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

Saint Elizabeths Hospital Compliance Report 6

October 7, 2010

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Janet Maher
Chief Compliance Officer

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.	**INTEGRATED TREATMENT PLANNING**	
	By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in. a single, integrated plan.	
V.A	**Interdisciplinary Teams**	
	By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	
V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Recommendation:** 1. Same as in V.A.2 to V.A.5 SEH Response: Same as in V.A.2 to V.A.5 2. Same as in V.B., V.C., V.D., and V.E. SEH Response: Same as in V.B., V.C., V.D. and V.E.
V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Recommendation:** Maintain practice of team leadership by psychiatrists and co-facilitation by clinical administrators. SEH Response: Psychiatrists/treatment team leader psychologists continue to lead team and clinical administrators continue to co-facilitate. See also 2.a below.
V.A.2.a	assume primary responsibility for the individual's treatment;	**Recommendation:** Continue work with consultant. SEH Response: Work with the consultant continues. ***See Tab # 2 (IRP consultation contract)***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Facility's Findings: See below. Please note that the tool was modified effective July 2010 to more closely align with the specific requirements of the Settlement Agreement; therefore available data from the comparable indicator of the earlier tool are set out in a separate table. See Tab # 8 (Table of Attachments), IRP Observation Audit tools. Because of the changes in the tools, we are not able to compare progress since the last reporting period. [1]

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C Indicator #1. The team is led by the treating psychiatrist or licensed clinical psychologist who shall assume primary responsibility for the individual's treatment					100	100	**100**

N = All IRP reviews scheduled in the review month
n = number audited (Audit sample plan provides for 2 audits per unit per month)
* Data not available as different tool was used during that month.
See Tab # 9 IRP Observation audit results.

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 9b Facilitator encouraged participation by all team members	89	100	100	100			**97**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital.
* Data collected using different tool
See Tab # 9 IRP Observation audit results.

Analysis/Action Plans: Data shows consistent high levels of compliance on this requirement. No corrective actions are required.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are	**Recommendation:** Determine what obstacles exist that prevent IRP teams from inviting families to conferences and develop a corrective

[1] Throughout this report, we will be using weighted means. Each table includes weighted mean for the previous review period (Aug-09 ~ Feb-10) under 'Mean-P' column wherever data is available and weighted mean for the current review period (Mar-10~ Aug-10) under Mean-C.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	active members of the treatment team;	action plan to overcome identified obstacles.

SEH Response: There was confusion in some teams as to the responsibility for inviting family and community support workers to the IRP meetings. It has been clarified that social workers are responsible for inviting family members (If the individual agrees) and community support workers to the IRP. Further, as of August, 2010, all but one of the social work vacancies has been filled, and recruitment continues for this vacancy.

Facility's Findings: Please note that the tool was modified effective July 2010 to more closely align with the specific requirements of the Settlement Agreement; therefore available data from the comparable indicator of the earlier tool is set out in a separate table. ***See Tab # 8, IRP Observation Audit tools***. Because of the changes in the tools, we are not able to compare progress since the last reporting period.

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C Data fields: Family Member invited?					45	17	**30**
%C Data fields: Community support worker invited					35	57	**47**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month)
* Data collected using different tool
See Tab # 9 for IRP Observation Audit Results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C 6a Invite family member	50	100	50	67			**67**
%C 6b Invite case manager	92	75	25	45			**59**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital.
* Data collected using different tool
See Tab # 9 for IRP Observation Audit Results

Analysis/Action Plans: Data show declining performance in inviting family members and community case workers since July, 2010. The Hospital is reviewing the IRP Observation Audit tool (Tab # 8) introduced in July, 2010 to ensure the instructions are clear in how to track this information and will make appropriate modifications if warranted. In

