *United States of America v. District of Columbia*

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## I. INTRODUCTION

This report is prepared by Saint Elizabeths Hospitals' (Hospital) internal compliance office pursuant to the June 25, 2007 Settlement Agreement (Agreement). The Agreement requires the District to submit to the United States a status report every six months that discusses the current status of each provision of the Settlement Agreement, along with a projection of the completion dates for each provision. The report will reflect progress as of October 31, 2007, unless otherwise noted. The report will be in two main parts. The first section is a narrative reporting the progress in implementing each section of the Agreement and includes the compliance officer's assessment of those areas in which progress has been made, areas in which significant challenges remain and a description of activities underway that are expected to move the Hospital closer toward compliance. The second section consists of a chart that provides a brief status report on each subsection of the Agreement.

Multiple sources of information were used to determine the direction of progress and form the basis of this office's view of the current status of progress. Because the Hospital still lacks a functioning information system from which administrative data can be obtained, data in this report is based upon manual data. In addition, the office is utilizing information provided by each of the Hospital's senior managers, as well as information the office itself collected through various monitoring activities discussed below.

## II. EXECUTIVE SUMMARY

As of October 31, 2007, the Hospital has made progress in areas that should serve as a foundation for further reform. Some key accomplishments include:

- Maintained certification by Center for Medicare and Medicaid Services (CMS) following a survey conducted in February, 2007;
- Awarded full three year accreditation of the Hospital's psychology training program by the American Psychological Association;
- Achieved CMS accreditation for the laboratory;
- Received a subgrant from National Association of State Mental Health Program Directors (NASMHPD) for training relating to implementation of trauma informed care;

- Trained staff and strengthened the Hospital's co-occurring disorders treatment program, through a grant awarded to the Department of Mental Health (DMH) from the Substance Abuse and Mental Health Services Administration;
- Screened every patient for smoking addiction and substance abuse in Spring/Summer, 2007;
- Implemented a fully smoke free campus effective August 1, 2007;
- Filled key leadership positions;
- Implemented the District's performance management system for managers and supervisors, known as the Management Supervisory System (MSS), which provides for more accountability and specific performance goals and at-will employment status for MSS staff;
- Began implementation of a pilot for trauma informed care on two units, with plan to expand it to all units within 18 months;
- Created positions for treatment team leaders and clinical administrators for all wards;
- Obtained approval of Hospital for staff participation in loan repayment program for doctors and registered nurses;
- Added 72 positions to increase direct care and other critical staffing;
- With Georgetown University, created a forensic fellowship training program for psychiatrists with interest in forensic services;
- Continued, on schedule, construction of new hospital.

Despite these accomplishments, there remain major areas in which little or no progress has been made, and where significant improvement is needed. Leadership at the Hospital, supported by the Director of the Department of Mental Health, early on recognized that there exist key infrastructure deficiencies that must be addressed if treatment and services at the Hospital are to meet the standards set out in the Agreement. The foundational areas include human resources, information technology, contracts and procurement, organizational structure, performance improvement and training. Staffing shortages in psychiatry, psychology and nursing are at significant levels, and more focused recruitment must begin immediately. There is no automated information system that serves the Hospital and provides regular data reports. Despite 200 new computers, there are at least 100 staff who do not have a computer or rely on old, outdated equipment. Further there is no identified funding for computers for the additional 72 staff funded in FY08. Contracts for basic hospital services were not in place at the beginning of the fiscal year, and the performance improvement division lacked the capacity to lead reform efforts. Action steps to address these key areas are included in the October 25, 2007 Corrective Action Plan, but they must completely and quickly be accomplished so that leadership may turn its full attention to more specific treatment and service reforms.

Patient care has not yet improved in any significant way. The Hospital is introducing, on a small scale, several "best practice" treatment interventions that it plans to expand to all treatment units in the next 12 -18 months but, after years of inattention, it is not surprising that the initiatives have not yet yielded the desired results. Patients are not yet experiencing the kinds of changes in assessment, treatment practices or services that the Agreement requires. Most treatment plans are not yet patient centered or based upon a case formulation. Assessments are at times out of date and/or not patient specific. Treatment services are not consistently or routinely individualized to meet the specific patient's needs. The Hospital leadership is realistic in

preparing for mid-course corrections as the best practice initiatives take hold, but staff at all levels have not yet embraced the new models and the new expectations they will need to meet. At this time it does not yet appear that meeting the timelines set out in the Agreement is in jeopardy, although the Department and Hospital must quickly address the issues around discharges and psychiatric assessments or satisfying those June 2008 requirements will be problematic.

The accomplishments to date are important first steps, but they are just that, first steps. The next eight to ten months will be critical and substantial improvement in patient care must occur if the time frames set out in the Agreement are to be met.

## III. MONITORING ACTIVITIES

The District of Columbia selected a compliance officer to promote compliance and implementation of this Agreement. After approval by the Department of Justice, the compliance officer began working at the Hospital on a part time basis in May, 2007, and became full time on July 9, 2007. Working with the compliance officer is a program analyst. The compliance officer and program analyst have unlimited access to all facilities, units and staff, and attend Executive staff and Senior staff meetings. They also meet weekly one-on-one with the Chief Executive Officer (CEO). The compliance officer presented the Agreement to all senior managers and at an "all-staff" meeting as required by section XVI B of the Agreement. Implementation of the Agreement was a focus of three senior staff retreats, and managers were active participants in the development of the Corrective Action Plan. In addition, the compliance office prepared charts summarizing the deficiencies and minimal remedial measures from Department of Justice's May 23, 2006 letter and distributed them to all managers in the Fall 2007.

In order to assess the current functioning of the Hospital and to gain insight from staff who have been at the Hospital for some time, the compliance officer met individually with key hospital managers, including the forensic and civil services leadership teams, the Medical Staff Executive Committee, nursing personnel on both the civil and forensic programs, rehabilitation services managers and line staff, administrators of the treatment mall and various administrative and facilities staff. The compliance officer visited all of the units in the Hospital, and regularly responds to various emergency calls in the Hospital (including Code 13s and medical codes). Compliance office staff attended treatment planning conferences, mortality review committee meetings, and reviewed charts on different units of the Hospital. The Office also conducted analyses of human resources functioning, and data analyses of groups conducted on the treatment mall. Compliance Office staff are also working closely with the Performance Improvement Department to expand monitoring and performance improvement activities throughout the Hospital.

# IV. HOSPITAL OVERVIEW

The Hospital currently operates 20 wards, 10 for civil services and 10 for forensic services. Patients are housed in RMB Building, CT2 and the John Howard Pavilion and treatment mall activities occur in CT 7 and CT 8. Staff offices are located in patient areas and also in CT3, CT5 and CT6, Smith Center, Behavioral Studies, Barton Hall, Blackburn Laboratory, the Chapel, the Motor Pool, the Glenside Building and the Barn.

## 1. Hospital Census

As of November 7, 2007, there were 432 patients in the Hospital, 222 on the civil side and 210 on forensic side. *See Table 1.* In addition, the Forensic Services serves 107 patients on court ordered conditional release.

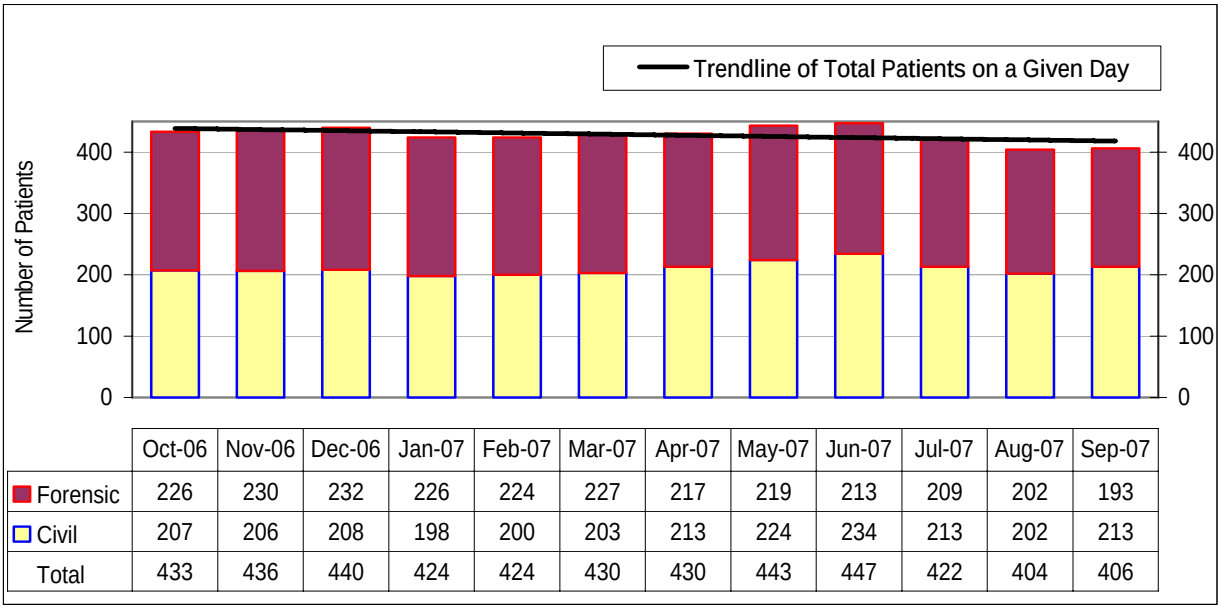
**Table 1: Number of Patients Served as of 11/7/07 by Program Area and Unit**

| Civil Program | | | | | Forensic Program | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Unit** | | **Female** | **Male** | **Total** | **Unit** | | **Female** | **Male** | **Total** |
| **CT2-A/B** | Long-term | 18 | 12 | **30** | **JHP-2** | Post-trial | | 19 | **19** |
| **CT2-C/D** | Geriatric | 10 | 14 | **24** | **JHP-4** | Post-trial | | 18 | **18** |
| **RMB-1** | Geriatric | 10 | 12 | **22** | **JHP-6** | Pre-trial | 26 | | **26** |
| **RMB-2** | Geriatric | 8 | 14 | **22** | **JHP-7** | Pre-trial | | 26 | **26** |
| **RMB-3** | Long -term | 8 | 10 | **18** | **JHP-8** | Post-trial | | 21 | **21** |
| **RMB-4** | Long-term | 8 | 11 | **19** | **JHP-9** | Pre-trial | | 24 | **24** |
| **RMB-5** | Acute | 9 | 10 | **19** | **JHP-10** | Post-trial | | 17 | **17** |
| **RMB-6** | Acute | 9 | 14 | **23** | **JHP-11** | Post-trial | | 21 | **21** |
| **RMB-7** | Long-term | 5 | 16 | **21** | **JHP-12** | Post-trial | | 21 | **21** |
| **RMB-8** | Long-term | 8 | 16 | **24** | **Subtotal** | | **26** | **184** | **210** |
| ***Subtotal*** | | ***93*** | ***129*** | ***222*** | ***Total*** | | ***119*** | ***313*** | ***432*** |

*Data source: STAR Census, 11/7/07. Data does not include patients documented in STAR as being on unauthorized leave.*

As set forth in Figure 1 below, the Hospital's overall census increased slightly in the last 13 months, with a spike in admissions to the civil side in late Spring, 2007, peaking in June, 2007. *See Figure 1.* The inpatient census in the forensic division decreased from 226 to 210 (down 7%) from October, 2006 to November, 2007, but the census in the civil division actually increased, from 207 to 222 (up 7%). The census was down by 1 between October 1, 2006 and November, 7, 2007.

**Figure 1: Trendline of Hospital Census, FY 2007**

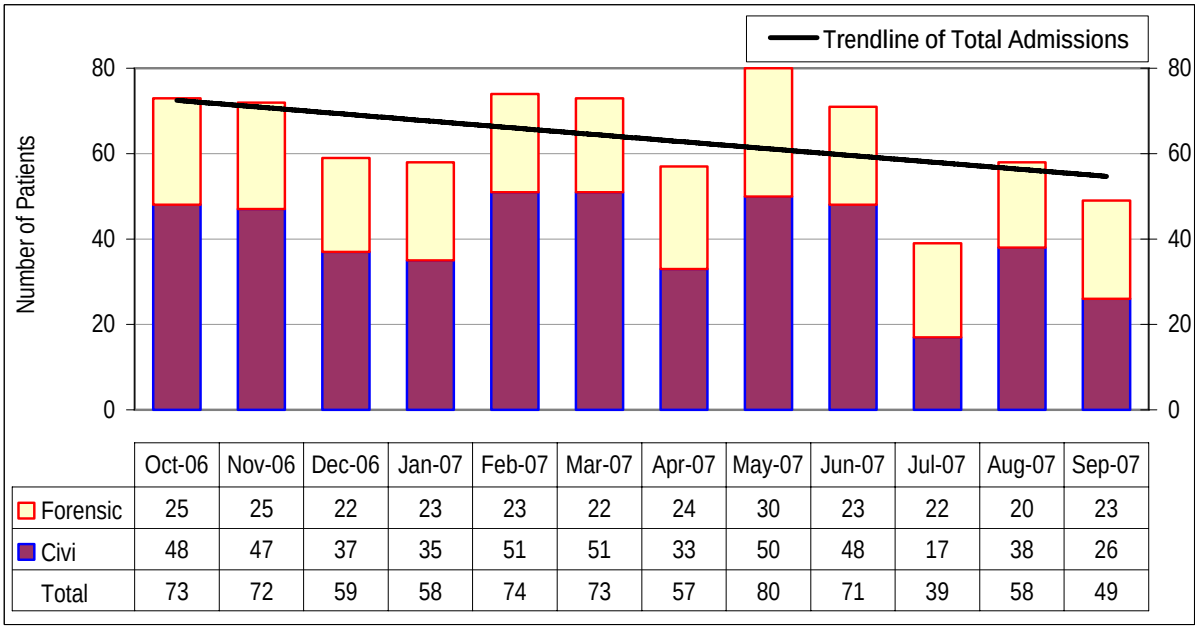



| | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Sep-07 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic | 226 | 230 | 232 | 226 | 224 | 227 | 217 | 219 | 213 | 209 | 202 | 193 |
| Civil | 207 | 206 | 208 | 198 | 200 | 203 | 213 | 224 | 234 | 213 | 202 | 213 |
| Total | 433 | 436 | 440 | 424 | 424 | 430 | 430 | 443 | 447 | 422 | 404 | 406 |

## 2. Admissions and Discharges

Admissions: Overall, admissions decreased in FY 07, but forensic admissions have been relatively stable. Admissions to the civil side decreased significantly between October, 2006 and September, 2007, despite the spike in admissions in Spring, 2007. Admissions ranged from a high of 80 in May, 2007, to a low of 39 in July, 2007. *See Figure 2.*

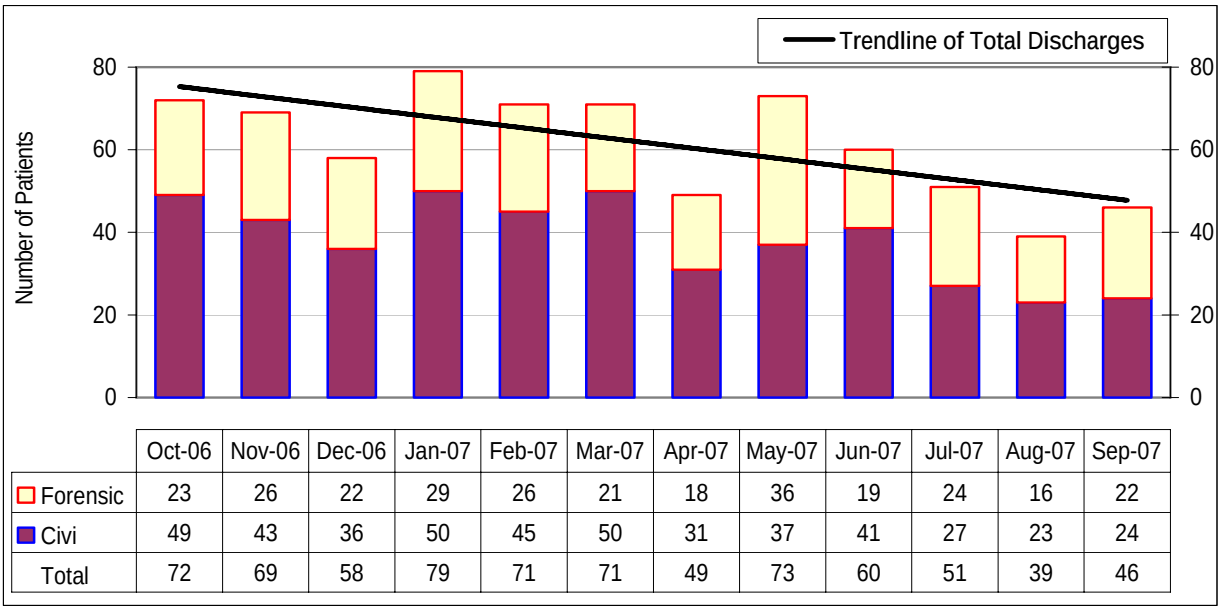
**Figure 2: Trendline of Admissions, FY 2007**




| | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Sep-07 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic | 25 | 25 | 22 | 23 | 23 | 22 | 24 | 30 | 23 | 22 | 20 | 23 |
| Civi | 48 | 47 | 37 | 35 | 51 | 51 | 33 | 50 | 48 | 17 | 38 | 26 |
| Total | 73 | 72 | 59 | 58 | 74 | 73 | 57 | 80 | 71 | 39 | 58 | 49 |

Discharges: Unfortunately, discharges also decreased in FY 07, from a high of 79 in January to a low of 39 in August, 2007. The high number of discharges in the early part of the year reflects a concerted effort by the Hospital and the Department of Mental Health to implement discharge plans for long term patients; between January 2, 2007 and November 13, 2007, 142 patients were discharged from the Hospital. *See Figure 3.* Despite this significant accomplishment, in only three of twelve months did monthly discharges on the civil side exceed admissions, and there continues to be a significant number of patients who are "ready for discharge" but for whom discharge is not effected. See Section B. 4, p. 31 infra for more detailed information.

**Figure 3: Trendline of Discharges, FY 2007**

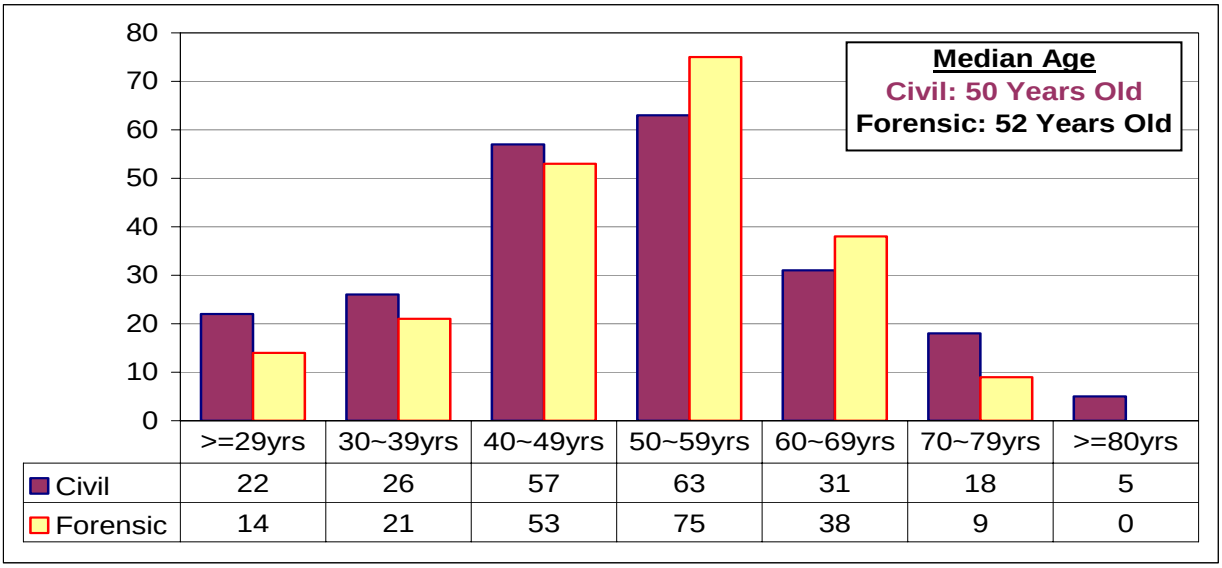



| | Oct-06 | Nov-06 | Dec-06 | Jan-07 | Feb-07 | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Sep-07 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic | 23 | 26 | 22 | 29 | 26 | 21 | 18 | 36 | 19 | 24 | 16 | 22 |
| Civi | 49 | 43 | 36 | 50 | 45 | 50 | 31 | 37 | 41 | 27 | 23 | 24 |
| Total | 72 | 69 | 58 | 79 | 71 | 71 | 49 | 73 | 60 | 51 | 39 | 46 |

### 3. Demographics

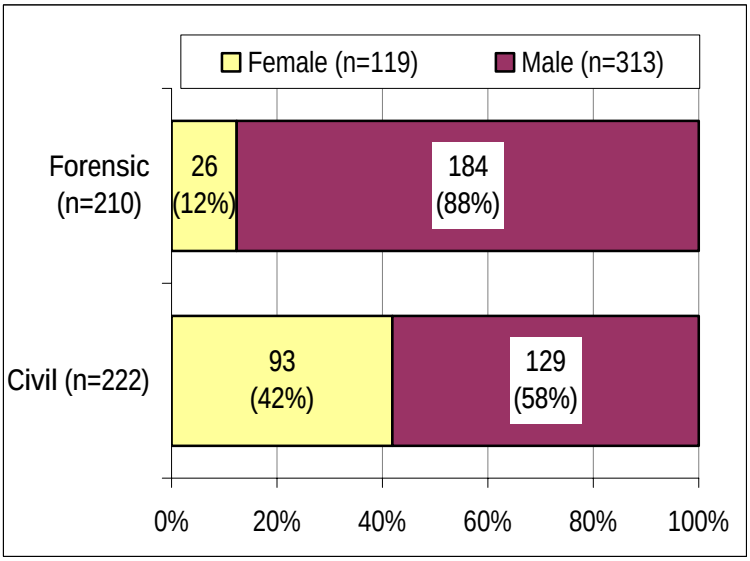
The age profile of Saint Elizabeths Hospital patients ranges from 18 to over 80; it reflects a bell curve, as the highest number of patients falls within the 50-59 age range. *Figure 4.* The median age is 50 for civil patients and 52 for forensic patients. The majority of the Hospital's patients are male, but that is somewhat skewed by the forensic program, where only 12% of the patients are female. *Figure 5.*