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		addition, social workers have been reminded that they are responsible for inviting family members and community case workers to IRP conferences and documenting same in the progress notes. Social work modified the guidelines for completion of the Social Work Initial Assessment form, the guidelines for completing the Social work update and the related audit tools to add an indicator to monitor documentation of whether the family and case manager is invited. These new instructions and tools will be effective October 1, 2010.
V.A.2.c	require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;	**Recommendations:** 1. Audit IRP conferences as per instructions found in Cell V.B.9 SEH Response: SEH is auditing IRP conferences through monthly observations by a core group of coaches/observer, targeted, as of June, 2010, to include two IRP conferences per unit per month. See ***Tab # 36 Audit Plan***. There are currently 13 units so 26 observations should be occurring each month. In July, 20 conferences were observed and 23 were observed in August. 2. Work with consultant to revise IRP training to include process for discipline-specific review of objectives/interventions and how to make timely changes. SEH Response: IRP training was revised and includes four modules - - engagement, discharge planning, development of focus areas, objectives and interventions, development of clinical formulation - - and coaching/mentoring. During the review period, there was significant training for all treatment teams on discipline specific review of objectives/interventions and how to make timely changes. Training included a specific module on focus areas, objectives and interventions, as well as extensive observation and coaching. See ***Tabs #1 IRP Training Summary Materials and Tab #2 IRP Consultation contract*** See V.A.3 for all IRP related training data. **Facility's Findings:** Please note that the tool was modified effective July 2010 to more closely align with the specific requirements of the Settlement Agreement. ***See Tab # 8, IRP Observation Audit tools***. Because of the changes in the tools, we are not able to compare progress since the last reporting period.

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #2. Each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatment					85	91	**88**

N = All IRPs scheduled in the review month
n = number audited per audit sample plan
* Tool not used, no data available
See Tab # 9 for full IRP Observation Audit Results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: Data shows high level of compliance with this requirement. Training that began in July and which is continuing should support continued high levels of compliance. IRP conference observations and discipline audits will continue.
V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Recommendation:** 1. Maintain current level of practice. SEH Response: Maintained current level of practice **Facility's Findings:**

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #3. The team functions in an interdisciplinary fashion					80	100	**91**

N = All IRPs scheduled in the review month
n = number audited
* Data not available as audits used different tool
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 9b Facilitator encouraged participation by all team members	89	100	100	100			**97**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital
* Data collected using different tool
Tab # 9 IRP Observation Audit results

Analysis/Action Plans: Data shows high rates of compliance. Continue IRP observation audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Recommendations:** 1. Ensure documentation of the psychiatrists' review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: The Hospital is implementing behavioral modalities through three stages - - an initial set of behavioral interventions developed by the ward psychologist with input from the treatment team, including the psychiatrist; behavioral guidelines when these are not as effective as expected, and finally, where needed a PBS plan. Under the process, the treatment team decides a behavioral intervention is necessary. They work with the unit psychologist and consult if necessary with the PBS team leader on an Initial IRP Behavioral Interventions (IIRPBI) plan. The team will then reconvene in 6-8 weeks (or sooner if behavior warrants) to evaluate the plan's effectiveness. If effective, they continue with the plan and modify it appropriately. If the IIRPBI is not successful, the treatment team refers the matter to the PBS team but continue to utilize and adjust the IIRPBI plan while the PBS team begins its assessment process. When behavioral guidelines or a PBS plan are needed and developed, the PBS team will develop the guideline or plan and PBS team leader meets with the treatment team, with the psychiatrist present, to review the plan and the psychiatrist will sign it. ***Acknowledgement of Receipt of Recommendations, Tab # 48***. The Hospital, using this structure, has a higher volume of IIRPBIs than guidelines or plans, as the IIRPBIs have generally been successful n most cases.

2. Ensure documentation in the psychiatric progress notes of an exchange of data between the psychiatrist and the psychologist for individuals receiving PBS interventions. This exchange must be utilized to distinguish learned behaviors from those that are targeted for pharmacological therapies and to update diagnosis and treatment, as clinically appropriate.

SEH Response: This is audited through the psychiatric update audit tool, indicator # 27. ***Tab # 18 Psychiatric Update Audit Tool and instructions.*** See related data below. In addition, as indicated below, most staff have completed PBS training; training will continue until all clinical staff are trained. Psychiatrists are participating in the development of Initial IRP Behavioral interventions, and PBS guidelines and Plans are reviewed with the team and the psychiatrist. By November 1st, a procedure for psychiatrist signoff will be implemented.