**Figure 4: Breakdown by Age, FY 2007**




| | >=29yrs | 30~39yrs | 40~49yrs | 50~59yrs | 60~69yrs | 70~79yrs | >=80yrs |
|---|---|---|---|---|---|---|---|
| Civil | 22 | 26 | 57 | 63 | 31 | 18 | 5 |
| Forensic | 14 | 21 | 53 | 75 | 38 | 9 | 0 |

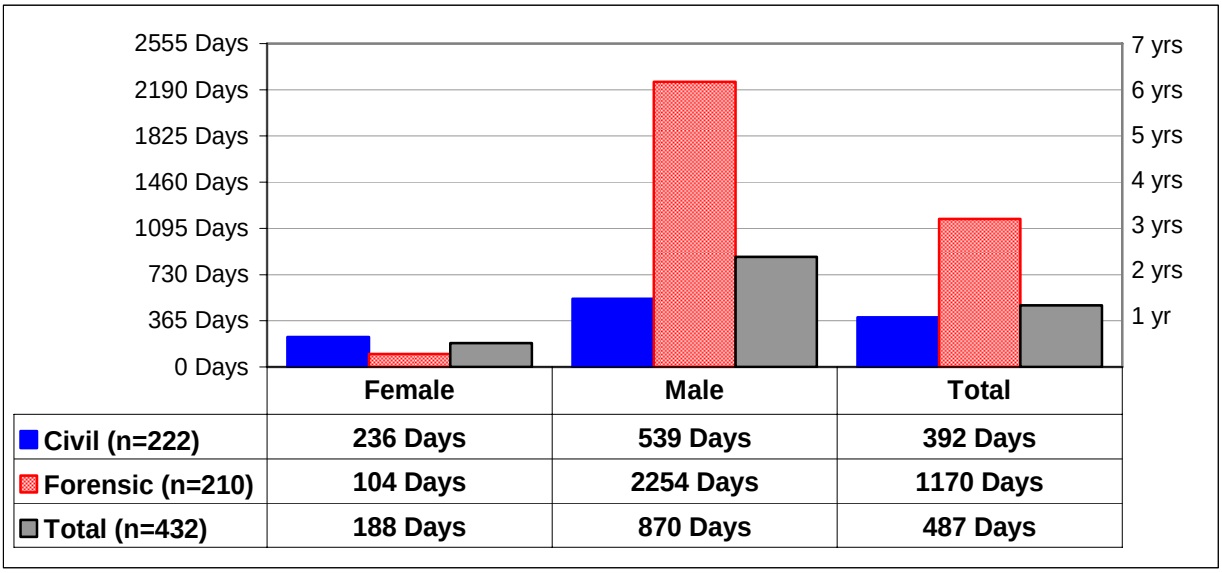
**Figure 5. Breakdown by Sex, FY 2007**




## 4. Length of Stay

Forensic patients have a higher median age compared with patients in the civil program. This trend appears to be highly correlated to the pattern of length of stay (LOS). As presented in Figure 6, the length of stay for the patients in the forensic program is much longer than that for civil side patients: 392 days or 13 months for civil patients and 1170 days or 28 months for forensic patients. *Figure 6.* Data also demonstrates that male patients are more likely to stay in hospital for a longer period than female patients. The median length of stay for female patients is 188 days or 6 months whereas that for male patients is 870 days or 29 months.

**Figure 6: Median Length of Stay by Program and Gender FY 2007**




| | Female | Male | Total |
|---|---|---|---|
| Civil (n=222) | 236 Days | 539 Days | 392 Days |
| Forensic (n=210) | 104 Days | 2254 Days | 1170 Days |
| Total (n=432) | 188 Days | 870 Days | 487 Days |

*Data Source: Length of Stay Analysis from STAR census data as of 11/7/07, Office of Monitoring Systems*

Table 2 below further provides median, average, and maximum length of stay breakdown by unit.

**Table 2: Length of Stay by Unit, FY2007**

***Unit: Months***

| Civil Program | | | | | Forensic Program | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Unit** | | Median | Average | Maximum | **Unit** | | Median | Average | Maximum |
| **CT2-A/B** | Long-term | 15 | 37 | 166 | **JHP-2** | Post-trial | 13 | 42 | 150 |
| **CT2-C/D** | Geriatric | 24 | 42 | 216 | **JHP-3** | Post-trial | 156 | 147 | 231 |
| **RMB-1** | Geriatric | 36 | 58 | 176 | **JHP-4** | Post-trial | 154 | 158 | 282 |
| **RMB-2** | Geriatric | 35 | 66 | 313 | **JHP-6** | Pre & post trial | 3 | 10 | 99 |
| **RMB-3** | Long-term | 12 | 29 | 108 | **JHP-7** | Pre-Trial | 2 | 2 | 5 |
| **RMB-4** | Long-term | 6 | 44 | 226 | **JHP-8** | Post-trial | 96 | 111 | 269 |
| **RMB-5** | Acute | 0.5 | 0.9 | 3 | **JHP-9** | Pre-Trial | 2 | 3 | 10 |
| **RMB-6** | Acute | 0.9 | 3 | 24 | **JHP-10** | Post-trial | 106 | 122 | 285 |
| **RMB-7** | Long-term | 34 | 55 | 335 | **JHP-11** | Post-trial | 135 | 127 | 257 |
| **RMB-8** | Long-term | 17 | 33 | 166 | **JHP-12** | Post-trial | 96 | 107 | 307 |
| **Civil (n=222)** | | **13** | **37** | **335** | **Forensic (n=210)** | | **38** | **75** | **307** |
| | | | | | **Grand Total (n=432)** | | **119** | **313** | **432** |

*Data Source: Length of Stay Analysis from STAR census data as of 11/7/07, Office of Monitoring Systems*
*Note: Data above does not include patients who are documented as being in unauthorized leave in STAR system.*

# V. ADMINSTRATIVE INFRASTRUCTURE

As noted in the Corrective Action Plan dated October 25, 2007, the Hospital's administrative infrastructure is so problematic that without early and aggressive reform, there is little likelihood that it will be possible to achieve or sustain the gains required in direct patient care. This portion of the report will identify the issues and will highlight actions that have been taken or still need to be taken in six key areas.

## 1. Leadership and Organizational Structure

There have been several significant actions taken to address leadership and organizational structure issues at the Hospital, but they have not yet been fully implemented and it is too early to assess if additional changes may be required.

Recognizing the need for new leadership at the Hospital in order to re-energize the needed reforms, Mayor Fenty appointed a new Hospital Chief Executive Officer, Patrick Canavan, effective January 2, 2007. Dr. Canavan, a clinical psychologist by training, worked at Saint Elizabeths Forensic Services Division for 5 years, first as a psychologist and then as Clinical Administrator. After obtaining his certification as a public manager from George Washington University, he led the District's Neighborhood Services initiative and served as the Director of the Department of Consumer and Regulatory Affairs. This change in leadership has been important in setting a new tone and direction for the Hospital, but this is only one step.

Dr. Canavan created a new leadership and an organizational structure designed to focus on patient care with an administrative structure supporting clinical work. He hired a new Director of Medical Affairs, a new Chief Operating Officer (COO) and a new Director of Civil Services. The new Director of Medical Affairs was not able to start until December 5, 2007, which has delayed reform in the psychiatric and medical practice areas. Likewise, the new COO only started in mid October, which also has hampered the implementation of some reforms in the administrative and facilities administrations. The Director of Civil Services was appointed in Spring, 2007, but the lack of administrative support and overburdened staff in patient care areas is slowing Civil Services Division reform efforts. Finally, recruitment just began for the Director of Training and Professional Development, another new senior position.

Dr. Canavan also made major changes in the Hospital's Table of Organization; implementation has begun but is not completed. Under the new structure, all direct care staff will report to either the Director of Civil Services or the Director of Forensic Services through their respective discipline chiefs. This is expected to centralize accountability, and, with the application of Management Supervisory Service to managers and supervisors, (discussed *infra*), should facilitate implementation of treatment and related reforms.

The new structure also creates a clinical administrator position to support every unit, in both the civil and forensic programs[1]. The clinical administrator is charged with organizing, administering and ensuring that psychiatric and other mental health services are provided to all patients on the inpatient unit and serves as the person with overall responsibility for the coordination of the ward and treatment provided by multidisciplinary personnel. *Attachment 1 (Clinical Administrator Position Description*). As of October, 31, 2007, all but two of the clinical administrator positions in the forensic program were filled and the remaining two are in recruitment; and three of six were filled on the civil side. Recruitment for the other three civil clinical administrator positions is underway.[2]

Other changes in the Table of Organization include restoring administrative officer (AO) positions for Civil and Forensic Services, Medical Affairs and Training and Professional Development;[3] consolidation of all medical and clinical professions in the Office of the Director of Medical Affairs; and the creation of a new and expanded Office of Training and Professional Development. In addition, there is a new position for an Administrator of Consumer Affairs that reports directly to the CEO. These changes are expected to enhance the quality of patient care through enhanced support and accountability.

While these changes are positive, expediting the implementation of this new structure is critical, and management vacancies must be filled more quickly than has been the case in the past. (See section B below). Further, implementation will require a culture change in the organization to increase the focus on patient care and outcomes. Leadership at all levels must understand that true reform does not occur on paper, and that all staff must change the way they interact with patients and do their jobs. The CEO held a series of retreats with approximately 60 of the Hospital's senior managers and labor leaders focusing on organizational change. Topics included extensive discussions around the Agreement and the work that is needed to achieve the Agreement's requirements, and managers participated in the development of specific work plans and initiatives to improve patient care. These retreats will continue, and the Hospital retained a well-known consultant to work with managers and direct care staff by providing guidance, advice and facilitation relating to strategic planning implementation and system improvements. The consultant will also observe and provide coaching to individual managers to improve leadership skills and management competencies, and to treatment teams to improve team functioning.

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[1] The clinical administrator function will be filled by on some wards by a licensed psychologist who will serve as treatment team leader, and on other units, by a licensed nurse, social worker or other licensed clinician. Treatment teams on units where the clinical administrator is not a psychologist will be led by a psychiatrist.

[2] The Hospital received an additional 72 positions in its allotted number of employees in FY 08, which began on October 1, 2007. The process of assigning positions has been completed, and the pace of recruitment is expected to increase.

[3] An administrative officer provides support to the manager by handling procurement and supply matters, processing of personnel actions and other key administrative tasks. For the past several years, these time consuming but important tasks have been handled by clinical staff, which has adversely impacted progress in clinical service areas.

## 2. Human Resources

The Human Resources (HR) function at the Hospital continues to be problematic, although recent changes seem to be having a positive impact on hiring. There remain critical shortages of nursing personnel, psychiatrists, rehabilitation specialists and psychologists that are adversely impacting patient care, and there has been little progress in addressing these shortages to date. Until mid-October, there were an insufficient number of HR staff dedicated to support the Hospital, and the hiring process was cumbersome. As described below in more detail, the addition of staff to the HR function and delegating full authority to SEH to recruit staff are expected to lead to the reduction in the vacancy rate at the Hospital.

### A. Staffing Report, SEH

During FY 07, there was little progress in hiring staff; in fact vacancies in clinical positions increased. At the conclusion of FY 07, the Hospital had 980 FTEs, of which 77 were vacant at the end of the fiscal year. *See Figure 7.* This translates into a vacancy rate of just under 8%.

**Figure 7: Vacancies by Month, FY2007**

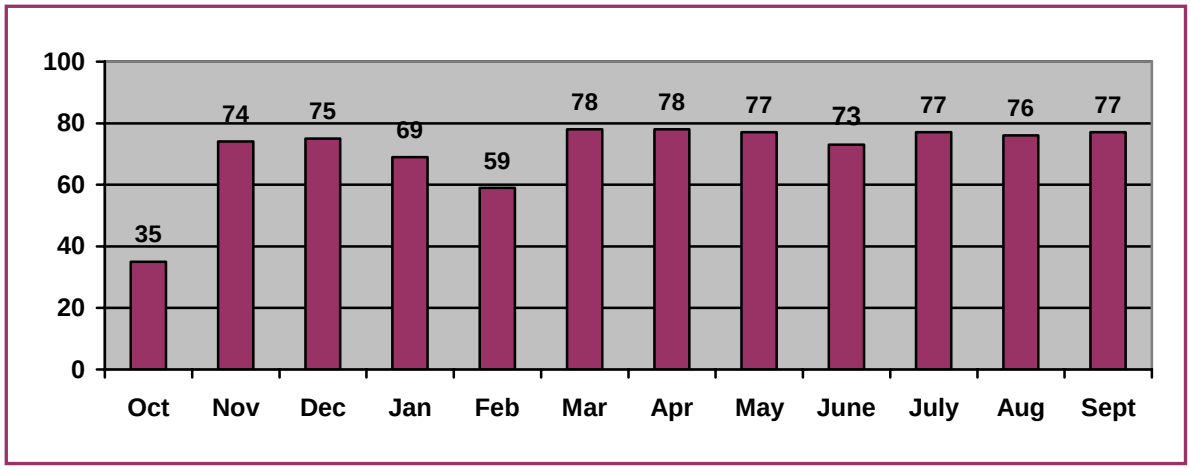
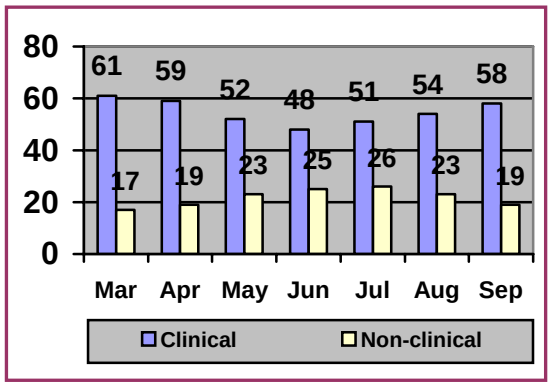
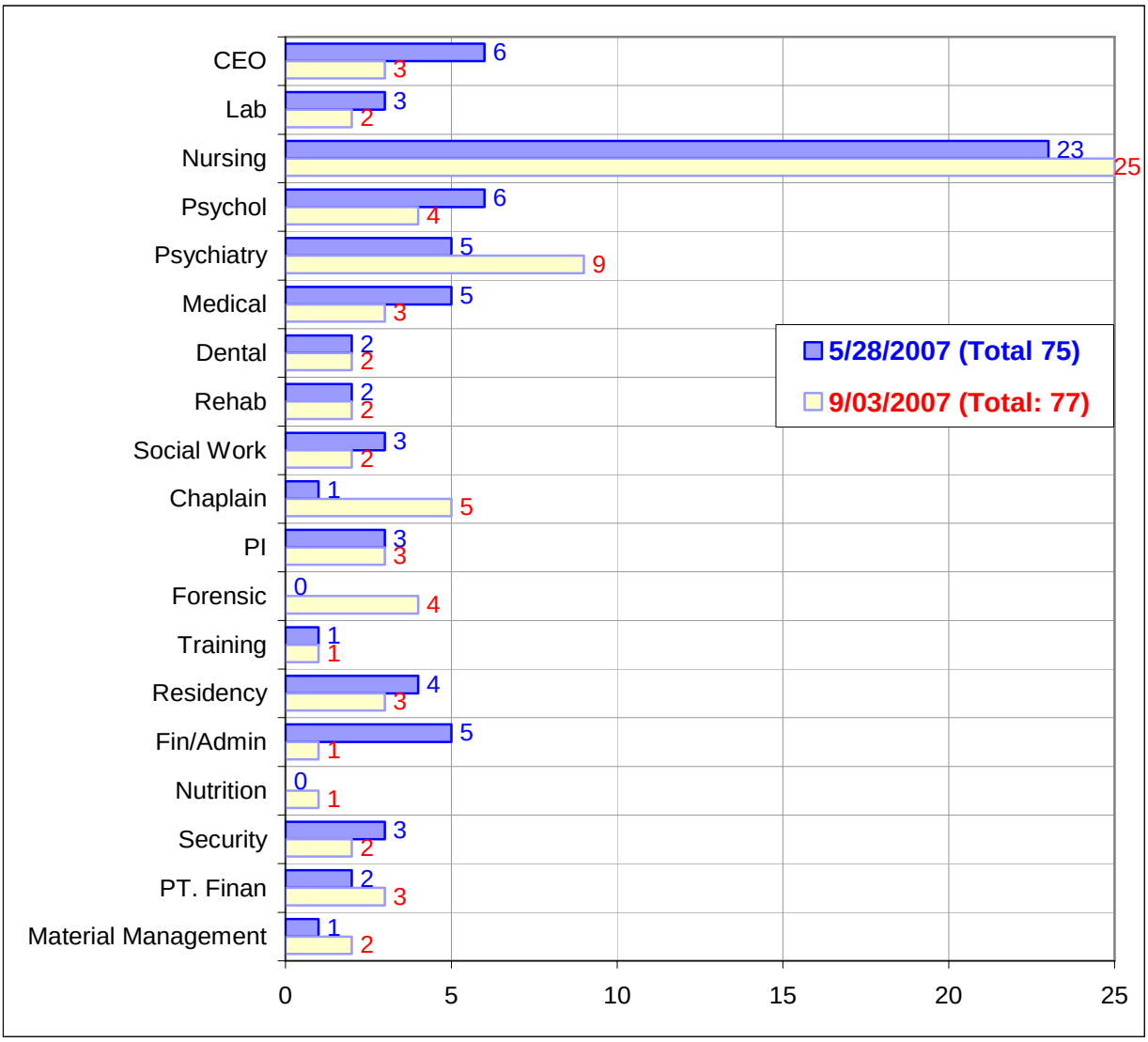



**Figure 8: Vacancies by Position Type, 2007**




There was no progress between May and September. By end of FY 07, 31% of the vacancies were nursing positions (24 out of 77), 11.6% were psychiatry positions (9 of 77) and 5% psychology positions. When you include other clinical positions such as social work and rehabilitation services, almost 50% of all vacancies at the end of FY07 were in DOJ specified positions. *See Figures 8 and 9.* Beginning in mid November, 2007 HR now reports vacancy information weekly, by discipline.

**Figure 9: Vacancies by program, May and September, 2007**




As of October 1, 2007, the Hospital was provided with 72 additional positions, so that its total number of full time positions jumped to 1052. The vacancy rate, just by virtue of these additional positions, increased to 14.2%.

### B. Description of HR function

Until October 14, 2007, the allocation of Department of Mental Health's (DMH) Human Resource staff was widely skewed. In FY 07, DMH had 1591 funded positions, of which 963, or 62%, were with SEH. *Figure 10.* For FY 08, the number and proportion of DMH FTEs assigned to SEH increased to 1052 of the Department's total of 1691 FTEs. *Figure 11.*

**Figure 10: FY07 DMH Positions by Organization**

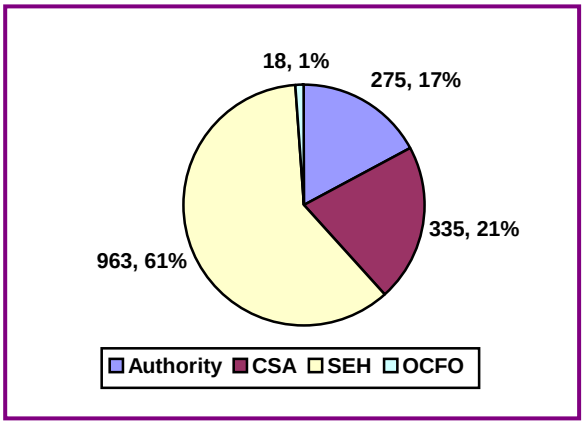
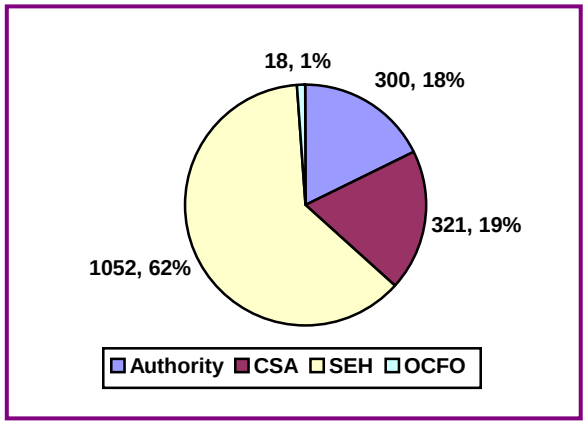



**Figure 11: FY08 DMH Positions by Organization**




Throughout FY 07, DMH's Human Resources Department included 16 FTEs. Although over 60% of the Department's positions were assigned to Saint Elizabeths, until late October, 2007, DMH only operated a small, three person satellite office to handle all Hospital related recruitment, under the day-to-day direction of off-site DMH HR managers. There was also one staff assigned to handle labor relations issues for the Hospital, and other DMH HR staff work on benefits and other issues for SEH employees. There were no clerical support workers assigned to SEH HR functions. In addition, classification work was centralized at DMH, and all personnel actions, applications, position descriptions and recruitment related actions went through the Department's HR office.

This structure caused significant delays, and hiring of Hospital staff competed for attention with recruitment activities on behalf of the other Department's organizations. Further, the Hospital was required to follow numerous process steps for hiring, such as completing a request to recruit memorandum each time a nursing staff, or other hard to fill staff, resigned. There were long delays in classifying positions, announcing vacancies, in issuing selection certificates and in issuing offers. For example, there are cases when it took more than four months from submission of a position description to get a position classified and more than seven months for issuance of a selection certificate upon the closing of the position.