3. Ensure adequate and consistent training of direct care providers on the principles and practice of PBS.

SEH Response: PBS training has been done by the PBS team leader for all disciplines. ***Tab # 40 PBS Training curriculum and Training Data***. Data shows the following:

Data Source: PBS Records DB, 9/30/2010

Positive Behavior Support					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	6	5	5	83%	83%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	13	1	1	8%	8%/100%
Dietary	4	1	1	25%	25%/100%
Medical	11	10	10	91%	91%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nursing - Nurse Manager	18	18	18	100%	100%/100%
Nursing - RN	87	83	83	95%	95%/100%
Nursing - LPN	31	31	31	100%	100%/100%
Nursing - RA	203	195	191	96%	96%/98%
Psychiatry	67	50	39	75%	75%/78%
Psychology	29	29	29	100%	100%/100%
Rehabilitation	20	20	20	100%	100%/100%
Social Work	16	15	15	94%	94%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	10	5	4	50%	50%/80%
Total	**531**	**479**	**463**	**90%**	**90%/97%**

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

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

See Tab # 40 PBS Training curricula and data

In addition, a consultant is providing additional training and coaching for PBS team members. ***Tab # 89 PBS Consultation contract.***

4. Complete the formation of the PBS team.

SEH Response: The team now has a PBS team leader, two PBS specialists, and a data analyst. A half time PBS nurse is expected to be identified and assigned to the team within 30 days; the team leader does not believe a full time nurse is needed.

5. Standardize the format for IIRPBIs.

SEH Response: Completed. ***See Tab # 98 IIRPBI Format***

6. Provide specific instructions in policy for how the success or failure of an IIRPBI is to be documented in the medical record.

SEH Response: The IIRPBI format and instructions require criteria to be stated within the IIRPBI for determining the success of the IIRPBI. The operational instructions instruct the psychologist to document by his or her progress note whether the criteria have been met.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		7. Develop a process for monitoring IIRPBIs. SEH Response: Since May, 2010 the Hospital has been using the same audit tool for IIRPBIs as for other behavioral plans and guidelines. An alternative tool may be developed. **Facility's Findings:**

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 27 Does the psychiatric update include an appropriate plan that includes integration of behavioral and psychiatric interventions?	97	100	100	100	90	100	**84**	**97**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: The Hospital will continue to audit this through the psychiatric update. PBS training was recently completed for the psychiatrists, and therefore the Hospital anticipates that the training will lead to improved *quality* of performance on this requirement.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.	**Recommendation:** 1. Maintain current level of practice. SEH Response: Maintained current level of practice **Facility's Findings:**

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #4. The team identified someone to be responsible for the scheduling and coordination of necessary progress reviews					90	100	**95**

N = All IRPs scheduled in the review month
n = number audited
* Data collected using different tool

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 9 IRP Observation Audit results **Analysis/Action Plans:** Data show high performance. Continue to monitor through IRP observation audits.
V.A.3	provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;	**Recommendation:** 1. Continue work with new consultant. SEH Response: Work continues. Training included modules on engagement; developing clinical formulations; developing focus areas, objectives and interventions; discharge planning; and also includes team coaching. ***Tab # 2 (IRP Consultant contract***) 2. Develop and implement a training plan for all IRP teams. SEH Response: Led by the Chief of Staff, the Hospital developed and implemented a training plan for IRP development that includes four modules - - engagement; developing clinical formulations; developing and writing focus areas, objectives and interventions; discharge planning - - and team coaching. ***Tab # 2 IRP Consultant contract.*** In addition, each month, at least two IRPs per unit are observed, and an average of 2 hours of coaching through IRP observations is provided. Clinical chart audits have begun, (2 per unit) and the results are shared with clinical staff. The engagement module provides training on involving the individual to participate fully in both the process and content of treatment and provides techniques on specific ways to engage the individual in IRP planning and in implementing the IRPs as intended. The Clinical Formulation module is designed to assist the treatment team in developing good treatment options, based upon an analysis of key factors, that are more likely to lead to positive outcomes for the individual; Treatment teams also learn how the clinical formulation can be used to assist the individual in understanding his illness, his triggers and what maintains them. The module around focus statements, objectives and interventions teaches teams how to develop and write focus statements that document an assessed need in behavioral terms, objectives that are "learning" or "doing", linked to a focus of hospitalization and written in behavioral, observable, and measurable terms, and interventions that detail what staff will do to assist the individual to achieve his or her objective. The final module concerns discharge, and teaches staff to consider discharge planning to include the reasons for the hospitalization, and skills and supports needed to minimize the likelihood of rehospitalization once the individual is discharged. This module also teaches staff how to develop discharge criteria that are linked to the anticipated placement, address discharge barriers and develop a discharge plan for implementation when the individual leaves the hospital. ***See Tab #1 for IRP related training outlines.*** Training has occurred for all units. This included observation for most units by an outside consultant reviewing the process used in IRP conferences (all will be observed by the end of October), classroom training, and hands on training in writing clinical formulations and IRP plans. Coaching and mentoring continues. **Facility's Findings:** Substantial training was provided during this review period through the contract with the IRP consultant. Data show:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Data Source: Training DB, 9/29/2010