### C. Recent Developments

Establishment of Expanded HR Unit at SEH. Recent modifications to the structure of SEH's HR office and to the hiring process address many of the identified barriers to recruitment. Effective October 14, 2007, DMH and SEH leadership finalized a plan to establish a 10 person, fully empowered human resources unit at the Hospital to handle recruitment activities and other routine personnel actions. The unit already includes a MSS-14 Human Resources manager, a Deputy, one labor relations staff, two general recruiters, a nurse recruiter, and an administrative assistant; recruitment is underway for two classification specialists and a human resources assistant. This unit has full HR authority relating to recruitment, position classification and salary negotiations consistent with the collective bargaining contracts and DC personnel law. For these steps to be fully effective, the full staff complement of 10 must be in place, and that staff must exercise the authority that has been delegated to them.

Implementation of MSS. A second significant development relating to staffing is implementation of Management Supervisory Service (MSS) for managers and supervisors at the Hospital. MSS is a personnel status within DC government that is intended to ensure the District has the highest quality of managers and supervisors. Employees in MSS serve "at will," receive higher salaries and are required to establish performance contracts with specific, measurable goals. The Hospital implemented MSS for 63 employees and 36 categories of positions, effective October 14, 2007. Because salaries on the MSS pay scale are higher than the regular scale, it is anticipated that MSS will also help in recruiting top-notch managers and supervisors, and will also positively impact retention.[4] Participation in MSS provides a clear mechanism to hold managers accountable for results, and, through performance plans and contracts, ensures that the performance of all managers and supervisors is tied to reform. Managers in MSS must complete a required curriculum of training on topics relating to supervision, leading and managing change and other relevant courses in order to maintain their status. The MSS program is in its early stages, but it has been effective in other DC agencies in improving individual manager and overall agency performance.

Participation in Loan Repayment Program. The Hospital has been approved for participation in the loan repayment program for physician and nursing staff. Under the program, registered nurses are eligible for up to $66,000 and physicians are eligible for up to $120,000 in loan repayments. The amount of loan repayment is based upon the length of service to the Hospital. Staff must be a U.S. citizen, work a minimum of 40 hours per week, and at least 4 days per week, and must commit to a minimum of two years service. This applies to both current and new employees, and should be an effective recruitment tool.

Support our Staff Teams. Fourth, the Hospital developed support teams who are available to support staff through crisis. Known as "SOS" (Support Our Staff), the team is made up of trained staff volunteers, and is available 24 hours a day, 7 days per week, to support staff who may be injured or traumatized by some event. The SOS team will go to the work site at any time, and will respond in the manner that best meets the employee's needs, such as accompanying the staff to the Hospital, leading a debriefing, or just talking with the employee. "Support our Staff" is expected to reduce their effects of a trauma and thereby support staff retention.

Conclusion. If the Hospital is to meet the performance requirements and time frames set out in the Agreement, the Hospital must significantly reduce its vacancy rates in nursing, psychiatry, psychology, and rehabilitation services. Currently, there is no strategic recruitment plan, positions are not being advertised in the right forums, there is no identified recruitment budget and there is no incentive program for current staff or new employees. Likewise, there are no recruitment materials developed, a notable absence given the storied history of the hospital, the

[4] In July, 2007 the Hospital also implemented a pay adjustment, that provided non-union staff with at least a 3% raise, and also corrected a pay disparity so that the pay of nurse managers would be at least 5% greater than those staff they supervised. For several years, recruitment of nurse managers was almost impossible because of the pay disparity issue. Data after the July correction still suggests that the pre MSS adjusted salary was not sufficient to recruit the full complement of needed nurse managers; the Hospital must continue to monitor this issue as MSS is implemented.

marketing appeal of a new hospital facility and the available loan repayment program. Further, the Hospital must simplify the hiring process so that staff can be on board within 30 days of a vacancy, not in 6 months as has been typical.[5] The Hospital's Corrective Action Plan (CAP) addresses these issues, and delivering on them on time will be essential.

### 3. Contracts and Procurement

In order for the Hospital to function properly and meet its obligations to the patients it serves, it is imperative that medical and other supplies, medications, food, heat, air conditioning, working ovens and refrigerators, beds, furniture and numerous other items be readily available, in sufficient quantities and of appropriate quality. Unfortunately, this is not always the case due in part to issues around contracting and procurement.

There are significant problems around contracting and procurement that impede hospital operations; contributing to these issues is that in the past some items were not procured consistent with DC law or regulations, and correcting these deficiencies has negatively impacted operations. At the start of FY08, contracts were not in place for food, medication, maintenance of kitchen equipment, HVAC and fire alarm systems, housekeeping supplies, water, or oxygen. Due to problems both within the Hospital and at DMH contract's office, contracts for nursing and psychiatrists were also delayed, but are in place at this time. As of November 15, 2007, there were no contracts in place for calibrating the glucometer machines or blood pressure machines. *See Attachment 2 (List of Items for Which There was No Contract in Place as of October 1).* Procurement for furniture for JHP patient areas began in January, 2007, yet as of the end of November, 2007, the furniture still has not arrived (it is expected in mid December). The lack of a contract and procurement system that ensures that there are no gaps in supplies or services compromises patient care and safety and is one of those critical functions that must immediately be improved.

The Director, DMH and the Hospital CEO recognize that there need to be significant operational improvements in contracting and procurement. An outside consultant engaged by DMH is reviewing contracting and procurement policies and practices within the Department. The consultants will meet directly the CEO and make recommendations to DMH on changes that will improve performance in this area. It is expected that the consultation will include specific recommendations specifying what contracting/purchasing functions should be located at the Hospital, to what extent the Hospital should have its own purchasing authority, and reporting and accountability requirements for all in the in contracting/procurement process.

While this evaluation is underway, other steps were taken with varying degrees of effectiveness. Presently, all contract and procurement for the Hospital is done by a centralized contract and procurement office located at DMH's main headquarters. On June 13, 2007, the Director, DMH

[5] There has been some improvement in the hiring process recently. HR issued a memorandum exempting hard to fill positions from the requirement that a manager submit a "request to recruit" memorandum each time a manager wishes to fill a position, and vacancies are at times being announced before the incumbent's last day. In addition, vacancies are now being posted as unlimited, as opposed to within department, except as required by a collective bargaining agreement. It is important that refinements like this continue.

approved the transfer of two positions from the Hospital to the Authority so the Contracts Office could hire two contract specialists but, as of the writing of this report, new staff are still not on board. The Hospital is in the final stages of receiving approval for the issuance of a "purchase card" that will permit the Hospital to make emergency and small purchases. There will be four senior managers who will receive the cards, which are limited to $2500/transaction, $10,000/month and $30,000/year. The purchase cards will be available to the Hospital by the first week in January, 2008.

### 4. Information Technology

The Hospital continues to lack an automated information system, and to the extent data is available, relies largely on manually collected data which is then entered into spread sheets to assess organizational performance. In addition, the Hospital, until recently, lacked appropriate hardware and software to support staff in meeting patient needs. The importance of having basic technology available to staff cannot be over emphasized. In July, 2007, physician staff described using one work station to type a court report, traveling to another floor to print it, and finally, walking to another building to fax it to the court. Obviously, that adversely affects morale and is a poor use of staff time and effort.

Hardware. The Hospital is making progress in meeting hardware needs, but additional hardware is needed. In late October, 2007, the Hospital received 200 fully configured computers that were deployed through the month of November. The majority of the computers went to staff in JHP, RM and the treatment mall, and to the computer training lab, pharmacy, laboratory, and performance improvement, with some to administrative services. Additionally, 25 laptops will be delivered to the Hospital once imaging is completed for use by clinicians. There is also a plan to refurbish some computers that were removed and redeploy them at a later date. By February, some 30 network compatible copier/printers will be installed and configured. The printers will be located in both clinical and administrative areas, mapped to workstations. It is estimated that an additional 100 - 135 computers (with corresponding printers) are needed by Hospital staff, but there is no identified funding to provide the additional needed hardware[6]; nor is there funding identified to purchase computers for the additional staff authorized for FY 08**.** Likewise, there is not sufficient hardware for a computer lab for patients in the treatment mall. These hardware issues must be quickly addressed, as bringing staff on board when they will not have access to a computer will only adversely affect productivity and create significant retention issues. Providing sufficient hardware for staff is a critical need that must be addressed quickly given the time frames for reform set out in the Agreement.

Software. Having useful hardware available to staff is only part of the issue. The Hospital recently purchased a new information system, AVATAR, which is being phased into the Hospital and once fully installed, will serve as an electronic medical record for the patient. The system has capacity to generate management reports, although it is not yet clear whether the system will have the capacity to meet the full reporting needs of the Hospital. Currently, the plan is to launch AVATAR in phases, the first for admissions, discharges, and laboratory and pharmacy orders, which will be implemented beginning May, 2008. AVATAR will replace the

[6] Beginning in FY08, DMH funded and instituted a 3 year replacement schedule for computer equipment.

obsolete STAR application and provide the Hospital with the ability to automate the ordering of labs and prescriptions and medications. Phase II which involves treatment planning, assessments and case notes will be implemented 6-9 months after Phase I. DMH and the Hospital are also exploring purchasing an additional AVATAR component, "EMAR" to assist on medication monitoring.

Outstanding issues. While these are important achievements since the signing of the Agreement and will provide a sound basis for reform, there are some major issues that must still be resolved. First, and most seriously, there are issues as to whether the AVATAR implementation project has the staffing support (both in number and in skill set) it needs to be successful, and that there is capacity at the Hospital to support Hospital staff when they encounter the inevitable hardware and software issues that come with implementation of a new system. Presently, there are only two IT staff identified to support the AVATAR implementation. This level of staffing is not sufficient given the size and complexity of the project particularly given the key role AVATAR plays in the Hospital's reform plan. Nor is it sufficient to develop management reports that are required just to monitor DOJ requirements. The risk to the success of AVATAR implementation of not having adequate staff, and the right complement of staff, is significant, and steps must be taken to minimize that risk.

Finally, the Hospital still lacks basic software needed to effectively manage a hospital, and requests to obtain needed software have been made without response. The Performance Improvement Department requested Microsoft Project software months ago and it is still not yet received, and no update on when it is likely to be available has been provided. It is critical that the Hospital be able to get the software needed to assess performance in a timely manner. Nor does the Performance Improvement Department have access to a color printer which will be critical as it develops the capacity for data analysis and critical reporting. The delay in getting basic software and hardware creates real risk in meeting the obligations of the Agreement.

### 5. Training

The CEO created an expanded Office of Training and Professional Development that will develop a "Saint Elizabeths Hospital Curriculum," develop and conduct interdisciplinary training on key treatment initiatives, and monitor staff development and compliance with training requirements. Training will be key to effect the necessary practice change but there has been only limited progress to date.

The Training Director position has been held by an "acting" staff member since Spring, 2007, but recruitment for a full time Director is now underway. Filling this position expeditiously is critical, as re-training staff in key functions such as treatment planning, assessments, case formulation, documentation and appropriate use of special interventions must be initiated within the next few months if the time frames of the Agreement are to be met. Further, filling of clinical staff vacancies is important, as ward staff often miss training due to lack of unit coverage. This is impacting the attendance at required training courses.

The Hospital lacks a comprehensive, integrated training plan, that will ensure the training of all staff is complementary and with the same focus and themes. Once the Training Director is

selected, an assessment of training needs must be completed quickly and a training plan developed. At this time, the training data is manual and is not captured in one place, which makes monitoring compliance challenging for all staff. The new Training Director must develop a comprehensive and strategic approach to collect training data in an automated way.

Some minimal training data are available, though the data do not appear to be wholly reliable; the data also do not reflect training conducted within specific programs. According to manual training data provided by the Office of Training, only 46.7% of designated staff completed the required annual training,[7] 81% have completed bi-annual CPR training,[8] 78.3% completed the biannual nonviolent crisis intervention training, and 91.6% completed restraint and seclusion annual training. The Medical staff, nursing, psychology, social work and rehabilitation departments also conduct training, but that data is not available. The failure to have 100% of staff trained in these key areas creates undue risk to patient safety, and will violate the competency-based training requirements of the Agreement due over the next three years.

### 6. Improve Quality

A key component of the DOJ Agreement is the creation of internal capacity of the Hospital to conduct comprehensive, honest and high-quality self assessments. To date, the Hospital has at best a rudimentary performance improvement system that is wholly reliant on manual data and is limited in capacity to conduct the kind of analyses expected for a Hospital. Most work was done by manual counting, and monitoring tools were at times redundant or did not capture critical data elements in a systematic way that produced information useful to managers. Staff were not proficient in available software systems[9] and had limited capacity to produce analytical reports. Finally, staffing levels were not adequate to conduct the kind of on-going assessments and analysis or produce reports of the quality or frequency that will lead to real improvements. With the key position of Director of Monitoring Systems vacant until mid-October, performance improvement was not effective.

From January 2007 through October 2007, the Performance Improvement Department conducted three self assessments and issued reports, collected data relating to Unusual Incidents and issued related reports, and issued quarterly reports on seclusion and restraint data and other demographic information. While the reports included some information, they were limited in analysis and quality of data. Further, the assessments did not always address management's priorities, and in some cases were too infrequent or reports too delayed and thus were only of marginal use to the managers. Managers at the Hospital are not accustomed to managing by data, and thus often did not utilize the reports even if the information was pertinent to their area of responsibility.

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[7] The annual required training includes courses around HIPPA, completion of unusual incident reports and relating reporting requirements, infection control, language access, fire safety, and discrimination in the workplace training.

[8] CPR recertification and non-violent crisis intervention training is required every other year. The data is inclusive only through October, 2007.

[9] Staff also were not provided with software often used for performance improvement activities.

There has been some recent progress in the PID. Recruitment is underway for a new Administrator for Performance Improvement, and the Hospital expects to make a selection by the end of the calendar year. A new Director of Monitoring Systems was hired in mid October, and already started reviewing potential data sources and issued the first monthly, as opposed to quarterly, report on key data and trends. *See Attachment 3 (Monthly Trend Analysis).* The report is somewhat abbreviated at this stage as it is dependent still on manual data, but the plan is to expand its scope every few months. Once the AVATAR system is fully phased in, PID will generate comprehensive and more thorough monthly reports. The Director of Monitoring Systems is also developing new systems for data collection and providing technical assistant to staff that should provide more relevant information in a more easily retrievable system. She will be providing training to PID staff on use of existing software systems, and is redesigning some data collection to eliminate redundant data collection and data entry that is inefficient.

PID is also expanding its staff by four, which will greatly enhance its capacity for data analysis, quality improvement and policy development. Recruitment is underway for three of the four new positions, and full staffing is expected by the end of January.

PID is increasing its chart reviews and presence on the wards. Managers throughout the Hospital have indicated a real desire for more frequent and visible quality assessments and timely feedback. PID, beginning in January, 2008, will review at least one record per ward per month, will provide immediate feedback to the ward's staff of the results of chart reviews and will eventually include findings in the monthly report. In addition, PID conducted a quarterly self-assessment in November that, for the first time, involved a statistically valid sample of cases. The self assessment did not evaluate all aspects of the Agreement, but focused on the treatment planning process (only in a very limited way did it look at content), the treatment environment, and discharge planning through a review of closed records.[10] *See Attachment 4 (Monitoring tool, Treatment Process); Attachment 5 (Monitoring Tool, Environment); Attachment 6 (Monitoring Tool, Discharge Medical Record Review); Attachment 7 (Active Case Record Summary); Attachment 8 (Closed Record Summary); Attachment 9 (Environment of Care Summary); Attachment 3 (Monthly Trend Analysis).*[11] Finally, beginning Spring 2008, the PID will identify issues and begin a process of "deep dives," looking intensively at a small number of cases which share an issue and identifying themes.

The Hospital reports that it is developing a statement of work for a consultant who will be available to provide coaching and support to key Hospital managers to map business processes, identify data sources from existing automated and manual systems, and develop a meaningful framework for performance management and improved efficiency. The consultant will also work to train staff and assist in developing basic methodology for accurate and timely reporting.

[10] The self assessment included a review of 130 active case records (just under 35%) and 73 closed records. It also included an environmental survey of all inpatient units and treatment mall areas. Staff participating in the self assessment indicated that they liked the new tool which included a Likert scale for some questions, though the tool continues to need refinements to address issues identified during the review and to fully conform to DOJ reporting requirements.

[11] The final report is expected in early January, 2008, but data has been provided to managers. It appears that the scores in some areas may be inflated, as some staff do not fully understand the self assessment process and thus some data may not be wholly reliable.

All of the above reviews and assessments, however, will still largely be dependent on manually collected data until the AVATAR system is fully implemented. The AVATAR system appears to have significant capacity to produce key reports, and PID staff are working with the AVATAR team to assess modifications that may be appropriate to meet DOJ reporting requirements.

# VI. REPORT ON PROVISIONS OF THE AGREEMENT

The following section will provide a more focused report on the specific provisions of the Agreement. Subsections are addressed in the narrative and in the summary chart that is attached.

**1. Compliance Officer (Agreement, Section III, page 5)**
The Compliance time frame not specified.

*Compliance*. The District selected Janet Maher to act as compliance officer. Ms. Maher met with the Department of Justice prior to her selection, and was approved by the Department. She began work on a part-time basis in May, 2007, and became a full-time employee on July 9, 2007. Her office includes one program analyst, and two additional positions (a second program analyst and administrative support person) were provided to the Office as of FY08. The compliance officer and her staff have unlimited access to all aspects of the Hospital and to all staff and patients. The parties had their initial quarterly meeting in September, 2007, and the second occurred on December 6, 2007 with the DOJ lead surveyor in attendance.

**2. Integrated Treatment Planning (Agreement, Section IV, page 7)**
Compliance required by June 25, 2010, unless otherwise noted.

**A. Interdisciplinary Teams (Agreement, Section IV A, page 7)**
Compliance required by June 25, 2010.

*Some progress has been made*. The Hospital is making progress toward meeting the requirements around interdisciplinary treatment teams, but is not yet in compliance. It has taken significant steps to create the framework for interdisciplinary teams, but presently the majority of wards do not have treatment teams operating in an interdisciplinary fashion, or in a manner that reflects individualized, integrated treatment. Currently, many units do not have a stable core of members, as some wards have "covering psychiatrists"; others are lacking nurse managers and there is not yet the full complement of clinical administrators. These staffing shortages have adversely impacted the full implementation of interdisciplinary teams.

The Hospital is implementing interdisciplinary teams through a clinical administrator model. Each treatment team will include a psychiatrist, a clinical administrator or psychologist treatment team leader, a social worker, a registered nurse, a rehabilitation specialist, and paraprofessional nursing staff. Psychologists will be included as indicated by the patient's needs. Each unit will have at least one psychiatrist (admissions units will have two), who will be supported by either a

clinical administrator or a psychologist treatment team leader; (the psychologist treatment team leader is a psychologist with admission and discharge privileges who also performs the duties of the clinical administrator). On those units where there is a non-psychologist clinical administrator, the treatment team leader will be the psychiatrist. Each admissions unit also will have a psychologist specifically assigned to provide support.

The role of the clinical administrator/treatment team leader is to ensure that assessments, plans and services are provided to all patients on the unit. The clinical administrator/treatment team leader serves as a single point of accountability for coordinating treatment programs by the multidisciplinary team. The clinical administrator/treatment team leader coordinates and directs all unit activities related to patient care, provides leadership and administrative direction to staff, coordinates the delivery of services to patients and ensures the medical record documentation is completed appropriately and on time. *Attachment 1 (Clinical Administrator Position Description).* Steps undertaken to implement this model include:

- Amending the Hospital bylaws to grant psychologists admitting and discharge privileges;
- Creating the clinical administrator/treatment team leader positions in forensic and civil services. There will be 12 clinical administrators/treatment team leaders in forensic services and 6 in civil services;
- Including the positions of clinical administrator and treatment team leader in the Management Supervisory Service;
- Through the new Table of Organization, ensuring all members of the treatment team are ultimately accountable to the same person, through discipline chiefs that report to the Directors of Civil or Forensic Services;
- Creating position description for position of clinical administrator, civil services[12];
- Filling 3 of 6 clinical administrator positions in civil services and 10 of 12 in the forensic services;

The Hospital is also providing training targeted at strengthening team functioning. In November, the Hospital began unit-based training on trauma informed care for one pilot ward in civil services and one pilot ward in forensic services. *See Attachment 10 (Trauma Informed Care Training Powerpoint).* The Hospital expects that training the entire treatment team as a unit will have the collateral effect of also improving team dynamics. Also in November, consultants, funded through the National Association of State Mental Health Program Directors (NASMHPD), presented an overview of person-centered treatment planning to managers, and conducted a readiness assessment which will be used to tailor ongoing training with some treatment teams planned for February 2008. *See Attachment 11 (Training Power Point).* The readiness assessment allows the consultants to develop curriculum reflecting the Hospital's planned implementation of interdisciplinary teams, and to emphasize those areas in which the Hospital's practice is particularly deficient. In the February training, some staff will be trained as a team, with all disciplines participating.

[12] The position description for clinical administrator in forensic has been completed. The position description for treatment team leaders is not yet completed.

Finally, a consultant is working with managers and individual treatment teams on leadership, team building, creating dialogue versus debate, and problem-solving. The consultant will observe treatment plan meetings, and offer coaching and dispute resolution strategies designed to improve team functioning.

Despite these steps, the treatment teams are not yet operating in an interdisciplinary fashion, and the Hospital is not yet implementing the requirements of the Agreement.

### B. Integrated treatment plans (Agreement, Section V. B)

Compliance by June 25, 2010.

*Minimal progress is being made.* The Hospital is making minimal progress in meeting the requirements around integrated treatment plans, and treatment teams are not yet functioning consistent with the Agreement. The revised Individual Recovery Plan document to conform to the Agreement's requirements is in the final stages of revision and approval but is not completed. The Hospital's revised treatment plan policy is in draft and under review; staff will need to be trained on it once it is finalized. The following outlines the specific progress over the last six months in meeting the Agreement's requirements.

- Attendance at treatment planning conferences. Patients generally are attending their treatment plans, but their level of engagement still varies and they are not routinely signing their treatment plans. *See Attachment 7 (Active Case Record Summary).* Ward nursing staff members attend at times, but it is not yet the practice for all core team members to attend all treatment team meetings. Results from the most recent self assessment on active records from August to October, 2007 show that all core members of the treatment may not be attending all treatment plans, as reflected by those who date and sign the treatment plan[13]:

    - Psychiatrists signed and dated 75% of treatment plans in civil services and 83% in forensic services;
    - Registered nurses signed and dated 89% of treatment plans in civil services and 74% in forensic services;
    - The patient signed and dated the treatment plan in only 18% of cases in civil services and 63% in forensic services;
    - The social worker signed and dated the treatment plan in 82% of cases in the civil services and 85% in forensic services.