Foci, Objectives, and Interventions in Treatment Planning (IRP Module I)					
Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Clinical Administrator	12	12	12	100%	100%/100%
Medical	n/a	n/a	n/a	n/a	n/a
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	21	95%	95%/100%
Psychology	14	12	12	86%	86%/100%
Social Work	13	12	12	92%	92%/100%
Total	**69**	**65**	**65**	**94%**	**94%/100%**

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

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

Data Source: Training DB, 9/29/2010

Engagement Training – IRP Module II					
Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Clinical Administrator	12	12	12	100%	100%/100%
Medical	n/a	1	1	n/a	n/a / 100%
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	21	95%	95%/100%
Psychology	14	12	12	86%	86%/100%
Social Work	13	12	12	92%	92%/100%
Total	**69**	**66**	**66**	**94%**	**94%/100%**

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

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

Data Source: Training DB, 9/29/2010

Case Formulation (IRP Module III)					
Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Clinical Administrator	12	12	12	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Medical	n/a	n/a	n/a	n/a	n/a
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	21	95%	95%/100%
Psychology	14	12	11	86%	86%/92%
Social Work	13	12	12	92%	92%/100%
Total	**69**	**65**	**64**	**94%**	**94%/98%**

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

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

Data Source: Training DB, 9/29/2010

Discharge Planning Case Formulation (IRP Module IV)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator	12	10	10	83%	83%/100%
Medical	n/a	n/a	n/a	n/a	n/a
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	20	95%	95%/95%
Psychology	14	12	12	86%	86%/100%
Social Work	13	12	12	92%	92%/100%
Total	**69**	**63**	**62**	**91%**	**91%/98%**

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

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

Summary Coaching Hours to Treatment Teams (July – August 2010)		
1A - Allison House	90	180
1B - Barton House	105	85
1C - O'Malley House	135	60
1D - Dix House	120	120
1E - Haydon House	0	120
1F - Shields House	45	0
1G - Howard House	135	85
2A - Gorelick House	75	0

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2B - Nichols House	75	135
2C - Blackburn House	135	120
2D - Franz House	85	205
Annex A	150	0
Annex B	60	0
Total Number of Coaching Minutes	1210	1110
Total Number of Coaching Hours	**20.17**	**18.5**

See Tab # 1 IRP Training data and outlines

Analysis/Action Plans: Training is ongoing and will continue.

V.A.4

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

Recommendation:

1. Determine obstacles to Social Work attendance of at least 90% of IRP conferences and implement corrective action plan to achieve this benchmark.

SEH Response: All but one social work vacancy has been filled, and that position is in recruitment. (An offer was made to a candidate but ultimately the candidate declined the offer.) The unit serving civil admissions has two social workers, and the admissions units that serve forensic admissions each have one social worker. The Hospital objects to a compliance rate requirement of 90%

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. # Data fields Attendance data of core team members: Clinical Administrator					85	100	**93**
Psychiatrist					95	100	**98**
Social Worker					75	57	**65**
RN					85	91	**88**
Individual					95	96	**95**