    *See Attachment 7 (Active Case Review Summary).* Further, the IRPs would be improved if documentation relating to the level of patient participation and the patient's comments would be included.

[13] The self assessment tool measured attendance based upon the signatures on the IRPs. The Hospital recognizes this may or may not accurately reflect attendance, although only those who attend are to sign the plan as attendees.

The Hospital initiated the tracking of attendance at treatment planning through a monthly report that will supplement the self assessment. The Forensic Services Division captures data on participation in treatment planning conferences since October, 2006, but the civil services division has just begun to record this type of data. Data from forensic services shows that since October 1, 2006, patient attendance at treatment planning conferences ranged from a low of 92.27% in FY07 third quarter to a high of 99.48% in first quarter of FY07; at the end of the FY07 (September, 2007), patient attendance at treatment planning conferences was at 97.79%. Forensic data also shows that psychiatrists participated in 100% of treatment planning conferences in the 4th quarter, with nursing at 90% and social worker participation at 92%. The lowest rate of participation was amongst para-professional nursing staff, at 74%.[14] Forensic does not keep data on participation by rehabilitation specialists. Information about patient attendance at treatment planning conferences for both forensic and civil services will be included in a monthly data report beginning in December, 2007.

- Timeliness of plans and assessments. The Hospital monitors the timeliness and pre-plan assessment requirements of treatment plans through a quarterly self- assessment. As noted, the quarterly self-assessment in November reviewed most, but not all, of the Agreement's process requirements around Individual Recovery Plans (IRPs) and made an effort to make an elementary assessment of the quality of pre-IRP progress notes, and IRP goals and interventions. *See Attachment 4 (Monitoring Tool for treatment process).* The Hospital will implement random reviews of one record per ward per month beginning in January, 2008, which will provide more immediate data to staff about the timeliness and quality of treatment plans and pre-plan assessments. Modifications to current tools and/or additional tools will be needed and additional strategies such as quality case reviews will be put in place to fully evaluate compliance with all aspects of this section of the Agreement.

  The self assessment data reflects that 79% of IRPs were current in forensic services and 76% current in the civil services. While the self assessment did not look in a comprehensive manner at the content and quality of notes preceding the comprehensive IRP, the self assessment did review whether progress notes were completed by each discipline prior to the IRP and whether the notes addressed progress or lack thereof in meeting goals.[15] The results are attached in *Attachment 7 (Active Case Record Summary)* and reflect that psychiatric, medical, psychology and rehabilitation services notes were rated lowest in addressing a patient's progress in meeting IRP goals. Further, there is some concern that the results may not be reliable as to the quality of the notes as to the patient's progress.

[14] The information provided by Forensic Services is not wholly consistent with information from the self-assessment, but it is unclear at this time which data is more accurate. PID staff will be working with Forensic staff to review and resolve the discrepancies.

[15] At this time, Hospital policy does not require discipline assessments before each IRP review, but does require them annually and as the patient's condition changes; monthly progress notes are required.

In addition to information from the self assessment, the compliance officer reviewed a very small sample of case records (12) to assess timeliness and quality of treatment plans and assessments. On the positive side, in eleven of the twelve records reviewed, the treatment plans were current. In the case the treatment plan was not current, staff specifically recalled the treatment planning conference and could identify the date and time of the conference but the copy of the IRP could not be located. On the other hand, in all but two records, the treatment plan did not reflect the kind of person-centered individual treatment planning or assessment that the Agreement contemplates; goals and interventions were often general and formulaic, i.e. "reduce psychosis," "prescribe medicine," or "reduce elopements." In the records where the treatment plans were individualized, patient strengths were identified (i.e., in one case, strengths included "likes to participate in sports" and "takes pride in his job," and interventions - - a work assignment and recreational therapy - - were tailored to the patient's strengths). Finally, in two charts, there were no assessments or progress notes by the treating psychiatrist, in one case for at least a three month period, although medications were reordered.

The Hospital does not yet have the capacity to assess whether patients are fully informed of the side effect of medications as required by the Agreement, but the Hospital's policy is to require informed consent. One option may be to assess compliance through the patient satisfaction survey, or to add it to a monitoring tool. Additionally, there is no evidence that the Medical Director reviews all high risk situations, and if so, how often it does occur. The compliance officer is aware that the Medical Director reviews cases involving non-emergency involuntary medication and the seclusion/restraint report, but there is no data tracking system yet in place for tracking Medical Director review of high risk cases.

- Next steps. Steps underway to move toward improving treatment planning include training on person-centered treatment planning and, for two pilot wards, unit based training on trauma-informed care. On November 30, 2007, NASMHPD trainers provided an overview of person centered treatment planning to executive and clinical leadership at the Hospital, and met with clinical administrators and treatment mall administrators to assess the Hospital's treatment planning process. In February, 2008 unit based training for direct care staff will begin, with a planned morning didactic training followed by experiential training for treatment teams, who will be trained as a team. That training will focus on changing the paradigm for treatment planning at SEH for creation of a recovery oriented plan, developed in collaboration with the patient and focusing on recovery services and supports which promotes patient preferences.

  Also, two admission units were selected as pilot units for trauma-informed care implementation. This follows seminars presented in the Spring, 2007 for existing staff on the principles of trauma-informed care, which is incorporated into new staff training as well. More intensive training for the pilot wards will focus on how staff implement trauma informed care specific to individual patients and in a manner that is collaborative, supportive and skill-based. That training, which will be on-going, began for the pilot units in November. The trauma informed care initiative is led internally by a psychiatrist who is specially trained in trauma informed care and an outside consultant (psychologist).

Training will include twice monthly, on ward (all shifts) sessions that focus on assessments and safety plans, therapeutic communication, de-stimulization options and the creation of comfort rooms on the pilot units. A plan needs to be developed for expanding this initiative to all wards.

The Forensic Services Division, effective October 1, 2007, instituted a policy requiring that the case of every forensic inpatient be reviewed by the Review Board[16] at least once per year. Previously, the Review Board only reviewed cases if the treatment team recommended a change in conditions of confinement or movement from one ward to another, or if a patient has pending in court a request for release. This new policy is designed to ensure clinical review of cases where the patient has not progressed.

### C. Case Formulation (Agreement, Section V. C)

Compliance by June 25, 2009.

*No progress has been made*. Integrated case formulations are not yet occurring, although Hospital policy is being modified to require that they occur. Steps underway to move toward case formations include the establishment of the clinical administrator/treatment team leader model for all wards, and the identification of training that will strengthen the assessments and treatment planning processes. The Hospital is pursuing access to automated outpatient records that will help in providing accurate historical data for the team. The duties of social work staff are also being reviewed, as under the Agreement, the social worker is responsible for obtaining accurate historical data that will be used as part of the case formulations. The Hospital will also use the services of a consultant to work with teams on team dynamics and team functioning, which it anticipates will have a positive collateral impact in case formulation. Finally, person centered treatment planning will also focus somewhat on strengthening case formulations.

At this stage, a final decision has not yet been made as to who will be responsible for the development of the case formulation, although a decision is expected shortly. Because there is not yet clear responsibility for case formulation, there is no specific monitoring yet underway. At this time, there is a current requirement that the comprehensive IRP include an integrated summary of each discipline's assessments[17], which was reviewed during the most recent self assessment. The data from the self-assessment shows that the integrated summary is not capturing each disciplines assessment in the significant majority of cases; this was identified as an area in need of improvement in both civil and forensic services. See Table 3. *Attachment 7 (Active Case Record Summary)*

[16] The Review Board consists of clinicians in the Forensic Services Division that reviews cases before a forensic patient is moved from one level of security to another, is granted privileges or is released to the community. It includes the Director, Forensic Services, Chiefs of Post-trial and Pretrial, Medical Director, Forensic Services, Associate Director for Nursing, Chief Social Work, representation from psychology, Chief, Co-Occurring Disorders, and Chief, Rehabilitation Services.

[17] This is not the case formulation contemplated by the Agreement, but is a brief summary of each disciplines assessment.

**Table 3: Reflection of Discipline Assessment in Integrated Summary of IRP**

| DISCIPLINE | CIVIL | FORENSIC |
|---|---|---|
| Psychiatry | 31% | 43% |
| Nursing | 25% | 35% |
| Medicine | 13% | 17% |
| Social Work | 31% | 39% |
| Psychology | 0% | 4% |
| Rehabilitation | 6% | 4% |

### D. Treatment Plans Driven by Individualized Factors (Agreement, Section V. D)

Compliance by June 25, 2009.

*No progress has been made*. There are a few cases in which treatment plans are driven by individualized factors, but the vast majority of treatment plans do not meet the standards set out in the Agreement. Most treatment plans are still generic, without measurable objectives and do not focus on rehabilitative interventions that are specific to the patient. Goals are not patient driven but are often described as "reduce psychosis," "medication compliance," and "outplace patient". Interventions are also generic, as most include "take medication as directed" or other similar descriptions. In one case reviewed, a patient who attended college prior to his hospitalization signed out of the Hospital because he felt the treatment in the treatment mall was for lower functioning persons, and the Hospital did not offer alternatives that met his needs. Further, the self assessment found that too many service referrals are not responded to and there is not clear evidence when services actually begin. It also noted that improvement is needed in incorporating referral recommendations into the treatment plan. *Attachment 7 (Active Case Record Summary)*

The Hospital is beginning its focus on improving treatment plans so progress should be seen by the next report. Steps underway include finalizing the new treatment planning process policy as well as developing guidelines for disciplines around treatment planning. Strategies must be developed on training all direct care staff throughout the Spring, and follow up support will also be required.

In January, 2008, PID will begin random reviews of one record per ward to evaluate treatment plans. Feedback will be provided immediately to the units and program management, and data will also be included in the monthly reports, beginning in Spring, 2008. These reviews will allow the Hospital to monitor treatment plans by units. The Hospital expects that these efforts, combined with filling all treatment team/clinical administrator vacancies and implementation of MSS, will lead to significant improvement in treatment plan development and implementation.

### E. Treatment Planning to be Outcome Driven (Agreement, Section V. E)

Compliance by June 25, 2009

*No progress has been made.* Treatment plans are not outcome focused or revised as a patient's condition changes, but remain on a 90 day cycle for revision, and in some cases, even that time frame is not met.[18]

[18] As noted, according to the most recent self assessment, 22% of the IRPs are not current.

There is insufficient documentation in many of the clinical records reporting on a patient's response to treatment. In some cases, there are no or so few psychiatric notes that it is hard to determine if the psychiatrist has even seen the patient, although medication is reordered. Nursing and social work notes are more regular, but only in some cases do the notes adequately report how the patient is doing in relation to treatment interventions. Of all disciplines, nursing and social work are most consistent in referring to IRP problem numbers in their notes, but there is often no specific information charting progress in most of the notes, so relating the notes to the effectiveness of interventions is difficult. Treatment mall notes are also missing from many records. The self assessment also noted that progress notes do not consistently address progress toward goals or tie progress (or lack thereof) to an intervention. *Attachment 7 (Active Case Record Summary).* The upcoming training and implementing peer review will be important to improvement of this measure.

### 3. Mental Health Assessments (Agreement, Section VI)

**Preamble (Agreement, Section VI)**
Compliance by December, 2008

*Minimal progress has been made.* In general, patients are assessed by psychiatry, social work, and nursing upon admission. However, the timeliness, quality and thoroughness of the assessments vary widely. Staff have complained that in many cases the patient's history is not readily available to them. The Hospital staff do not have access to outpatient records or the Anasazi system[19] which adversely impacts their ability to use historical information in their admission assessments. The decision not to give access to Hospital staff was a cost one, and while access to that system will not in and of itself create compliance, it is a critical piece, and needs to be revisited if the Hospital is to meet this requirement.

**A. Psychiatric Assessment and Diagnosis (Agreement, Section VI. A)**
Compliance due by June 25, 2008, December 25, 2008 and June 25, 2009.

*Minimal progress has been made*. The Hospital made minimal progress on some of the requirements of this section, and no progress on others.

On the three twelve month indicators, there is only slight progress. Psychiatrists now have a pocket copy of the DSM IV and the Hospital also provides access to DSM IV through the Internet. The Hospital is revising its policy on assessments to meet the requirements of this section, but that has not yet been completed. In most cases, a psychiatric assessment is completed within 24 hours of admission, although the assessments often do not meet expectations around content and some records lack regular psychiatric notes post admission. The assessments do not consistently contain sufficient information or detail to assess whether they meet DSM IV diagnostic standards, and patients continue to carry "deferred" diagnoses for months and even years after admission. There are still some instances in which a physician

[19] The Anasazi information system includes data about the patient's course of outpatient treatment.

trainee's notes are not countersigned, but doctors have been reminded that this is required and incidents have decreased. There is no regular psychiatric peer review conducted, which is necessary if the Hospital is to improve the quality of the assessments. Finally, the Hospital has not developed an admissions risk assessment procedure, although psychologists are beginning to provide risk screening assessments for all newly admitted patients.

Improving the timeliness and quality of psychiatric assessments will need to be an early focus of the new Director of Medical Affairs; there are activities underway designed to improve the quality of diagnosis and assessment. The Hospital is instituting a "Center for Diagnostic Excellence" which will have two main components. This includes an interactive listserve was developed and will be fully functional in January 2008. Available to all medical doctors (both psychiatric and general medical officers), psychologists and clinical administrators, staff can seek assistance in diagnosis or interventions and dialogue about any patient, or alternatively, report on successful interventions that were used for previously hard–to–treat patients. The listserve will also include the Saint Elizabeths Hospital diagnostic manual, which will be wholly consistent with DSM IV but will also encourage dialogue on certain aspects of Axis II diagnosis that will be used to further refine the DSM V. In addition, monthly case conferences open to all patient care staff will be held to discuss complex diagnostic cases. At times, these will be led by an outside consultant. A subcommittee of the Medical Staff Executive Committee will oversee the project. Case conferences will begin by February 2008. Finally, psychiatric practice standards should be finalized by February, 2008 and peer review activities will follow.

### B. Psychological Assessment (Agreement, Section VI B)

Compliance by June 25, 2009

*Minimal progress has been made*: There has been some progress on the provision of psychological assessments despite not yet meeting the staffing standards in DOJ. The quality of assessments is generally high, but insufficient numbers of psychologists hampers satisfying the demand for assessments. For several years the number of psychologists in the Hospital was well below minimum standards. With the additional positions provided this year by the District, the Hospital will hire seven additional psychologists and three treatment team leaders, who will be psychologists. That will bring the total psychology staff in the Department of Psychology to 12 psychologists. There will also be five psychologist treatment team leaders, one post-doctoral student, and five interns. The plan is to assign one psychologist to each of the two admission wards in Civil Services, who will conduct risk and other assessments.

The Psychology Department is also expanding its scope of services. It is increasing its capacity to provide individual and group therapies to civil and forensic patients, and will create and lead a behavioral track curriculum for the treatment mall. In addition, it is increasing its capacity for developing behavioral plans; the psychology staff completed behavioral plans for six patients, and have pending requests for eight more. As with the other disciplines, psychology will be finalizing revised discipline practice standards and will initiate monthly peer review activities by February, 2008.

### C. Rehabilitation Assessments (Agreement, Section VI C)
Compliance by June 25, 2009

*Some progress has been made.* Rehabilitation Services currently has 13 staff among five specialties. Effective December 1, 2007, Rehabilitation Services conducts assessments on every civilly admitted patient within 3 business days of admission; forensic patients are assessed on admission or when a referral is made. Rehabilitation Services staff have completed 287 assessments since January, 2007. So far this year, the Rehabilitation Services has not been able to conduct assessments in only one case where a referral was made, due to the unavailability of the patient. Rehabilitation Services recently revised its assessment tool. Previously the tool focused on recreational and leisure interests, but the new tool, which is based on a tool used by a JCAHO accredited psychiatric hospital, now focuses more on the patient's condition and life skills needs. *See Attachment 12 (Rehabilitation Assessment Tool).* Training on the new tool was completed in November, and the staff started using the new tool on December 3, 2007. Recreational therapists provide significant treatment services in the treatment mall, as set forth in more detail below.

Rehabilitation Services will hire six new specialists in FY08, with two additional positions for the civil side and four for forensic services. The new positions will include one additional art and one recreational therapist on the civil side, and one vocational rehabilitation specialist, dance therapist, music therapist and another recreational therapist for forensic services. Rehabilitation Services is also implementing a plan to review previous assessments completed on patients as required by the Agreement. Under the plan, all civil and forensic patients will have a rehabilitation services assessment, regardless of whether one was previously completed. The assessors will utilize the new instrument, and eight to ten assessments will be completed each month in each of the forensic and civil services. In addition, all new admissions will be assessed. All wards are assigned a rehabilitation specialist who will review the prior assessments and conduct the new assessments. Reassessments are expected to be completed by December, 2008.

### D. Social Work Assessments (Agreement, Section VI D)
Compliance by December 25, 2008

*No progress has been made*. While social work staffing has not been an issue for the Hospital, there has not yet been a focus on improving the quality of social work assessment. Some peer review has occurred, but it does not address the criteria set out in the Agreement and is more focused on timeliness of social work notes. Specifically, social work assessments do not attempt to identify/resolve factual inconsistencies, and thus the treatment team may not have the benefit of an accurate assessment of the patient's social history or relationship issues. The Hospital is reviewing the duties of the social worker to ensure they meet the requirements of the Agreement and to focus staff on discharge. Next steps include reviewing social work practice standards and revising the peer review tools.

**4. Discharge Planning and Community Integration (Agreement, Section VII, A through E)**
Compliance required June 25, 2008.

*Minimal progress has been made.* There has been some improvement in discharges to the most integrated appropriate setting from the beginning of a patient's hospitalization, most of the efforts in the last six months focused on getting patients who are "ready for discharge" out of the hospital. That effort led to the discharge of 142 patients from the Hospital. Treatment plans require that staff address discharge needs, but recent surveys suggest that issues around discharge are still not individualized and are not consistent with the Agreement's requirements. The recent self-assessment found that all disciplines need to improve their documentation of discharge planning in their progress notes, that improved documentation is needed around discharge instructions given to the patient, and that psychiatric discharge summary notes were not complete. *Attachment 7 (Closed Case Record Summary).*

Barriers to discharge identified in a treatment plan routinely do not specifically address the prior unsuccessful placements or skills necessary to live in the community. At most, the treatment plans reflect behavioral or housing requirements, not skills needed to increase likelihood of a successful community placement. Further, Hospital staff appear overly reliant on group housing, and it may be additional training on alternatives to and availability of community residential facilities would be useful. Patients usually participate in the discharge planning process and often are involved in choosing housing; however, in some cases, patients seek housing that differs from that recommended by the treatment team. In other cases, the lack of housing options reduces patient choice and sometimes forces patients into housing for which they are not well suited.

There are some transition activities occurring. Patients are assisted in their transition to the community by participation in recreational and other community activities, as well as, in some cases, attendance at community day treatment programs. Each week, some patients who attend the psychosocial rehabilitation program at the treatment mall visit the library in Takoma Park and a downtown social center. In addition, the Hospital is working with DMH on a pilot for day rehabilitation treatment that would be available to patients as they transition from long term care to community living. But additional transitional activities are needed to improve the likelihood of a successful community adjustment, such as trips to the grocery and other stores to ready the patient for community living. The Hospital also needs skills development programs that patients will utilize when transitioned to the community, such as cooking and budgeting.

In January, 2007, the Hospital began weekly meetings with Department of Mental Health to address the delays in patient discharges. Each Wednesday, senior staff from the Hospital and the Authority review those patients who are ready for discharge and problem solve about barriers and progress. Staff identified a shortage of appropriate beds as a main barrier and Authority staff are working on strategies to address this shortage, which is increasingly problematic. Data reveals the following:

- As of November 13, 2007, 142 patients have been discharged since January, 2007;

- As of October 31, 2007, there were 42 patients on the "ready for discharge" list.
- Of those on the list on October 31, 2007, 64% have been waiting for discharge for over 60 days; 50% have been waiting for discharge for over 90 days; and 20% have been waiting for over 6 months.[20]

The "ready for discharge" list provides narrative status reports that identify issues affecting discharge. Among the most often cited reasons are frequent changes in community clinical managers and lack of appropriate housing. Strategies underway include restoring the role of Hospital social workers to directly support discharges, and changing the pool of housing to better meet patient preferences[21].

The Agreement also calls for the District to monitor the discharge process and aftercare services, with the Mental Health Authority as the lead. The Hospital will soon pilot a tool to monitor quality of Hospital discharge activities from the beginning of hospitalization. The tool will be completed by the clinical administrators at the time of discharge, and results will be monitored by PID. *See Attachment 13 (Quality Discharge Checklist).* The Authority is working to complete its plan for monitoring aftercare services for discharged patients.

### 5. Specific Treatment Services (Agreement, Section VIII)

Overview of treatment services

Treatment Mall. The Hospital provides treatment to patients through on ward activities, a work adjustment training program (WATP) and a multi-disciplinary treatment mall from 9:45 a.m. to 3:15 p.m., Monday through Friday, embracing an Enhanced Recovery Model. The treatment mall offers some 417 group sessions among seven programs, and as of October 31, 2007, was serving 186 patients. New leadership was appointed for the treatment mall in Spring, 2007, (it now reports to the Director, Civil Services, and not the Director, Rehabilitation Services), and doctors and other staff offices were relocated to the treatment mall so they could be with their patients. Further, treatment planning is now done at the treatment mall.