N = All IRPs scheduled in the review month
n = number audited
* Data collected using different tool
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see table below) N = All IRP reviews scheduled in the review month n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital * Data collected using different tool ***Tab # 9 IRP Observation Audit results*** **Analysis/Action Plans:** Continue to monitor through audits. Social work has reduced its vacancies and this should assure the more consistent presence of a social worker at most IRPs. In addition, a second social work supervisor was hired and began work in mid August; her hiring should assist in supervising workers and assuring they prioritize attendance at the IRP conferences.
V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Recommendations:** 1. Continue auditing as per the instructions in Cell V.B.9. SEH Response: Audits are continuing. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See below. **Facility's Findings:**

	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C. # Attendance data of core team members: Clinical Administrator	100	100	100	92			**98**
Psychiatrist	100	100	100	92			**98**
Social Worker	79	100	0	89			**67**
RN	100	100	100	92			**98**
Individual	89	71	75	100			**84**

CLINICAL CHART AUDIT RESULTS							
	Mar	Apr	May	Jun	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S					12	13	**13**
%C. #1. The IRP was reviewed and revised as per IRP required schedule (at day 30, day 60 and every 60 days thereafter)					95	79	**86**

N = Total number of IRP reviews scheduled
n = number audited
Targeted sample size is 26 reviews per month (2 per unit)
Tab # 3 Clinical chart audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C #1a Scheduled per policy	85	71	100	77			**83**
%C # 1b Held as scheduled	89	71	100	77			**90**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital.
* Data collected using different tool
Tab # 9 IRP Observation Audit results

Analysis/Action Plans: Data shows relatively high rates of compliance. However, there appears to be a drop in the month of August. This will continue to be monitored through the clinical chart audits to identify any patterns, and appropriate steps will be taken if compliance remains at 79%. Further, a management report is in development so that once completed, this data will be available on a weekly basis to managers. The report should be completed by the site visit.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
B	**Integrated Treatment Teams**	
	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:	
V.B.1	where possible, individuals have input into their treatment plans;	**Recommendations**: 1. Provide specific information to indicate that each IRP team has a dedicated mentor and that mentors provide consistent feedback to the teams and to the facility management regarding the IRP process. Ensure that the self-report specifies the number of mentors, their disciplines and the process of mentoring the teams. SEH Response: Each team has been provided mentoring during the review period. Mentors include consultants pursuant to the IRP consultation contract, and include Nirbhay Singh, Ph.D; Ramasamy Manikam, Ph.D; Angela Adkins,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Ashvind Singh, Ph.D, Amy Van Wysnsberghe, Ph.D, Chandni Patel, Behavioral specialist, Rachel Myers, Ph.D, RN, Judy Singh, Ph.D. Dr. Manikam, with the internal Hospital mentors, has observed and provided coaching to all but one treatment team. The consultants have provided intensive training around all aspects of treatment planning, and have provided hours of assistance in writing focus statements, objectives and interventions for IRPs. In addition, the Hospital is using internal mentors: Beth Gouse, Ph.D; Haylee Bernstein, LICSW; Nicole Rafanello, Ph.D; Robert Benedetti, Ph.D; Christine Arena, MSW; Yolanda Williams, professional counselor ; and Robert Morin, Psy.D. The mentors are observing at least two IRP conferences each month per unit, and provide feedback to the treatment teams in accordance with guidelines developed jointly by the Chief of Staff and the Performance Improvement Department. ***Tab #1 Feedback guidelines; IRP meetings, Phase II Icebreakers***. The guidelines provide areas for mentors to focus on during and after IRP observations and clinical chart audits. In addition, mentors are working with their assigned teams on how to engage individuals during Phase II. Mentors are guided by the IRP-Phase II icebreakers guidelines. Janet Maher, Attorney and June Walden-Yeager, program analyst, also act as auditors of the IRP process observations. All observers/mentors have received the full complement of IRP training including developing foci, objectives and interventions, engagement, developing clinical formulations and discharge planning.

TREATMENT TEAM	CONSULTANT MENTORS/INTERNAL MENTOR/IRP OBSERVER
1A	Manikem/Benedetti & Bernstein/Bernstein
1B	Manikem & Myers/Arena/Arena
1C	Manikem & Adkins/Gouse/Maher
1D	Manikem & Van Wysnsberghe /Arena/Arena
1E	Manikem & Van Wysnsberghe /Rafanello/Maher
1F	Manikem & A. Singh/Morin/Morin
1G	Manikem & A. Singh/Rafanello/Walden-Yeager
2A	Manikem & N. Singh/Rafanello/Rafanello
2B	Manikem & N. Singh/Benedetti & Bernstein/Bernstein
2C	Manikem & Adkins/Benedetti & Gouse/Gouse
2D	Manikem & Adkins/Gouse/Walden-Yeager
ANNEX A	Manikem & N. Singh/Williams/Williams
ANNEX B	Manikem & N. Singh/Williams/Williams

See V.A.3 for training data.