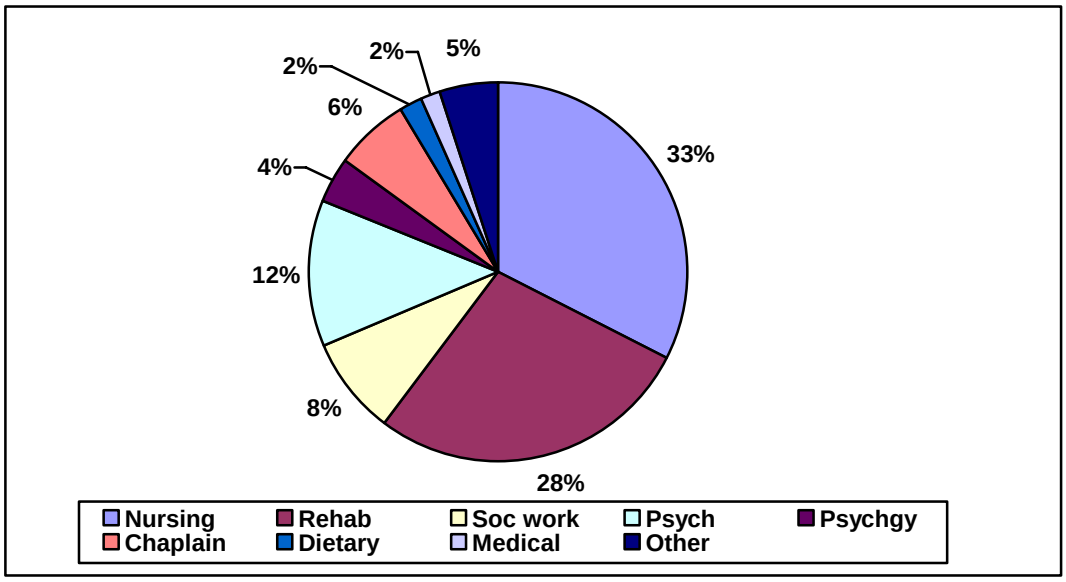
The recovery based programs at the treatment mall include Psychosocial Rehabilitation, Dual Diagnosis program, Cognitive Development, Behavior Management, Skill Development, the Geriatric Center, the Geri mall, and the Restorative Care program. *See Attachment 14* (*Description of the Treatment Mall Programs and Schedule of Activities).* Co-occurring disorder groups were implemented in the Dual Diagnosis, Psychosocial Rehabilitation and Cognitive Development Programs for patients in those programs with substance abuse disorders. The treatment mall is led by three managers who are each responsible for approximately 50-60

[20] One patient on the list has been waiting since January as he needs a community residential facility that provides access to someone with limited mobility, which has not been located.

[21] Housing choice is likely to become an even bigger issue as the new Hospital is completed. In the new hospital, patients will have their own rooms, and it should be anticipated that once that occurs, their willingness to live in group homes will be further reduced. More supported independent living homes will need to be developed.

patients. Treatment planning is done by treatment teams through the treatment mall.[22] Patients are provided some degree of choice as to "elective" groups that supplement such core groups as mental health training, physical health training, medication skills, social skills and community living skills. Groups are led by nursing staff, rehabilitation services staff, psychiatry, psychology, social work and other disciplines such as dietary or dental staff. The breakdown of groups by discipline is set forth in *Figure 12.* There is an effort made to tailor therapies to patients' functional levels, as low functioning track patients have more rehabilitation therapies than talk therapies, a change since 2005.

**Figure 12: Treatment Mall Group Leaders by Discipline**

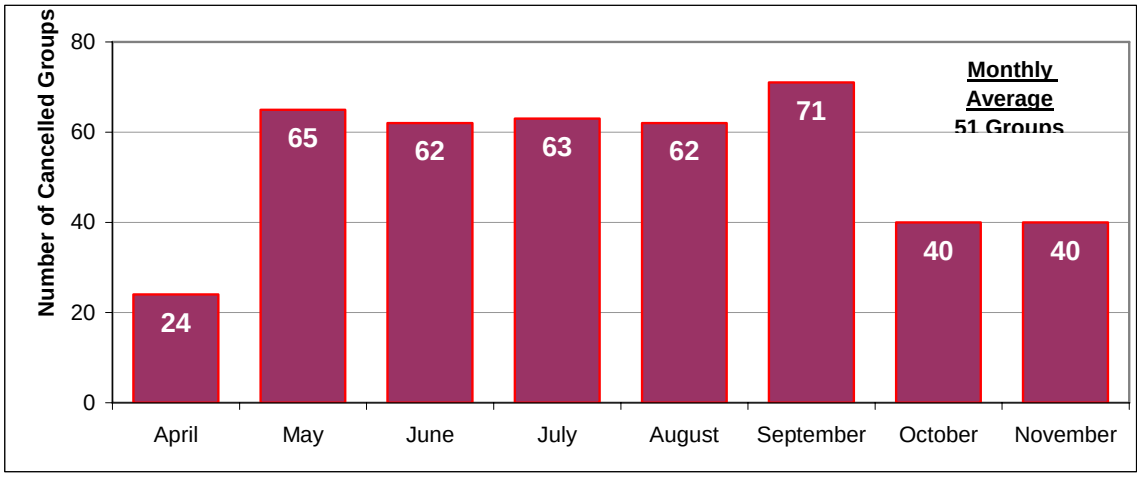



For patients who do not attend the treatment mall, there are treatment activities on the forensic units but not all patients receive 20 hours of active treatment per week. *See Attachment 15 (Ward activities for forensic wards.)* Ward based treatment programs have recently been developed on the civil side for patients who are not yet ready for the treatment mall, but again not all patients are receiving 20 hours of active treatment per week. Eighteen forensic inpatients attend the treatment mall and 107 have work assignments as well. As stated earlier, Rehabilitation Services will expand its services in the forensic program, with four additional rehabilitation services specialists to be hired this year.

Despite the many activities occurring on the treatment mall and on some wards, treatment services do not meet standards set out in the Agreement. The Compliance Officer initiated are view of group cancellations in the treatment mall, which is now included in the monthly report. On average, 51 groups per month are cancelled in the treatment mall; in 40% of those cases, the group leader simply does not show up. *Figure 13 and 14.* With no "back-up" group leaders, the high number of cancellations interrupt patient treatment and likely delays patient progress.

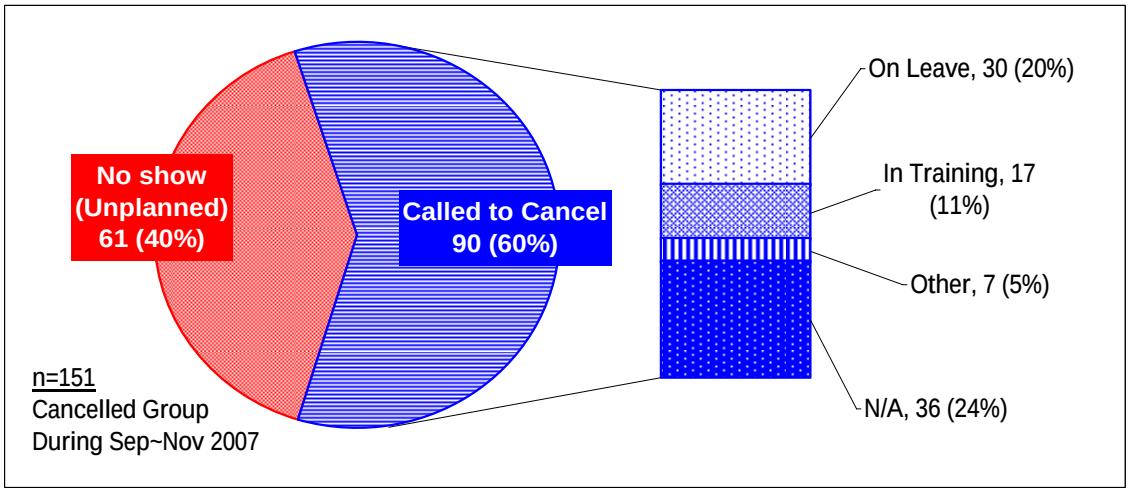
[22] At the time of the DOJ investigation, the treatment mall was led by Rehabilitation Services staff, and treatment planning was conducted on the residential units. Now the treatment mall is lead by three administrators reporting to the Director of Civil Services. Treatment planning is done at the Mall, and ward staff offices were moved to be closer to the patients.

**Figure 13: Group Cancellations by Month, April – November, 2007**




*Data is provided by treatment mall managers.*

**Figure 14: Cancellation Notice, September – November, 2007**




The Hospital also reviewed cancellations by program in the treatment mall, and by discipline. Data shows that of the groups cancelled, the Dual Diagnosis Program has the highest percentage of cancellations, and the Geri-Center the lowest percentage. *See Figure 15.* Finally, of the groups cancelled, the data shows that psychiatry by far constitutes the highest percentage of cancellations, followed second by rehabilitation services. *Figure 16.* The Hospital is seeing a reduction in group cancellations since monitoring began, although it is still too high.

**Figure 15: Cancellation by Program, September – November 2007**

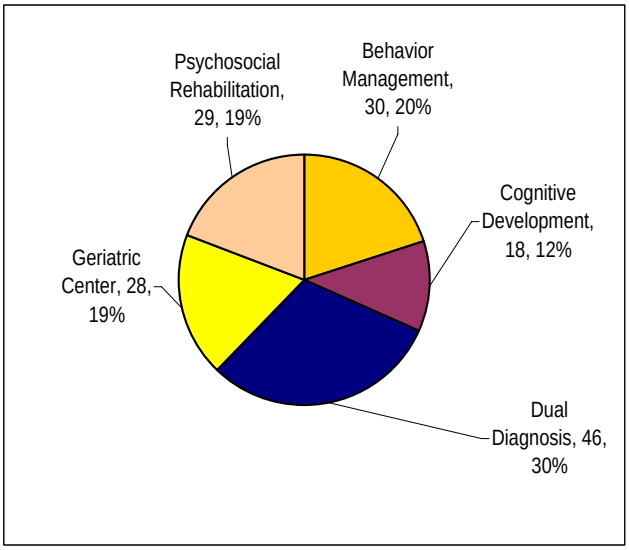
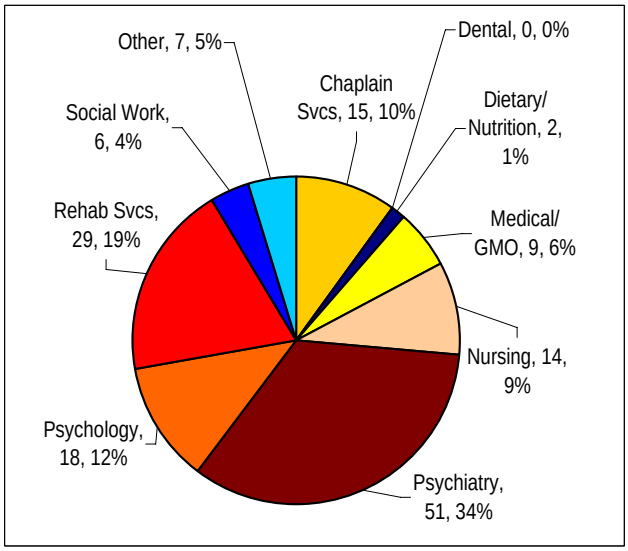



**Figure 16: Cancellation by Discipline, September – November 2007**




In addition to the high number of cancellations, there are other issues that diminish services in the treatment mall. There is not adequate discipline-specific supervision of group leaders, which leads to inconsistency and ineffectiveness; likewise training on leading groups is lacking. Further, while patients are afforded a choice among groups within a program, the treatment mall is not yet able to assign an individual to a group across the eight programs (i.e., attend groups in two programs based upon level of function in a particular activity), which might allow for a more individualized treatment program. There are no treatment activities that are geared for higher functioning or for severely developmentally disabled patients; in one case, a patient signed out against medical advice specifically citing dissatisfaction with the treatment options. Fourth, the treatment path as patients progress is not clear. Patients tend to stay within programs, and may move to a different track, but once they reach the highest track they often do not proceed further or transfer to a different program. While there are daily living skill groups, there is no "model" housing or kitchen set up for patients to develop housekeeping or kitchen skills, and there are inadequate computers on which patients could learn basic work skills. Finally, a review done by PID in September concluded that some patients are placed in the treatment mall even if they are not ready. PID also found that treatment planning conferences are not always held as scheduled. Finally, there is no group module on file for the many groups, which makes it difficult for substitute group leaders.

### A. Psychiatric Services (Agreement, Section VIII A)

Compliance by December 25, 2008, June 25, 2009 and June 25, 2010.

*Minimal progress has been made.* Psychiatric services do not yet meet the requirements of the Agreement. Staffing continues to be a challenge; to meet the minimum staffing levels, the Hospital will need 27 ward psychiatrists (two per acute care unit and one for every other unit); as of October 31, 2007, each unit on the civil and forensic side have an assigned psychiatrist (although not all are full-time), but the none of the admission units has the required two psychiatrists needed to meet staffing ratios. Recruitment is underway for additional

psychiatrists. There is no regular psychiatry peer review, and no current practice standards for psychiatrists. For the most part, the documentation by psychiatrists is lacking both in content and timeliness; a random sample of a small number of charts by the compliance officer found several charts lacked any documentation by psychiatrists other than medication orders. This is consistent with findings in the recently concluded self-assessment. *See Attachment 7 (Active Case Record Summary)*

There are activities underway to implement the Agreement's requirements. A new Chief Pharmacist was hired as were three additional pharmacists. A fourth will also be hired with one of the new 72 positions. Pharmacy completed an assessment of all patients' medication regimens for major contra-indications; forensic services had 12 contraindicated therapies and that civil services had 14. The data was provided to the Hospital's Pharmacy and Therapeutics Committee and to the former Medical Director. In each instance, the medical staff either discontinued or changed the medication. In the future, this will be done by pharmacy on an on-going basis. The former Medical Director also distributed new guidelines on the use of multiple medications. *Attachment 16 (Memorandum from Allen Gore MD).* In an effort to improve patient care and reduce of seclusion or restraint, the Hospital has begun training on Trauma-Informed Care on two units. *Attachment 10 (Power Point from Trauma Informed Care Training).*

The Hospital also hired a Director of Co-occurring Disorders, and participates in a grant received by DMH from DHHS' Substance Abuse and Mental Health Services Administration to improve how staff screen, assess and plan treatment of co-occurring disorders. The Hospital screened every patient in the Hospital for substance abuse history in the Spring, 2007. The Hospital also conducted a baseline review by reviewing charts in nine inpatients units. The review established screenings were occurring during the initial assessment but without a formal tool, and that patients whose screenings were positive almost never received an integrated assessment. *See Attachment 17 (Baseline Report, Co-Occurring Disorders).* Based upon the baseline review, a uniform screening tool was adopted (MIDAS), but the recent self assessment found a completed MIDAS tool in only 49% of the charts in forensic services and 42% of the charts in civil services. The training made possible the grant will permit approximately 50 Hospital staff to be trained on screening, assessment, and treatment of co-occurring disorders. In addition, approximately 20 forensic staff were trained on the "cognitive behavioral therapy" model of treatment and have begun to lead groups using this model.

There has been significant work around medical acuity of patients as well. General Medical Officers reviewed the charts of all patients and classified their medical acuity[23], which was later tested by a review of a random number of records.

- 100 patients (22%) were classified as in the minimum acuity level.
- 218 patients (49%) were in the midrange acuity level.
- 89 patients (20%) were in the most severe acuity level.

[23] The three categories were healthy; stable chronic illness (i.e., hypertension, diabetes); and acute illness/unstable chronic illness (uncontrolled hypertension or diabetes)/special needs(dialysis, chemotherapy, HIV)/geriatric and medically compromised.

Based upon this review, plans are underway to create medical/psychiatric units in forensic and civil services to address the medical needs of the most medically acute patients. The units are expected to be up by early next calendar year, subject to staffing. Additional work around medical services is needed however. Chart reviews have shown that in many treatment plans, while there is an Axis III diagnosis, there is no medical intervention identified in the treatment plan. *Attachment 7 (Active Case Record Summary).* There have also been instances in which there was insufficient, or no follow up, to recommendations arising from medical consultations, lack of adequate medical follow-up on patients returning from general medical hospitals, and orders for medical treatments were allowed to lapse. In one case, this oversight led to a patient suffering a seizure. A new nursing procedure is designed to address this latter issue, and clear requirements around annual physicals and blood work have been put in place, but further work must be done. There also is inconsistent communication between psychiatry and general medical officers; for example when a neurological consultation results in a recommendation for Aricept, it is unclear whether the general medical officer or the psychiatrist is responsible for prescribing it.

The new Medical Director will undertake a major review of all medical services within six months, addressing an issue the Hospital recognizes is adversely affecting patient care and outcomes. He is expected to identify specific practices that will be implemented to address the myriad of medical care issues affecting patients at the Hospital.

**B. Psychology services (Agreement, VIII B)**
Compliance by December, 2008

*Minimal progress has been made.* For the most part, the assessment and testing services provided by psychology are high quality. However, lack of staffing translates into delays in assessment and testing. As of October 31, 2007, there were 11 psychologists, one neuropsychologist, three postdoctoral students, and five predoctoral interns. The Hospital's Psychology training program received a full three year accreditation from the APA, and the Hospital now has three postdoctoral students doing who also do risk assessments, psychological evaluations, consultations, and individual and group therapies. The goal is to have a combined total of 27 psychologists and psychologist treatment team leaders. The Hospital anticipates a net gain of seven psychologists in the Psychology Department and three treatment team leaders in FY 08.

Thirty four patients are receiving psychology individual therapy and over 100 are receiving group therapy. In Calendar Year 2007 through November, 2007, there were 61 referrals for testing; eight patients refused testing, seven were discharged before testing was completed, in 25 cases, testing was completed, and in 21 cases testing is underway. At this time, due to the need for additional staffing, there is only minimum capacity to complete timely behavioral plans for patients. To date in Calendar Year 2007, six behavioral plans were completed. Requests for eight additional plans are pending. By February, 2008, each admissions unit will be assigned a psychologist on a full-time basis, who will complete a psychological and risk screening.

### C. Pharmacy Services (Agreement, Section VIII C)
Compliance by June, 2010.

*Minimal compliance to date*. Understaffing in pharmacy has limited progress toward the requirements in the Agreement; in FY07, a Chief Pharmacist and three additional pharmacists were hired, and additional pharmacist will be hired this year. This level of staffing should be sufficient to complete the required monthly medication reviews. In addition, DMH has invested in a new information system, AVATAR, that will phase in over the next 18 months. Phase I will involve laboratory and pharmacy orders and is expected in Spring, 2008. The AVATAR system will alert physicians of contra-indicated medications or drug allergies, and is designed to reduce or eliminate medication errors. The pharmacy module will allow doctors to enter medication orders electronically. This will increase efficiency by reducing transcription errors, decrease the time of order fulfillment, decrease physician time in order writing, and improve the Hospital's ability to monitor drug interactions and drug allergies. The Department is also considering purchasing EMAR, a module of AVATAR, a medication administration record that will facilitate monitoring the administration of medication and reduce medication errors and adverse medication interactions. The system includes patient identification, a list of all medications ordered, dosing schedules and administration, patient drug allergies and diagnosis and other clinically relevant information. The system will alert physicians to contra-indications of use of medications, and is designed to reduce or eliminate medication errors.[24]

### D. Nursing services/Infection control (Agreement, Section VIII, D)
Compliance by June 25, 2009.

*No progress to date*. Nursing services are inadequate to meet patient needs. Nursing notes in the records do not meet the content and quality provisions of the Agreement, and at times are not timely. Nursing staffing, with approximately 50 vacancies, is at a critical level, and contracting delays in getting a nursing contract finalized to supplement Hospital staff complicated staffing. Without an adequate number of nurses, improvements in nursing services are impossible.

There is also a lack of nursing leadership on the units. Each unit does not have a nurse manager, but filling those vacancies is a priority. Nursing staff do not feel empowered to take leadership during behavior or medical codes or raise issues or concerns with doctors about medication or other doctor's orders. And on some occasions, nursing staff have failed to provide a minimum standard of care which presented risks to patients. Vital signs are not taken in all cases as ordered, and when they are abnormal, there have been cases when nursing did not notify the doctor. There have been lapses regarding compliance with orders for 1:1 supervision of patients, and some nurses have not completed CRP recertification classes or are not familiar with medical code procedures. Further, nurses are not exercising their clinical expertise when faced with symptoms that may be indicative of an adverse reaction to medication or similar situation.

The Hospital is implementing a number of strategies designed to address these issues. A new nurse recruiter began on November 26, 2007, and may be assisted by a contract recruiter until

[24] The Hospital continues to monitor medication errors through a manual reporting system, which leaders believe are not capturing all errors. This will be an area of focus for the new Medical Director.

staffing levels increase. New nursing positions have been added from the 72, and registered nurses are eligible to participate in the loan repayment program up to $66,000. Reducing the vacancy rate is critical if the Hospital is to address the deficiencies in nursing care.

The new table of organization expands the capacity of the Training Office, and a new trainer with experience in nurse training is considering an employment offer. Further, the administrative structure of nursing was solidified. Nursing will now report to the Directors of Civil and Forensic Services respectively, in order to better supervise nursing practice. In addition, the Chief Nurses for forensic and civil services will each be assisted by an assistant chief nurse and a nurse consultant. Each ward will have a nurse manager, who will be part of MSS.

Additional training is underway to improve competency of nurses. Nursing staff in Forensic Services completed training on airway management, security checks, medical services consultation, glucometer use, unusual incident reporting, code blue documentation, and reporting and recording of vital signs. Civil nursing staff completed training in security checks, medication assessment competency, medical services consultation, unusual incident reporting, monitoring of vital signs, and training on airway management, emergency equipment competency and daily bowel movement monitoring is underway.[25] Nursing will also review practice standards by February, 2008, and will begin peer review activities thereafter. Nursing staff will be key participants in training around trauma-informed care and person-centered treatment plans, and will also be supported by the consultant hired to work with treatment teams. It is expected that competency based training for nurses will be an early focus of the new Director of Training.

At the time of DOJ investigation in 2005, the Hospital did not have a functioning Infection Control Office; that is no longer the case, as it now has a qualified Infection Control Officer who regularly monitors all areas of the Hospital. The Infection Control Officer also conducts infection control/environment of care surveys as part of the Hospital quarterly self-assessment, and issues regular reports on those activities. The Infection Control officer also conducts interim inspections and notifies relevant managers of issues. This year, an assessment of MRSA cases involving patients and staff was conducted, and established that no staff contracted MMRSA from patients, and vice versa, based upon genetic testing. The Infection Control Officer does not publish yet quarterly summary reports on key indicators or trend any data she collects.