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

SEH Response: Mentors reinforce training principles during coaching sessions, and provide ongoing support to teams as needed. IRP data is shared with mentors as well as with the management of Clinical Operations, to whom clinical administrators report.

3. Ensure that the self-report contains a summary outline of the engagement training provided during the review period. Specify the participating disciplines in the training and the training process (didactic, observation,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		feedback to teams) and content.

SEH Response: Led by the Chief of Staff, the Hospital developed and implemented a training plan for IRP development that includes four modules - - engagement; developing clinical formulations; developing and writing focus areas, objectives and interventions; discharge planning - - and team coaching. ***Tab # 2 IRP Consultant contract.*** In addition, each month, at least two IRPs per unit are observed, and an average of 2 hours of coaching through IRP observations is provided. Clinical chart audits have begun, (2 per unit) and the results are shared with clinical staff. The engagement module provides training on involving the individual to participate fully in both the process and content of treatment and provides techniques on specific ways to engage the individual in IRP planning and in implementing the IRPs as intended. The Clinical Formulation module is designed to assist the treatment team in developing good treatment options, based upon an analysis of key factors, that are more likely to lead to positive outcomes for the individual; treatment teams also learn how the clinical formulation can be used to assist the individual in understanding his illness, his triggers and what maintains them. The module around focus statements, objectives and interventions teaches teams how to develop and write focus statements that documents an assessed need in behavioral terms, objectives that are learning or doing, linked to a focus of hospitalization and written in behavioral, observable, and measurable terms and interventions that detail what staff will do to assist the individual to achieve his or her objective. The final module concerns discharge, and teaches staff to consider in discharge planning the reasons for the hospitalization, skills and supports needed to minimize the likelihood of rehospitalization once the individual is discharged. This module also teaches staff how to develop discharge criteria that are linked to the anticipated placement, address discharge barriers and develop a discharge plan to implementation when the individual leaves the hospital. ***See Tab #1 for IRP related training outlines.*** Training has occurred for all units. This included observation for most units by an outside consultant reviewing the process used in IRP conferences (all will be observed by the end of October), classroom training, and hands on training in writing clinical formulations and IRP plans. Coaching and mentoring continues.

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

SEH Response:

Data Source: Training DB, 9/29/2010

Engagement Training – IRP Module II					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator	12	12	12	100%	100%/100%
Medical	n/a	1	1	n/a	n/a / 100%
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	21	95%	95%/100%
Psychology	14	12	12	86%	86%/100%
Social Work	13	12	12	92%	92%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Total	69	66	66	94%	94%/100%

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

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

5. Monitor the individual's attendance and participation in the IRP conferences using process observation data based on at least 20% sample during the review period.

SEH Response: SEH is monitoring IRP conferences through observation and resulting data. Its goal is to monitor two IRP conferences per unit per month, and not a 20% sample. ***Tab # 36 (Audit Plan)***. See data below.

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

SEH Response: See data below.

7. Reorganize the IRP manual to ensure conceptual flow of the document and to include more accurate examples of foci, objectives, interventions and individualized discharge criteria.

SEH Response: IRP Manual has been reorganized. ***See separate IRP manual to be available during the site visit***.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. Data Fields: Individual attends the IRP conference					95	96	**95**

N = IRPs scheduled in the review month

n = number audited

* Data collected using different tool

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see below)

%C. Data Fields: Individual attends the IRP conference	89	71	75	100			**84**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital
* Data collected using different tool
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #5. Individuals have input into their treatment plans					95	80	**90**

N = IRPS scheduled in the review month
n = number audited
* Data collected using different tool
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 7d Individual had input into development of objectives	94	80	66	69			**77**
#7e Individual had input into development of interventions.	94	80	100	91			**91**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital
* Data collected using different tool
Tab # 9 IRP Observation Audit results