There still however, remain significant issues around infection control. There are still issues around water temperature for patient laundry and kitchen areas due to the aging structure of the Hospital. Surveys conducted by the Infection Control Officer at times reveal a lack of soap in dispensers in bathrooms, or that staff are not always wearing protective gloves in the kitchen or while performing housekeeping duties. Pests remain a problem in some areas, and temperatures in the ovens and refrigerators must continually be monitored. The preventive maintenance contracts for kitchen equipment (ovens and refrigerators) need to be maintained without interruption; as of the writing of this report, preventative maintenance contracts for these services are not in place. There are also issues around materials management and logistics; supplies are not always available, and when available, are not always on the units. There are plans to hire a

[25] It is unclear to what degree this training is "competency-based."

manager for this unit, and better inventory control must be put in place. While the move to a new hospital will remedy many of these problems, the Hospital must address many now on an interim basis.

**6. Documentation (Agreement, Section IX)**
Compliance by June 25, 2009.

*No progress being made*. See prior sections for additional information about documentation. In most cases, documentation is not adequate. At times, it is not timely, but even when entered in a timely manner, it is not complete or accurate. The self assessment noted all disciplines need to improve documentation, including tying a patient's progress to the IRP intervention, as well as documenting patient's behavior and responses. *See Attachment 7 (Active Case Record Summary).* While staffing shortages may account for much of the lapses, additional training around documentation for all staff should be considered.

The Hospital reports that some steps are underway to improve documentation. First, an updated Medical Records policy is in the review process. The policy incorporates the specific requirements of the Agreement relating to documentation. In addition, as noted elsewhere in this report, each of the disciplines is expected to develop practice standards (including specific documentation requirements) by February, 2008, and thereafter begin peer review activities. It is expected that the peer review will also evaluate the quality and timeliness of documentation, and this will be addressed in more detail in the next six month report.

**7. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications. (Agreement, Section X)**
Compliance by June 25, 2008.

*Some progress in being made*. Overall, the use of seclusion and restraint has decreased significantly since 2005, although there remain significant issues around use and application of restraints and seclusion. The Hospital recently finalized a policy on use of emergency involuntary medication that meets provisions of the DOJ agreement and a revised draft of the revised seclusion and restraint policy is under review.

PID has been monitoring use of seclusion and restraint on a quarterly basis, which as of December, will now be reported monthly. While data is manually reported, the Hospital has seen a significant reduction in the use of seclusion and restraint since 2005. Further, the Hospital expects seclusion and restraint episodes to decrease further once trauma informed care is fully implemented, as has been the case in hospitals where it was implemented.

As set forth in Figure 17, there were 83 restraint episodes and 25 seclusion episodes in the twelve month period of October 1, 2006 to September 30, 2007. *See Figure 17.* The average episode of restraints in FY 2007 was under 2 hours in both civil and forensic services, but the average seclusion episode was over 3 hours in civil division and almost 12 hours in forensic. *See Figure 18.*

**Figure 17: Seclusion and Restraint Episodes, FY2007**

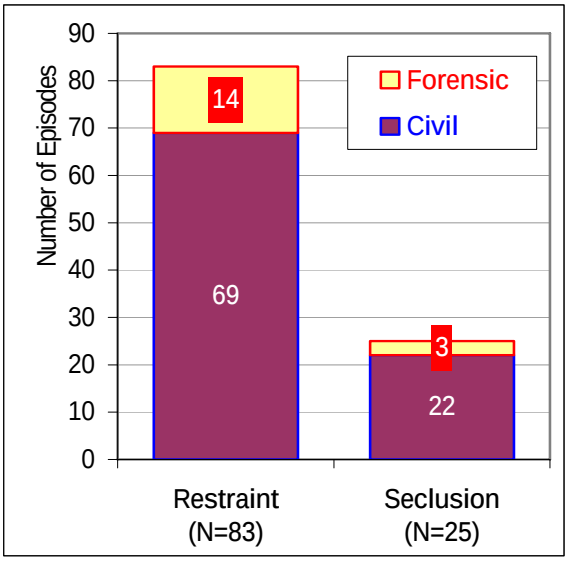
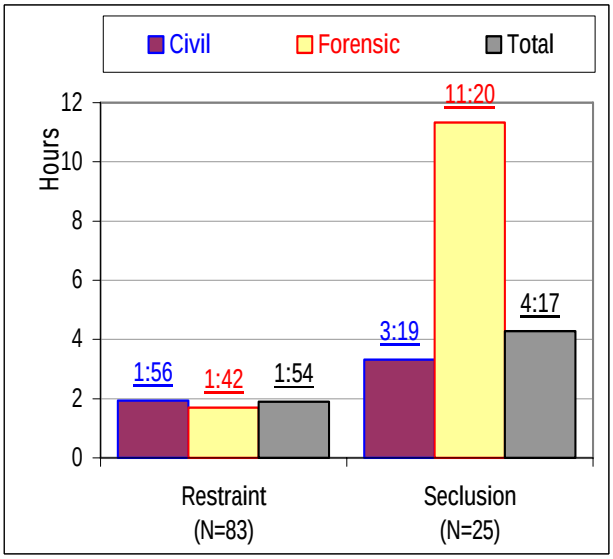
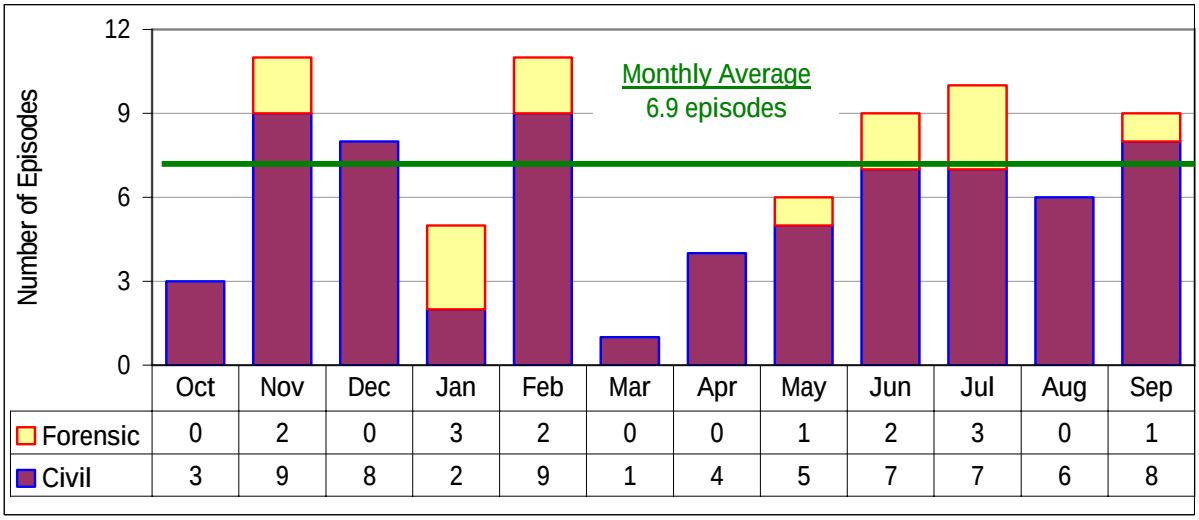



**Figure 18: Seclusion and Restraint Episodes in FY2007 (Average Number of Hours)**



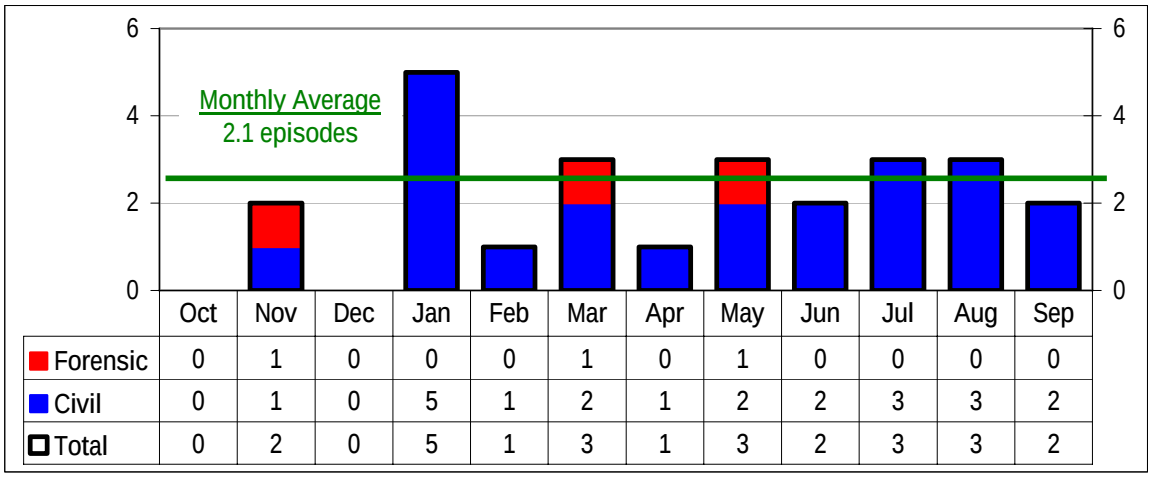

As is reflected in Figure 19, there were five months in which Forensic Services did not use any restraints, and the Civil Services did not use restraints more than 10 times in any one month. Figure 20 summarizes seclusion episodes by month. Forensic services did not use any seclusion in 9 months, and civil services did not utilize seclusion in two months. Thus, while seclusion results in longer hours of use, it is not used as often as restraints.

**Figure 19: Restraint Episodes by Month, FY2007**




| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic | 0 | 2 | 0 | 3 | 2 | 0 | 0 | 1 | 2 | 3 | 0 | 1 |
| Civil | 3 | 9 | 8 | 2 | 9 | 1 | 4 | 5 | 7 | 7 | 6 | 8 |

**Figure 20: Seclusion Episodes by Month, FY2007**




| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| Civil | 0 | 1 | 0 | 5 | 1 | 2 | 1 | 2 | 2 | 3 | 3 | 2 |
| Total | 0 | 2 | 0 | 5 | 1 | 3 | 1 | 3 | 2 | 3 | 3 | 2 |

While the hours and episodes are reduced from 2005, there remain serious issues around use of seclusion and restraints, however. In January 2007, a patient died during a restraint episode when staff used a particular technique to restrain. (An interim revision to policy was implemented to prohibit prone restraint after the death.) Similarly, when a behavior code is called, staff quickly respond, but often there is no organization in the response, and nursing staff on the ward do not act in a coordinated way or and effectively manage the staff who respond. This often leaves uninvolved patients upset and anxious, and staff often stand around rather than interact with non involved patients. Most seriously, until October when new restraints were purchased, there was a shortage of restraints on wards in the Hospital's civil side, and staff often were forced to run to another ward during the incident to retrieve restraints. This was remedied with the purchase of new restraints for all wards. While the Hospital has a procedure for post event debriefing to learn from the incident, it is occurring in less than half the cases; finally, updating the treatment plan when seclusion or restraint is required more than three times in a four week period is occurring only in about 66% of the cases.

Steps are planned to review in a more systemic way the use of seclusion and restraints. Beginning in Spring, 2008, the PID will be conducting more frequent reviews of charts of patients who have been secluded or restrained to ensure compliance with policy requirements, and will issue monthly, as opposed to quarterly reports that reflect seclusion and restraint data. Further, the new Director of Medical Affairs will need to put in place a mechanism for his review of a patient's care in cases of three or more incidents of restraint in a four week period. As of yet, that is not occurring, or if it is, it is not being tracked in any way that allows for reporting or evaluation of the effectiveness of the Medical Director review.

The Hospital does not yet have a mechanism for tracking emergency use of involuntary psychotropic medication. The PID is working with nursing on developing a mechanism, and will pilot two approaches, one in forensic and one in civil services to evaluate which is most effective. First, staff will be trained on the new Involuntary Medication Policy. Then under the pilot, units on the civil side will complete an unusual incident report each time emergency involuntary medication is used. On the forensic side, nurses will instead keep a log on each ward specifying when emergency involuntary medication is used. After three months, PID and the

Chief Nurses from forensic and civil services will evaluate which tracking mechanism was most effective.

### 8. Protection from Harm (Agreement, Section XI)

Compliance by June 25, 2010

*Minimum progress to date.* The Hospital has just begun to address this requirement. To date, overall practice and services are not consistently at a level that protect patients from harm. The Hospital is still not conducting criminal background checks or drug screens on prospective or current employees, and there is no plan yet in place to do so.

Data for January 1, 2007 though October, 2007, relating to incidents involving patient injury or allegations of abuse or neglect is somewhat unreliable. Data reflects that there were 12 deaths, 17 allegations of abuse, 6 assaults or major altercations and 2 suicide attempts. The two most frequently reported types of high critical severity unusual incidents involve unauthorized leave and medical emergencies, which include unscheduled trips to a general medical hospital. *See Table 4.*

**Table 4: Number of Incidents by Type, January – October 2007**

| UI Type | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | N/A | Total | Monthly Average | Percent |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High Critical Severity | Abuse | 2 | 0 | 2 | 2 | 1 | 1 | 1 | 3 | 2 | 2 | 1 | **17** | **2** | **1%** |
| | Assault/ Altercation | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 2 | 0 | **6** | **1** | **0%** |
| | Contraband | 1 | 0 | 0 | 1 | 1 | 0 | 5 | 2 | 6 | 10 | 0 | **26** | **3** | **2%** |
| | Death | 1 | 1 | 0 | 0 | 0 | 1 | 2 | 2 | 0 | 4 | 0 | **11** | **1** | **1%** |
| | Injury | 3 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | **7** | **1** | **1%** |
| | Medical Emergency | 8 | 14 | 11 | 14 | 9 | 20 | 11 | 32 | 18 | 28 | 0 | **165** | **17** | **14%** |
| | Suicide Attempt | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** | **0** | **0%** |
| | UL/Elopement | 11 | 11 | 10 | 10 | 15 | 18 | 24 | 26 | 27 | 35 | 0 | **187** | **19** | **15%** |
| | Other (Highly Severe) | 0 | 0 | 0 | 0 | 3 | 1 | 1 | 1 | 1 | 0 | 1 | **8** | **1** | **1%** |
| | ***Sub-total*** | ***26*** | ***26*** | ***25*** | ***28*** | ***30*** | ***44*** | ***46*** | ***67*** | ***54*** | ***81*** | ***2*** | ***429*** | ***43*** | ***35%*** |
| Less Critical Severity | Assault/ Altercation | 44 | 33 | 34 | 32 | 37 | 45 | 42 | 38 | 47 | 47 | 2 | **401** | **40** | **33%** |
| | Minor, Fall, etc | 19 | 14 | 24 | 15 | 24 | 22 | 21 | 19 | 19 | 31 | 0 | **208** | **21** | **17%** |
| | Other (Less Severe) | 15 | 11 | 15 | 17 | 16 | 21 | 21 | 27 | 15 | 17 | 1 | **176** | **18** | **14%** |
| | ***Sub-total*** | ***78*** | ***58*** | ***73*** | ***64*** | ***77*** | ***88*** | ***84*** | ***84*** | ***81*** | ***95*** | ***3*** | ***785*** | ***79*** | ***65%*** |

The Risk Manager/other staff conducted 22 investigations, including 11 death investigations ( a 12th is pending) and 11 investigations into allegations of patient abuse or neglect. As a result of the abuse/neglect investigations, three were substantiated, seven unsubstantiated and one deemed inconclusive. In the cases where the allegation was substantiated, termination was recommended; the affected staff are in varying stages of the disciplinary process. This is a

change, as for the first time in recent years, staff who failed to meet minimum standards when a death occurred were disciplined (terminated or suspended), and there is an increase focus on accountability. In one incident, a patient was "peppered sprayed" by a staff member, who has been on unpaid administrative leave since that time pending completion of termination proceedings.

The Hospital also created an expanded Office of Consumer Affairs but has not yet been able to fill the Administrator position. The Administrator of Consumer Affairs a direct report to the CEO, and additional staff have been added to strengthen its capacity. The number, type and response to patient grievances is being tracked; in CY 2007, there were 45 grievances filed by patients, with 26 filed by patients in forensic services, 18 by patients in civil services and the location of one patient could not be determined. All but four of the grievances were resolved to the satisfaction of the patient; in two cases, the matters went to arbitration, and in two cases, the patients were discharged before arbitration.

In 2006, the Hospital conducted a patient satisfaction survey, using a modified version of the 2001-2005 NRI Inpatient Consumer Survey tool.[26] The survey was administered by the SEH patient advocate assisted by the Consumer Action Network, a community based consumer led organization. The tool included questions to elicit patient's perception of dignity and perception of rights. A total of 101 of 600 eligible patients completed the survey. Fifty nine percent of patients agreed they were treated with dignity, while almost 41% stated they were not. Three quarters of patients reported they felt staff believed they could grow, change and recover, and 66% stated they felt comfortable asking questions about treatment and medications. Only 57% of patients felt they could complain about issues without fear of retaliation, and only 54% stated they felt safe to refuse medication or treatment. Finally, 50% of patients felt their complaints and grievances were addressed. While the completion of a patient satisfaction survey is important, it should be noted that the low response rates raised concerns of how the survey was disseminated and administered. Further the results, which will need to be compared with the results of the 2007-08 survey, establish that substantial work remains to be done to improve patient satisfaction with care at the Hospital. (That survey is not yet underway.)

Finally, the Hospital is planning to contract with a trainer in to train employees, on each shift, in the fundamentals of caring for persons with psychiatric challenges. Part 1 of the RESPECT Seminar has been presented to senior managers, and a contract is being developed which will provided for all staff training.

**9. <u>Incident Management (Agreement, Section XII)</u>**
Compliance by June 25, 2009.

<u>*Minimal progress to date.*</u> The Hospital improved its incident management reporting system, but it is not yet meeting the requirements of the Agreement. The Hospital Unusual Incident Reporting Policy is in the final stages of revision and is expected to be completed by February, 2008. Training will be provided for all staff, and will be incorporated into new staff training as well. Presently, unusual incident training is included in the annual training required of all staff.

[26] Results from the 2007 survey are not yet available.

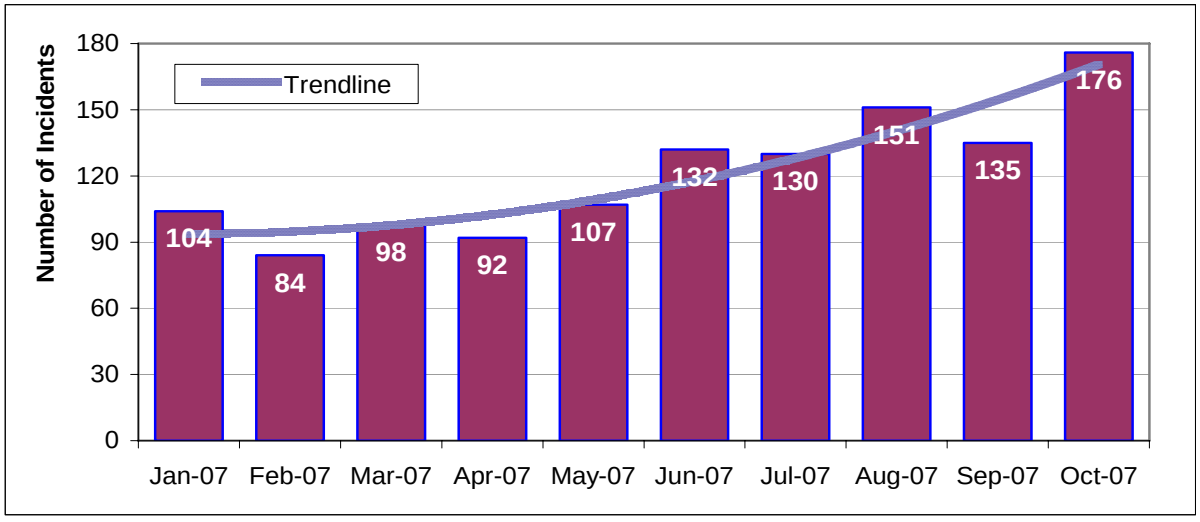
The Hospital is conducting investigations into serious incidents, including deaths and cases involving serious injury. PID will begin focused, issue specific small sample case reviews of categories of unusual incidents in the Spring. Topics suggested for early review included patients with multiple elopements or patients with repeated trips to the emergency rooms.

At the time of the survey in 2005, the surveyors raised a concern about the Risk Manger's lack of focused training. Since that time, the Risk Manager completed courses in Basic Investigations for DHS conducted by the Institute of Police Science, and also a four day course in Conducting Serious Incident Investigations. He also is participating in a four session, competency based training that will be concluded by the end of December. The quality of the investigation reports however, is not yet at the level required.

The Risk Manager had been producing monthly statistics and a quarterly report about Unusual Incidents. The Director of Monitoring Systems is working with the Risk Manager to modify and streamline the report to reflect critical data needs and the specific requirements of the Agreement. UI Data is included in the monthly report.

The most recent data on incident reporting shows an increase in the volume of reported incidents; it is not yet known whether that is due to more incidents or better reporting. *See Figure 21.*

**Figure 21: Volume of Reported Unusual Incidents, January – October 2007**




On average, there are 121 incidents each month, seven of which do not involve patients; on average 114 incidents involve 95 patients. Twenty two patients had over 10 incidents during 2007. A little over one-third of the incidents involve high severity cases. More incidents occur before the treatment mall begins and after it ends. *See Figures 22 and 23.*

**Figure 22: Incidents by Severity, Monthly Average, January – October 2007**

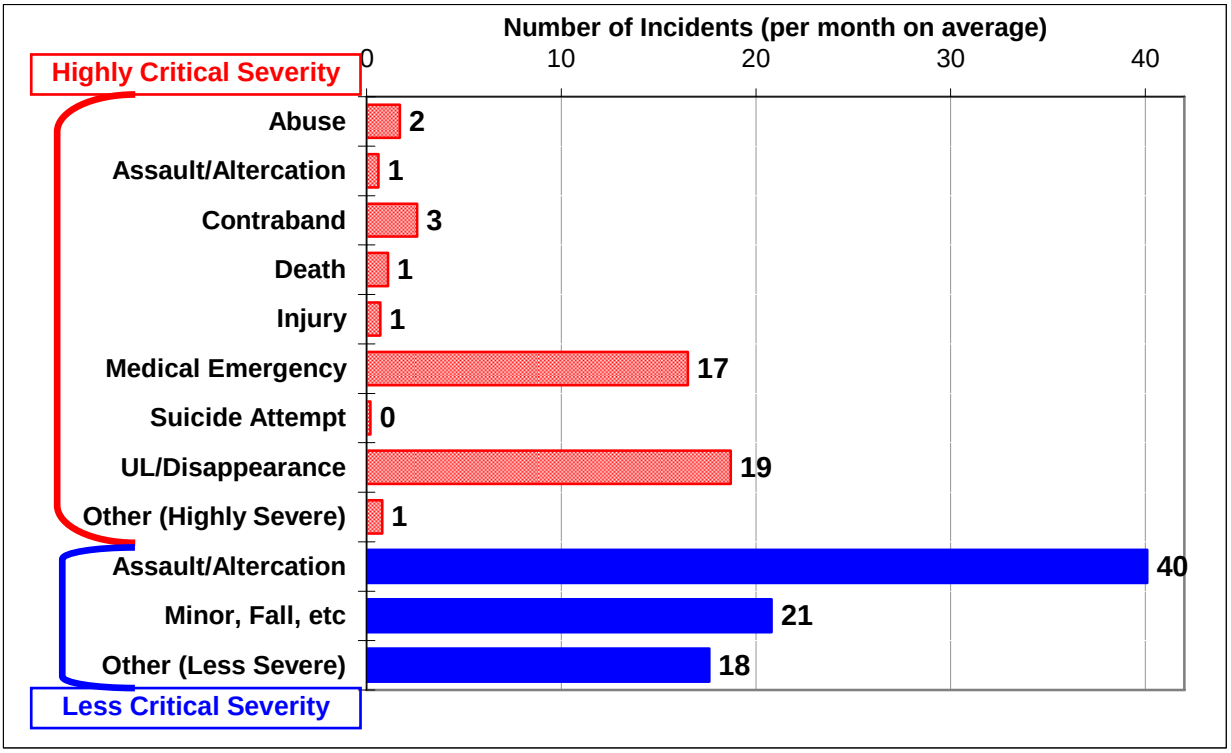
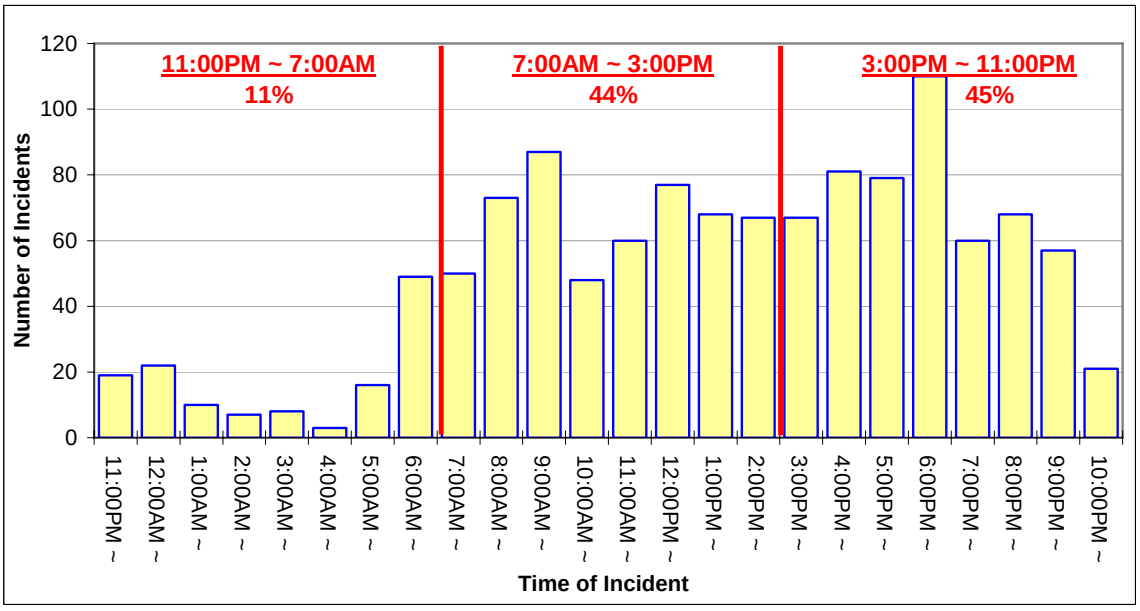



**Figure 23: UI by time and Shift, January – October 2007**




Further analysis is in the monthly report, which was first issue in December, 2007, but will be issued monthly thereafter. *Attachment 3 (Monthly Trend Analysis)*

**10. Quality Improvement (Agreement, Section XIII)**
Compliance by June 25, 2010.

*Minimal progress to date*. See prior section above at page 21-22 for progress. Currently used monitoring tools and the preliminary data from the most recent self assessment relating to IRPs, environmental conditions and discharge processes are attached. *Attachment 4 (Monitoring tool, Treatment Process); Attachment 5 (Monitoring Tool, Environment); Attachment 6 (Monitoring Tool, Discharge Medical Record Review); Attachment 7 (Active Case Record Summary Chart); Attachment 8 (Closed Record Summary); Attachment 9 (Environment of Care Summary chart); Attachment 3(Monthly Trend Analysis).*

**11. Environmental Conditions (Agreement, Section XIV)**
Compliance by June 25, 2010

*Some progress has been made*. Construction of the new 292 bed hospital is well underway, and completion is targeted for October, 2009. Thirty percent of the work is complete; 99% of the concrete slab on grade is installed, 90% of the masonry block walls are complete, and steel is 65% complete. Steel decking and concrete slabs for the upper level are on-going, as is electrical, mechanical and plumbing work. The brick veneer is also being installed. While construction is proceeding, Hospital staff are working with transition planning management group to begin planning for the move.

In November, 2007, each patient unit and the treatment mall were surveyed using an instrument attached as Attachment 5. The surveys were conducted by eight teams of two persons; four of the teams had persons other than Hospital employees. The assessment reflects mixed results. All but one of the units were rated as generally clean and free from clutter, and all units were rated as free from odor. Likewise, all units were rated as acceptable concerning medication refrigeration practices and temperatures, and linens. General unit maintenance was generally rated as acceptable, except on those units which have not yet been painted or had walls repaired, but many units were not meeting standards around the nutrition refrigerator, and some housekeeping issues such as soap dispensers being filled and the availability of manuals and therapeutic milieu. Certain units, such as JHP9 and CT 8, were rated low in many areas, and other units received high marks in most categories. Specific information is reflected in *Attachment 9 (Environment Summary Chart).*

The District is enhancing infrastructure in the existing structure as well. Electrical and other upgrades are being made to RMB. RMB wards 1, 2, 3 and 4, JHP wards 7 -12, the CT patients cafeteria, CT 8 (treatment mall), and the Chapel all have walls repaired and painted, and the rest of John Howard and CT 2 are targeted for this year. The Hospital is planning to contract for painting RMB wards 5-8, and they are badly in need of attention, with peeling paint and missing baseboards. Floor tiles were replaced in 4 wards in JHP. New washers and dryers were placed in JHP 10 and 2, and new refrigerators were placed in all units of RMB. Safety film was placed on glass panels in doors and side panels in RMB, and all safety and security mirrors were replaced in RMB. New curtains were installed in RMB, CT 2 and the patient dining areas in CT 2, RMB and JHP. Other projects for the remainder of the calendar year include replacing all

furniture in JHP and upgrading electrical components to the front and rear sally port doors in JHP.

The Hospital is also revising its policy for screening patients for contraband. It should be completed in the first quarter of Calendar Year 2008.

# VII. SUMMARY OF ASSESSMENT OF PROGRESS

| DOJ Due Date | Item # | Requirement | Status |
|---|---|---|---|
| No date listed | DOJ 3 Preamble | The District shall select, subject to the United States' approval, a Compliance Officer to promote compliance with and implementation of the provisions of this Settlement Agreement. The District shall pay the salary, costs, and expenses associated with the Compliance Officer and, if needed, shall provide sufficient funds to permit the Compliance Officer to hire staff and consultants to assist in carrying out the Compliance Officer's duties and responsibilities under the Agreement. | Completed. Compliance Officer selected in May, 2007. Began working part-time in May, 2007 and began full time July 9, 2007. Office includes one program analyst and capacity for two additional persons. |
| 06/25/10 | DOJ 5 Preamble | 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. | See specific sections below for details. |
| 06/25/10 | DOJ 5.A.1 | 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:<br><br>1. Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability; | Some progress has been made to create a structure to facilitate individualized, integrated treatment but such treatment is not yet occurring. Clinical administrators, who will be assigned for all units, are charged with ensuring that assessments, plans and services are provided to all patients and are the single point of accountability for coordinating each patient's treatment. The Clinical Administrator also ensures referrals are made, followed up and services provided consistent with patients' needs. To date, 10 of 12 clinical administrators are in place in forensic, and 3 of 6 are in place in civil services. Recruitment is underway for the remaining staff. Training on several pilot "best practice" initiatives (trauma informed care and person centered treatment planning) are in early stages, and a consultant has been hired to specifically work with direct care staff around team functioning. |

| DOJ Due Date | Item # | Requirement | Status |
|---|---|---|---|
| 06/25/10 | DOJ 5.A.2a-f | 2. be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:<br><br>a. assume primary responsibility for the individual's treatment;<br><br>b. require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;<br><br>c. require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;<br><br>d. require that the treatment team functions in an interdisciplinary fashion;<br><br>e. verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and(31)<br><br>f. require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur. | The Hospital has modified its Bylaws to give psychologists admit and discharge privileges. A revised draft of the Hospital policy addressing the makeup of the treatment team and the treatment planning process and content is under review but not yet final. The draft policy requires that patients are afforded the opportunity to participate fully in their treatment planning and identifies the treating psychiatrist or psychologist (in those cases where the psychologist is also serving as the clinical administrator) as the treatment team leader. In addition, the policy will require each core member to complete periodic assessments and treatment plan reviews. St. Elizabeths is implementing the clinical administrators for all wards who will serve as administrative managers of the treatment team to support the treatment team leaders. The disciplines have begun working on standards that will include fundamental requirements for discipline specific assessments, but that work is not completed at this time.<br><br>Treatment teams are not yet routinely functioning in an interdisciplinary fashion and treatment is not yet integrated. |
| 06/25/10 | DOJ 5.A.3 | 3. provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., i | Training in two pilot initiatives is underway. Training on trauma informed care began for two wards (one in civil services and one in forensic services) and will continue for several months. Over the next 12-18 months, trauma informed care will be expanded to all units. Additionally, all managers in clinical areas attended an overview of "person centered treatment planning" and training of several (2-3) direct care treatment teams will begin in February. An expanded Office of Training and Professional Development has been created, and recruitment is underway for a Director of that Office. That Office will be responsible for creating a training curriculum that meets staff needs and DOJ requirements and is competency based. Finally, a consultant has been hired who will work with direct care staff and managers on improving team functioning. |

| DOJ Due Date | Item # | Requirement | Status |
|---|---|---|---|
| 06/25/10 | DOJ 5.A.4 | 4. consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and | A draft policy has been completed that meets this requirement, but staffing levels are not sufficient yet to meet this requirement. |
| 06/25/10 | DOJ 5.A.5 | 5. meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader. | Not yet implemented. Currently, policy provides that the comprehensive treatment plan is done within 30 days and updated every 90 days thereafter. Recent self assessment data suggests that about 76-78% of treatment plans are current with the 90 day time frame. |
| 06/25/10 | DOJ 5.B Preamble | 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: | A draft policy meeting these requirements is being reviewed, but not all members are attending treatment plans and treatment plans are not consistently timely or follow assessments. |
| 06/25/10 | DOJ 5.B.1-4 | 1. where possible, individuals have input into their treatment plans;<br><br>2. treatment planning provides timely attention to the needs of each individual, in particular:<br><br>a. initial assessments are completed within 24 hours of admission;<br><br>b. initial treatment plans are completed within 5 days of admission; and<br><br>c. treatment plan updates are performed consistent with treatment plan meetings.<br><br>3. individuals are informed of the purposes and major side effects of medication;<br><br>4. each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented; | The Hospital is revising its IRP form, but it is not yet completed. The self assessment did not specifically look at patient input in treatment plans but data reflects that only 18% of patients signed treatment plans in civil services and 39% signed in forensic services. The initial assessment and initial treatment plans are being completed within the time frames, but quality varies significantly. Policy requires that patients be informed of purpose of the medication and side effects, but there is no way to evaluate if this is occurring. Treatment goals are not individualized on a consistent basis, and are often not the patient's goals. Treatment plan interventions are not consistently related to treatment goals and in many cases, there are no interventions for identified problems, or problems are not identified where they should be (ie. obesity) |
| 06/25/10 | DOJ 5.B.5 | the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints; | The Medical Director is reviewing the cases involving "non-emergency" involuntary medication, and reviews the seclusion and restraint report, but it is not clear to what extent he reviews specific high risk cases. |

| DOJ Due Date | Item # | Requirement | Status |
|---|---|---|---|
| 06/25/10 | DOJ 5.B.6 | 6. mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status; | Forensic services' monitoring of timeliness and attendance at treatment plan conferences since October 2006, shows high levels of participation, though the self assessment review did not show participation as high as forensic data. It recently implemented a policy that requires every patient to be presented to the Review Board at least once per year. This is designed to provide at least annual consultation and review of cases. The Director of Monitoring Systems is working with Forensic staff around data collection and analysis. |
| 06/25/10 | DOJ 5.B.7 | 7. treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs; | No information to report at this time. |
| 06/25/10 | DOJ 5.B.8 | 8. an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and | The Hospital has a transfer process in policy, but it only generally outlines the content of transfer notes and assessments and does not satisfy the specificity content of this subsection. The rate of compliance with the documentation requirements around transfers is not known at this time. |
| 06/25/10 | DOJ 5.B.9 | 9. to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart. | Not yet developed. Most disciplines have standards, but they have not yet been evaluated by the disciplines against DOJ standards and peer review of the type contemplated is not occurring. Tools will be developed once standards are in place for each discipline. |

| DOJ Due Date | Item # | Requirement | Status |
|---|---|---|---|
| 06/25/09 | DOJ 5.C | By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall: | A treatment planning policy has been drafted but is not yet finalized. Case formulations are not occurring, but the addition of clinical administrators is in part designed to address this requirement. (The decision who completes case formulations is pending.) The recent self assessment evaluated which discipline assessments were included in the integrated summary that is part of the comprehensive IRP (does not meet the case formulation requirement), and results ranged from 0% to 31%. Person centered treatment planning training will address this requirement, but it will not begin until February, 2008, and will be several months for all staff to be trained. The Hospital is establishing practice standards that will include requirements relating to assessments. |
| 06/25/09 | DOJ 5.C.1-7 | 1. be derived from analyses of the information gathered including diagnosis and differential diagnosis;<br><br>2. include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history; (40)<br><br>3. include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials; (53)<br><br>4. consider biochemical and psychosocial factors for each category in Section V.C.2., supra;<br><br>5. consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;<br><br>6. enable the treatment team to reach determinations about each individual's treatment needs; and<br><br>7. make preliminary determinations as to the setting to which the individual should be | Case formulation meeting these requirements is not occurring. |

| DOJ Due Date | Item # | Requirement | Status |
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| | | discharged, and the changes that will be necessary to achieve discharge whenever possible. | |

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| 06/25/09 | DOJ 5.D.1-6 | D. 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:<br><br>1. develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;<br><br>2. provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);<br><br>3. write the objectives in behavioral and measurable terms;<br><br>4. provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;<br><br>5. design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and<br><br>6. provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals. | A revised policy is drafted and under review, but is not yet finalized. Current treatment planning does not consistently meet these requirements. Training on trauma informed care and person centered treatment planning are two initiatives underway to improve performance, but it will take months for all staff to be trained. Not all patients are receiving 20 hours a week of active treatment; those attending the treatment mall are receiving 20 hours a week of active treatment. The clinical administrator will provide the administrative support to the treatment team leaders to ensure this requirement is met. Recruitment to fill all clinical administrator vacancies is underway. |

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| 06/25/09 | DOJ 5.E.1-5 | E. 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:1. revise the objectives, as appropriate, to reflect the individual's changing needs;2. monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;3. review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;4. provide that the review process includes an assessment of progress related to discharge; and 5. base progress reviews and revision recommendations on clinical observations and data collected. | The Hospital has not made progress on this requirement. No additional information to report at this time |
| 12/25/08 | DOJ 6 Preamble | 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. | The Hospital has not made progress on this requirement. It is modifying the role of the social worker and is exploring access to the public core service data base to access outpatient records. |
| 06/25/09 | DOJ 6.A.1 | By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions | A draft policy is under review that will establish requirements around timeliness and content of assessments. Psychiatry needs to review its practice standards and restart a peer review process that is focused on improving performance. At this time, the psychiatric assessments are not meeting this requirement. |

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| 06/25/09 | DOJ 6.A.2 | By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk | No information to report at this time, other than each admission ward will have a psychologist assigned to it to conduct risk screenings and assessments as warranted. Recruitment for additional psychology staff is underway. |
| 06/25/08 | DOJ 6.A.3 | By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses | Doctors have copies of the DSM and access through the internet, but additional training and peer review is needed around diagnosis. |
| 12/25/08 | DOJ 6.A.4 | By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols | The Hospital is implementing a listserve around diagnosis and monthly case conferences to present complex diagnostic cases. This will begin in January, 2008. |
| 06/25/08 | DOJ 6.A.5 | By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols | A draft policy around initial psychiatric assessments is in the review process. QID is undertaking random chart reviews beginning in Winter, 2008, will evaluate compliance with the timeliness aspect of this standard. Quality of assessments will be reviewed through psychiatric peer review, but that has not yet begun. |
| 06/25/08 | DOJ 6.A.6 | By 12 months from the Effective Date hereof, SEH shall ensure that:<br>c. differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); | QID is undertaking random chart reviews and is evaluating compliance with standard. Quality of assessments will be reviewed through psychiatrist peer review, but that has not yet begun. The November self assessment data suggests that only 54% of patients in forensic have psychiatric diagnosis that reflect DSM IV standards, and 47% in civil services. |
| 06/25/08 | DOJ 6.A.6a,d | By 12 months from the Effective Date hereof, SEH shall ensure that:a. clinically supported, and current assessments and diagnoses are provided for each individual;d. each individual's psychiatric assessments, diagnoses, and medications are clinically justified. | QID is undertaking random chart reviews and is evaluating compliance with standard. Quality of assessments will be reviewed through psychiatrist peer review, but that has not yet begun. The November self assessment data suggests that only 54% of patients in forensic have psychiatric diagnosis that reflect DSM IV requirements, and 47% in civil services. |

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| 06/25/08 | DOJ 6.A.6b | By 12 months from the Effective Date hereof, SEH shall ensure that:<br>b. all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments | No information to report at this time. |
| 06/25/09 | DOJ 6.A.7 | By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization. | Beginning November 1, 2007, the Forensic Division Review Board will review every patient's case at least once yearly to assess the patient's diagnosis, treatment, progress and prognosis and to offer suggestions for changes to patient's treatment that may positively impact patient's course of hospitalization/discharge. The Hospital has a draft policy under review that will address reassessment requirements, and peer review will be utilized for evaluating compliance with this requirement. |
| 06/25/09 | DOJ 6.B.1 | By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments. | The Hospital added 7 additional psychology positions in FY08 and recruitment is underway. In general, the quality is high but staffing shortages have limited the capacity to provide assessments. |
| 06/25/09 | DOJ 6.B.2 | 2. By 24 months from the Effective Date hereof, all psychological assessments, shall:<br><br>a. expressly state the purpose(s) for which they are performed;<br><br>b. be based on current, and accurate data;<br><br>c. provide current assessment of risk for harm factors, if requested;<br><br>d. include determinations specifically addressing the purpose(s) of the assessment; and<br><br>e. include a summary of the empirical basis for all conclusions, where possible. | The Hospital will be developing practice standards for each discipline. The requirements for content of psychological assessments will be set forth in those standards. |

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| 06/25/09 | DOJ 6.B.3 | 3. By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment. | No information to report at this time. |
| 06/25/09 | DOJ 6.B.4 | 4. By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team. | The Hospital added 7 additional psychology positions in FY08 and recruitment is underway. In general, the quality is high but staffing shortages have limited the capacity to provide assessments. Additionally, each admissions unit will have a psychologist assigned to it. |
| 06/25/09 | DOJ 6.B.5 | 5. By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment. | Six additional rehabilitation specialists will be hired in FY08. Staff have been assigned to each unit to complete assessments on all patients. |
| 06/25/08 | DOJ 6.C.1 | When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision. | Rehabilitation services completed all but one referral in CY2007. |
| 06/25/09 | DOJ 6.C.2 | By 24 months from the Effective Date hereof, all rehabilitation assessments shall: a. be accurate as to the individual's functional abilities;b. identify the individual's life skills prior to, and over the course of, the mental illness or disorder;c. identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and d. provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive. | Rehabilitation services will be reviewing its practice standards and will institute peer review against these new standards. While it has been doing chart reviews, the standards are not yet consistent with the DOJ agreement. |

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| 06/25/09 | DOJ 6.C.3 | By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment. | A schedule was developed to ensure all patients will have updated rehabilitation services assessments by December 2008, using a new tool recently developed. |
| 12/25/08 | DOJ 6.D | By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors. | The Hospital is developing new practice standards for all disciplines. Those standards for social work will include this standard. Further, the Hospital is revising the role of the social worker, which is expected to return to a more traditional social work role. |
| 06/25/08 | DOJ 7. Preamble | 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. | The Hospital and DMH established a work group that meets weekly to review discharges of patients who the Hospital has identified as "ready for discharge". The group has focused on barriers to discharge, especially around housing, but patients are still spending too long on the list. To date in 2007, 142 patients have been discharged, and as of November 15, 2007, 424 remain on the ready for discharge list. |
| 06/25/08 | DOJ 7.A.1-4 | 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:<br>1. those factors that likely would result in successful discharge, including the individual’s strengths, preferences, and personal goals;<br>2. the individual’s symptoms of mental illness or psychiatric distress;<br>3. barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and<br>4. the skills necessary to live in a setting in which the individual may be placed. | The self assessment indicates that additional work is needed around discharge planning, including better transition to the community, more housing choices and more flexibility by treatment team in considering discharge options. |

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| 06/25/08 | DOJ 7.B | By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate. | See prior discussion around person centered treatment planning. |
| 06/25/08 | DOJ 7.C.1-3 | 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:<br><br>1. measurable interventions regarding his or her particular discharge considerations;<br><br>2. the persons responsible for accomplishing the interventions; and<br><br>3. the time frames for completion of the interventions. | The Hospital in the Winter, 2008 is expected to begin utilizing a discharge quality checklist to be completed by the Clinical Administrators to evaluate the Hospital's discharge process. This will also be reviewed as part of a self assessment of discharged patients. Information will be provided to PID who will review data and provide trend information. See data accompanying this report related to review of closed records. |
| 06/25/08 | DOJ 7.D | By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge. | Some inpatients attend activities in the community as part of a transition process, but transition to the community is not occurring in any systematic way. The Hospital is reviewing the role of the social worker to increase responsibility around transition to community, but the role has not been finalized. |
| 06/25/08 | DOJ 7.E | Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual. | Not occurring in a systemic manner. Data from the self assessment shows discharge planning is not adequate and that there is not documentation that appointment and other important information is provided to the patient. |
| 06/25/08 | DOJ 7.F.1 | [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:]<br><br>1. developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge*;* | This will be led by the Mental Health Authority, but additional information is not available at this time. |

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| 06/25/08 | DOJ 7.F.1-2 | 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:<br><br>1. developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and<br><br>2. hiring sufficient staff to implement these provisions with respect to discharge planning. | The Hospital in the Winter, 2008 is expected to begin utilizing a discharge quality checklist to be completed by the Clinical Administrators to evaluate discharge process. This will also be reviewed as part of a self assessment of discharged patients. Information will be provided to PID who will review data and provide trend information. See data accompanying this report related to review of closed records. |
| 06//25/09 | DOJ 8.A Preamble | 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. | No information is available, although the Hospital has 24 hours staff including coverage by a psychiatrist and a general medical officer. |

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| 06/25/09 | DOJ 8.A.1a-g | 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:<br>a. documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;<br><br>b. documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;<br><br>c. timely and justifiable updates of diagnosis and treatment, as clinically appropriate;<br><br>d. documentation of analyses of risks and benefits of chosen treatment interventions;<br><br>e. assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;<br><br>f. documentation of, and responses to, side effects of prescribed medications;<br><br>g. documentation of reasons for complex pharmacological treatment; and<br><br>h. timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use. | No progress yet, but there are plans underway to address this. AVATAR, an automated information system, will be phased in beginning in Spring, 2008, and pharmacy will be in Phase 1. The system has the capacity to alert physicians to contra-indicated medications or drug allergies. The system also has the capacity to produce reports. There is no peer review underway, nor are there psychiatric practice standards that are in place to measure performance. |

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| 12/25/08 | DOJ 8.A.2a.i-vi | 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:a. monitoring of the use of psychotropic medications to ensure that they are: i. clinically justified; ii. prescribed in therapeutic amounts, and dictated by the needs of the individual; iii. tailored to each individual's clinical needs and symptoms; iv. meeting the objectives of the individual's treatment plan; v. evaluated for side effects; and vi. documented. | See above |
| 12/25/08 | DOJ 8.A.2b | [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:] b. monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall: | See above. |
| 12/25/08 | DOJ 8.A.2bi | i. develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary; | No information is available at this time. |
| 12/25/08 | DOJ 8.A.2bii | ii. develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a | No information is available at this time. |

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| | | result of PRN uses; | |
| 12/25/08 | DOJ 8.A.2biii | iii. establish a system for the pharmacist to communicate drug alerts to the medical staff; and | The pharmacy has the capacity to communicate drug alerts. AVATAR will permit this to be done electronically. |
| 12/25/08 | DOJ 8.A.2biv | iv. provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees. | The pharmacy has the capacity to communicate drug alerts. AVATAR will permit this to be done electronically. |
| 06/25/10 | DOJ 8.A.3 | By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units. | There remain shortages of psychiatrists. Currently, none of the admissions units meet the required 1:12 staffing, and on some long term wards, the psychiatric coverage is not full - time, so staffing there likewise does not meet DOJ standards. |
| 06/25/09 | DOJ 8.A.4a-c | 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:<br><br>a. ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case; (55)<br><br>b. ensure regular exchanges of data between the psychiatrist and the psychologist; and (56)<br><br>c. integrate psychiatric and behavioral treatments. (54) | IN CY 2007, 6 behavioral plans were completed, and 8 are pending. In addition, 25 comprehensive psychological assessments have been completed and another 21 patients are being assessed. There is no information available as to psychiatric review of behavioral plans or that psychiatrists and psychologists are discussing testing results. |
| 06/25/09 | DOJ 8.A.5 | By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment. | No information is available at this time. |
| 06/25/09 | DOJ 8.A.6 | By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse. | Hospital policy requires these screenings. The November self assessment however, found the completed tool in only 50% of charts. |

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| 06/25/09 | DOJ 8.A.7 | By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments. | No information is available at this time. |
| 12/25/08 | DOJ 8.B Preamble | By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological supports and services to individuals who require such services. | |
| 12/25/08 | DOJ 8.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: | Psychology is providing individual therapy services to 34 patients and over 100 patients in group therapies. Six behavioral plans were completed, and 8 are pending. 25 full tests have been performed this calendar year and 21 are pending. Staffing continues to be an issue, but 7 additional positions for psychologists have been identified for FY08. Each admissions ward is targeted to receive an assigned psychologist. Psychology will be implementing monthly peer review in Winter, 2008. |
| 12/25/08 | DOJ 8.B.1a | a. ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications; | See above. |
| 12/25/08 | DOJ 8.B.1b | b. ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement; | See above. |
| 12/25/08 | DOJ 8.B.1c | c. ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies; | See above |
| 12/25/08 | DOJ 8.B.1e | e. ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and | See above |

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| 12/25/08 | DOJ 8.B.1f | f. ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs. | See above. |
| 12/25/08 | DOJ 8.B.2 | By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs. | No information is available. |
| 12/25/08 | DOJ 8.B.3 | By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available. | Patients are receiving treatment in treatment mall and some ward based activities. However, groups are not consistently meeting patients' needs and are not individualized. |
| 12/25/08 | DOJ 8.B.4a-g | By 18 months from the Effective Date hereof, SEH shall ensure that:a. behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible; b. programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;c. where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;d. programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment; e. psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;f. clinically relevant information remains readily accessible; andg. staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions. | The treatment mall and JHP treatment calendars reflect treatment activities. The Hospital is participating in a training grant for leaders of substance abuse groups for mentally ill. The Forensic Services is implementing annual review of cases. The Hospital has a number of patients with significant cognitive impairments, but for those with developmental disabilities, has been unsuccessful in working the District's Department of Disability Services to address their needs. No additional information is available. |

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| 06/25/10 | DOJ 8.C | By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. | Additional pharmacists have been hired, and staff are working more closely with physicians on medication issues. The AVATAR systems will focus on pharmacy issues in phase I. |
| 06/25/10 | DOJ 8.C.1-2 | By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:<br>1. pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and<br>2. physicians to consider pharmacists' recommendations and clearly document their responses and actions taken. | Pharmacy has policies involving review of medication and completed a review of contra-indicated medications. Medication errors and adverse reactions are tracked by pharmacy are reported to Pharmacy and Therapeutics committee (there is some concern that not all errors or adverse reactions are being reported), but there is no tracking of this data. Information around physician response is not available at this time. |
| 06/25/09 | DOJ 8.D | SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall: | Critical shortages in nursing has hampered progress in all nursing indicators; there are some 50 nursing staff vacancies. Moreover, nursing staff are not meeting the standards set out for nursing care. As noted, nurses are not on a consistent basis monitoring (or documenting) patient responses to treatment and are not identifying medical issues or engaging in appropriate nursing care. |
| 06/25/09 | DOJ 8.D.1 | 1. Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status; | The nursing training for new employees is only one week and is not sufficient to meet Hospital needs. The Chief Nurses in Civil and Forensic Services provide other training but it is unclear how competency is assessed. |

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| 06/25/09 | DOJ 8.D.10a-g | Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:a. actively collect data with regard to infections and communicable diseases;b. assess these data for trends;c. initiate inquiries regarding problematic trends;d. identify necessary corrective action;e. monitor to ensure that appropriate remedies are achieved;f. integrate this information into SEH's quality assurance review; andg. ensure that nursing staff implement the infection control program. | The Hospital has an infection control officer but has not yet created a data system that allows for monitoring or trending of data. |
| 06/25/09 | DOJ 8.D.11 | Ensure sufficient nursing staff to provide nursing care and services. | There are approximately 50 nursing staff vacancies (all types). When sufficient staff are not available, wards are being covered by overtime and through a nursing contract. |
| 06/25/09 | DOJ 8.D.2 | Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions | Self assessment data suggests that progress notes are not as thorough or detailed as required, and do not routinely describe specific patient behavior or responses to treatment interventions. |
| 06/25/09 | DOJ 8.D.3 | Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits | No additional information is available, though training has occurred in some areas. |
| 06/25/09 | DOJ 8.D.4 | Ensure that nursing staff document properly and monitor accurately the administration of medications | No additional information is available. |
| 06/25/09 | DOJ 8.D.5 | Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration | No additional information is available. |

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| 06/25/09 | DOJ 8.D.5 | Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records | No information is available. |
| 06/25/09 | DOJ 8.D.6 | Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors | No information is available. |
| 06/25/09 | DOJ 8.D.7 | Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses | No information is available. |
| 06/25/09 | DOJ 8.D.8 | Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan | See results of self assessment for information relating to treatment plans. No additional information is available. |
| 06/25/09 | DOJ 8.D.9a-c | Ensure that each individual's treatment plan identifies:<br><br>a. the diagnoses, treatments, and interventions that nursing and other staff are to implement;<br><br>b. the related symptoms and target variables to be monitored by nursing and other unit staff; and<br><br>c. the frequency by which staff need to monitor such symptoms. | Self assessment data suggests that nursing interventions do address frequency, care needs, duration, and person responsible in about 3/4 of the time. |
| 06/25/09 | DOJ 9 | [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. | Policies around documentation are in final stages of review. Peer review standards for each discipline are targeted for 2008. |

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| 06/25/08 | DOJ 10.A.1-3 | 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:<br><br>1. the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.<br><br>2. training in the management of the individual crisis cycle and the use of restrictive procedures; and<br><br>3. the use of side rails on beds, including a plan:<br><br>a. to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and<br>b. to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms. | A new emergency psychotropic medication policy has been completed. A revised seclusion and restraint policy is in draft and is being reviewed. |
| 06/25/08 | DOJ 10.B.1-4 | 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:<br><br>1. are used after a hierarchy of less restrictive measures has been considered and documented;<br><br>2. are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;<br><br>3. are not used as part of a behavioral intervention; and<br><br>4. are terminated as soon as the individual is no longer an imminent danger to self or others. | Policy is under final review |

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| 12 06/25/08 | DOJ 10.C.1-8 | By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include: 1. the specific behaviors requiring the procedure; 2. the maximum duration of the order;3. behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired; 4. ensure that the individual's physician be promptly consulted regarding the restrictive intervention;5. ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;6. ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day; 7. comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and8. 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. | Policy is under final review. Training will be required and monitoring is not yet in place. |
| 06/25/08 | DOJ 10.D | By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications. | Data is now produced monthly. Checking for accuracy is not yet underway. |
| 06/25/08 | DOJ 10.E | By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate. | Policy under development |

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| 06/25/08 | DOJ 10.F.1-3 | 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:<br>1. such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;<br><br>2. a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and<br><br>3. the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate. | Policy under development |
| 12/25/08 | DOJ 10.G | By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions. | Annual training on use of seclusion and restraint is required; as of mid November, 2007, 92% of mandated staff attended. |
| 06/25/10 | DOJ 11 | 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. | Initial steps underway include creation of Administrator for Consumer Affairs that reports directly to the CEO, with three staff. In cases where abuse allegations have been substantiated, staff have been terminated, and others are in process of being terminated for patient abuse or neglect. The Risk Manager received 11 reports of alleged abuse or neglect and has conducted investigations into these claims; three were substantiated and disciplinary actions are pending. |

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| 06/25/10 | DOJ 11 | 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. | No action taken to date. |
| 06/25/10 | DOJ 11 | 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. | No information is available at this time. |
| 06/25/10 | DOJ 11.A | By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment. | New hospital is under construction. Painting, new furniture and other repairs have been made on various units. Despite these gains, additional areas for improvement are identified in the Environment of Care self assessment, the results of which are attached. |
| 06/25/09 | DOJ 12 Preamble | 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. | The Hospital has improved its incident management reporting system, but it is not yet meeting the requirements of the Agreement. The Hospital Unusual Incident Reporting Policy is in the final stages of revision and is expected to be completed by January, 2008. Training will be provided for all staff, and will be incorporated into new staff training as well. Presently, unusual incident training is included in the annual training required of all staff.<br><br>The Hospital is conducting investigations into serious incidents, including deaths and cases involving serious injury. PID will begin focused, issue specific small sample case reviews of categories of unusual incidents in the Spring. Topics suggested for early review included patients with multiple elopements or patients with repeated trips to the emergency rooms.<br><br>At the time of the survey in 2005, the surveyors raised a concern about the Risk Manger's lack of focused training. Since that time, the Risk Manager completed courses in Basic Investigations for DHS conducted by the Institute of Police Science, and also a four day course in Conducting Serious Incident Investigations. He also is participating in a competency based training that will be concluded by the end of December. The quality of the investigation reports however, is not yet at the level required. |

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| | | | The Risk Manager had been producing monthly statistics and a quarterly report about Unusual Incidents. The Director of Monitoring Systems is working with the Risk Manager to modify and streamline the report to reflect critical data needs and the specific requirements of the Agreement. UI Data is included in the monthly report, which is attached. |
| 06/25/09 | DOJ 12.A.1-8 | By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:<br><br>1. identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;<br><br>2. immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;<br><br>3. mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome; | The Hospital has improved its incident management reporting system, but it is not yet meeting the requirements of the Agreement. The Hospital Unusual Incident Reporting Policy is in the final stages of revision and is expected to be completed by January, 2008. Training will be provided for all staff, and will be incorporated into new staff training as well. Presently, unusual incident training is included in the annual training required of all staff. The Hospital is conducting investigations into serious incidents, including deaths and cases involving serious injury. PID will begin focused, issue specific small sample case reviews of categories of unusual incidents in the Spring. Topics suggested for early review included patients with multiple elopements or patients with repeated trips to the emergency rooms.<br><br>At the time of the survey in 2005, the surveyors raised a concern about the Risk Manger's lack of focused training. Since that time, the Risk Manager completed courses in Basic Investigations for DHS conducted by the Institute of Police Science, and also a four day course in Conducting Serious Incident Investigations. He also is participating in a competency based training that will be concluded by the end of December. The quality of the investigation reports however, is not yet |

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| | | 4. adequate training for all staff on recognizing and reporting incidents;<br><br>5. notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;<br><br>6. posting in each unit a brief and easily understood statement of how to report incidents;<br><br>7. procedures for referring incidents, as appropriate, to law enforcement; and<br><br>8. mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | at the level required.<br><br>The Risk Manager had been producing monthly statistics and a quarterly report about Unusual Incidents. The Director of Monitoring Systems is working with the Risk Manager to modify and streamline the report to reflect critical data needs and the specific requirements of the Agreement. UI Data is included in the monthly report, which is attached. |
| 06/25/09 | DOJ 12.B | By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. | The risk manager reports conducting 22 investigations into 11 deaths, and 11 involving patient abuse. One death investigation is pending. |
| 06/25/09 | DOJ 12.B.1 | Require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators | The Hospital is conducting investigations into serious incidents, including deaths and cases involving serious injury. PID will begin focused, issue specific small sample case reviews of categories of unusual incidents in the Spring. Topics suggested for early review included patients with multiple elopements or patients with repeated trips to the emergency rooms. The Reports into the investigations do not consistently meet requirements of the agreement as to comprehensiveness. |

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| 06/25/09 | DOJ 12.B.2 | Require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings | At the time of the survey in 2005, the surveyors raised a concern about the Risk Manger's lack of focused training. Since that time, the Risk Manager completed courses in Basic Investigations for DHS conducted by the Institute of Police Science, and also a four day course in Conducting Serious Incident Investigations. He also is participating in a competency based training that will be concluded by the end of December. The quality of the investigation reports however, is not yet at the level required. |
| 06/25/09 | DOJ 12.B.3 | Include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents | See above. In addition, the Risk Manager is now part of MSS; he will have a performance plan that requires comprehensive and independent investigations and thorough reports. |
| 06/25/09 | DOJ 12.B.4 | Include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations | PID will utilize information from the UI report to identify issues that warrant further review. The Director of Monitoring Systems has begun working with the Risk Manager on improving the UI data and analysis thereof. |
| 06/25/09 | DOJ 12.D | By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident. | The Risk Manager had been producing monthly statistics and a quarterly report about Unusual Incidents. The Director of Monitoring Systems is working with the Risk Manager to modify and streamline the report to reflect critical data needs and the specific requirements of the Agreement. UI Data is included in the monthly report, which is attached. |

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| 06/25/09 | DOJ 12.E.1a-g | 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:<br>1. Track trends by at least the following categories:<br>a. type of incident;<br>b. staff involved and staff present;<br>c. individuals involved and witnesses identified;<br>d. location of incident;<br>e. date and time of incident;<br>f. cause(s) of incident; and<br>g. actions taken. | The Hospital has a UI tracking database, but it is wholly reliant on manual data, and there is some evidence that not all UIs are being reported. At this point, the tracking is just beginning, and follow up when trends are identified is not occurring. Finally, the follow up on actions taken is not occurring. |
| 06/25/09 | DOJ 12.E.2 | Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen. | There is a policy that requires post event analysis and treatment team meetings post seclusion and restraint incidents, but it is not occurring as required. |
| 06/25/09 | DOJ 12.E.3 | Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record. | No information is available. |
| 06/25/10 | DOJ 13 Preamble | 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. | Currently used monitoring tools and the preliminary data from the most recent self assessment relating to IRPs, environmental conditions and discharge processes are attached. These tools reflect some, but not all of the IRP process requirements, and fewer of the content requirements. It is expected that once discipline standards are established, additional assessment tools will need to be developed. |

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| 06/25/10 | DOJ 13.A | Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved. | Currently used monitoring tools and the preliminary data from the most recent self assessment relating to IRPs, environmental conditions and discharge processes are attached. These tools reflect some, but not all of the IRP process requirements, and fewer of the content requirements. It is expected that once discipline standards are established, additional assessment tools will need to be developed. |
| 06/25/10 | DOJ 13.B.1-3 | 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: 1. the action steps recommended to remedy and/or prevent the reoccurrence of problems; 2. the anticipated outcome of each step; and3. the person(s) responsible and the time frame anticipated for each action step. | Currently used monitoring tools and the preliminary data from the most recent self assessment relating to IRPs, environmental conditions and discharge processes are attached. Also attached is the first monthly report, that will be expanded as more data is available. |
| 06/25/10 | DOJ 13.C.1-3 | Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:<br><br>1. disseminating corrective action plans to all persons responsible for their implementation;<br><br>2. monitoring and documenting the outcomes achieved; and<br><br>3. modifying corrective action plans, as necessary. | The first corrective action plan was developed with input from all managers, and was disseminated to all managers and numerous other staff. |
| 06/25/10 | DOJ 13.D | Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes. | See above. |

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| 06/25/10 | DOJ 14 Preamble | 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: | Construction of the new 292 bed hospital is well underway, and completion is targeted for October, 2009. .<br><br>In November, 2007, each patient unit and the treatment mall were surveyed using the instrument attached. The surveys were conducted by eight teams of two persons; four of the teams had persons other than Hospital employees. The assessment reflects mixed results. All but one of the units were rated as generally clean and free from clutter, and all units were rated as free from odor. Likewise, all units were rated as acceptable concerning medication refrigeration practices and temperatures, and linens. General unit maintenance was generally rated as acceptable, except on those four units which have not yet been painted or had walls repaired, but many units were not meeting standards around the nutrition refrigerator, laundry rooms, and some housekeeping issues such as soap dispensers being filled and the availability of manuals and therapeutic milieu. Certain units, such as JHP 9 and CT 8, were rated low in many areas, and other units received high marks in most categories. Specific information is reflected in the attachment.<br><br>While the new Hospital is being built, the District is enhancing infrastructure in the existing structure as well. Electrical and other upgrades are being made to RMB. RMB wards 1, 2, 3 and 4, JHP wards 7 -12, the CT patients cafeteria, CT 8 (treatment mall), and the Chapel all have walls repaired and painted, and the rest of John Howard and CT 2 are targeted for this year. The Hospital is contracting for painting RMB wards 5-8, and they are in need of attention, with peeling paint and missing baseboards. Floor tiles were replaced in 4 wards in JHP. New washers and dryers were placed in JHP 10 and 2, and new refrigerators were placed in all units of RMB. Safety film was placed on glass panels in doors and side panels in RMB, and all safety and security mirrors were replaced in RMB. New curtains were installed in RMB, CT 2 and the patient dining areas in CT 2, RMB and JHP. Other projects for the remainder of the calendar year include replacing all furniture in JHP and upgrading electrical |

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| | | | components to the front and rear sally port doors in JHP.<br><br>The Hospital is also revising its policy for screening patients for contraband. It should be completed in the first quarter of Calendar year 08.<br><br>There is no information about the fire and safety evacuation plan, although I have been informed that one exists. |
| 06/25/10 | DOJ 14.A | By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them. | See above. |
| 06/25/10 | DOJ 14.B | By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband. | A draft policy is under review. |
| 06/25/09 | DOJ 14.C | By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm. | Staffing is not adequate. Currently, there are 152 vacancies. |
| 06/25/10 | DOJ 14.D | By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities. | Elevators have been repaired, but continue to break at times. |

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| 06/25/08 | DOJ 14.E | By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority. | No information is available. |
| 06/25/10 | DOJ 14.F | By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas. | See above. |