Analysis/Action Plans: Data shows somewhat erratic performance on this requirement. Given that the teams were trained in August and September around engagement of the individual and development of focus statements, objectives and interventions, the Hospital will monitor this over the next several months through IRP observations to determine if additional corrective steps are needed.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.B.2	treatment planning provides timely attention to the needs of each individual, in	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	particular:	
V.B.2.a	initial assessments are completed within 24 hours of admission;	**Recommendations:** 1. Monitor the timeliness of the initial disciplinary assessments during this review period. SEH Response: Timeliness of initial assessments is being monitored through the clinical chart audit for psychiatry and through discipline specific audits. Data is presented below. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. 3. Same as in VI.A.1 to VI.A.5. SEH Response: See VI.A.1 to VI.A.5 **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #2. Initial [psychiatric] assessments are completed within 24 hrs of admission					100	100	**100**

N = Total number of IRP reviews scheduled
n = number audited
* Data not available as data was collected using different tool
Tab # 3 Clinical chart audit results

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # Data fields -CIPA completed within 24 hours of admission	100	100	100	100	100	100	**95**	**100**

N = Admissions during the month
n = number audited- target is 20% sample per month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

* Data not available for subsections in prior review

Tab # 16 CIPA audit results

COMPREHENSIVE INITIAL NURSING ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	5	7	8	5	6	**9**	**7**
%S	24	12	21	25	11	15	**26**	**17**
%C. #2. Initial nursing assessments are completed within 8 hrs of admission	100	100	71	88	20	33	**94**	**72**

N = Number of admissions during the month

n = number audited

Tab # 4 (CINA audit results)

INITIAL PSYCHOLOGICAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	46	39	**37**	**38**
n	7	5	2	4	5	4	**7**	**5**
%S	21	12	6	13	11	10	**20**	**12**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	86	60	0	50	33	25	**50**	**50**
%C # 1 (Part B) If Part B completed within 12 days of admission?	57	60	100	75	67	50	**59**	**64**

N = Number of admission

n = number audited-target is 20% sample (Audit sample plan)

Tab # 21, IPA audit results

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	7	9	6	6	9	8	**8**	**8**
%S	21	22	18	19	20	21	**21**	**20**
%C # Completed within 5 days of admission	100	44	33	50	67	63	**85**	**60**

N= Number of admissions

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

Tab # 33 Social work audit results

Analysis/Action Plans: The data shows that psychiatric initial assessments are being completed in most cases within the first 24 hours and that other disciplinary assessments were also completed within the required timeframes. For

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		many initial assessments, however, the trend seems to show a decline in performance once the assessment went into Avatar, but the Hospital has reviewed the data and generally has concluded that the decline in timeliness reflects that initial assessments by many disciplines were saved in “draft” status, rather than “final” within the Avatar system and not because the assessments are later than in the prior review period. (Audit tools/instructions advise the auditor to look for final assessments, not draft assessments.) After reviewing the assessments and after speaking with staff, the Hospital learned that “draft” status was used in many cases because the individual was not cooperative and thus the assessment could not be fully completed or because the assessor was not aware that he or she had saved the assessment in “draft” status. To address this issue, reports are now available to managers to review those assessments that remain in draft status. Further, audit instructions are being revised so that assessments that remain in draft status would be rated as timely ***if*** the assessment specifically reflects that the reason the assessments could not be completed was due to the unavailability/uncooperativeness of the individual in care.
V.B.2.b	initial treatment plans are completed within 5 days of admission; and	**Recommendations**: 1. Monitor the timeliness of the initial and comprehensive IRP based on at least 20% sample during this review period. SEH Response: As indicated in the audit sample plan, the Hospital plans to monitor the timeliness of the initial and comprehensive IRPs by reviewing two per admissions unit, not a 20% sample. A management report is being developed to track the timeliness of the IIRP. The timeliness of the IRP is monitored through the clinical chart audit, see below. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average mean. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. 3. Present a summary of the aggregated monitoring data in the progress report of both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences, with weighted average compliance for the review period. SEH Response: See below. **Facility’s Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C. #1. The IRP was reviewed and revised as per IRP required schedule (at day 30, day 60 and every 60 days thereafter) | | | | | 95 | 79 | **86** %C. #3. The Comprehensive IRP was developed on the 7th ± 3 calendar days from the day of admission | | | | | 50 | 100 | **83** N = Total number of IRP reviews scheduled n = number audited ***Tab # 3 Clinical chart audit data results*** **Analysis/Action Plans:** The Clinical chart audit shows high levels of performance with a mean of 86 percent, but with only two months data, and given the month-to-month discrepancies, it is too early to draw definitive conclusions. This will continue to be monitored through the clinical chart audit to identify any trends.
V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Recommendations:** 1. Monitor the treatment plan reviews using the process observation tool based on at least 20% sample during the next review period. SEH Response: Timeliness of IRP updates is being monitored through the clinical chart audit and just developed management reports. Per the audit sample plan, the audits are not completed on a 20% sample, but rather at a target rate of 2 per unit per month. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See below. **Facility's Findings:** See V.A.5 **Analysis/Action Plans:** See V.A.5
V.B.3	individuals are informed of the purposes and major side effects of medication;	**Recommendations:** 1. Continue the process of Consumer Satisfaction Surveys and provide a summary of results. SEH Response: The consumer satisfaction survey was completed and results were shared at an all staff meeting and were published on the Hospital intranet. ***Tab #50, Consumer Satisfaction Survey results***. The following data are from the Consumer satisfaction survey:

INDICATOR	AGREED OR NEUTRAL	DISAGREED
Doctor discussed what medication was for	70%	30%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Given information about side effects 62% 38% Given choice of treatment options 74% 26% 2. Provide information regarding medication education groups provided during the interval, including number of groups scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education. SEH Response: The TLCs continue to evolve, and revised programming was implemented effective September 20, 2010. The new programming has four key components. These include more comprehensive cognitive programming, which includes an online cognitive skill building program for those with mild cognitive impairments, a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. In addition, there will be far more dosing of groups, which will allow for material to be presented in a more in depth manner. There will also be TAMAR groups (trauma informed care) and more basic social skills/living with people groups that will include videotaping and role playing. Schedules are built based upon the individual's diagnosis, level of functioning, IRP group guide and the needs and choices of the individual. Medication groups include "Understanding Your Illness and Treatment" (psychiatry) (184), "What's Up Doc?" (psychiatry) (20); "Mental Health Teaching" (psychiatry) (48); "Medication Education" (nursing) (190) and "Understanding Your Illness and Treatment" (nursing) (20). ***See Tab # 69 for TLC Group Catalogue; Tab #163 for Cognitive group and medication group capacity data.*** **Facility's Findings:** No additional data is available at this time. However, the new psychiatric update that is expected to be available in Avatar in early October, 2010, will include a prompt for information concerning medication education around side effects, and it will be added to the revised psychiatric update audit tool developed to correspond to the revised form once it is in Avatar.
V.B.4	each treatment plan specifically identifies the therapeutic means *by* which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;	**Recommendations:** 1. Same as in V.D.1, V.D.2 and V.D.3. SEH Response: See V.D.1, V.D.2 and V.D.3 2. Same as in V.D.4 and V.D.5. SEH Response: See V.D.4 and V.D.5 **Facility's Findings:** **CLINICAL CHART AUDIT RESULTS**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(continued)

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #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					89	100	**95**

N = All IRP reviews scheduled in the review month
n = number audited
See Tab # 3 Clinical chart audit results

Analysis/Action Plans: Data from the initial round of clinical chart audits show high rates of compliance but is only based upon two months of audits, and thus it is too early to determine a trend. It should be noted that most of the audits were completed prior to the intensive training provided to treatment teams and auditors about development of the clinical formulation and focus statements, objectives and interventions which may affect the reliability of this data. However, as audits now will occur each month, this will continue to be monitored.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	see below

Recommendations:
1. Same as in XII.E.2.

SEH Response: See XII.E.2

2. Provide documentation of the Medical Director's review of high risks as outlined in the facility's revised process.

SEH Response: ***See Tab #56, Risk Indicator Event System: Tracking Reports for High Risk Indicators.*** The Hospital's Risk Manager is monitoring unusual incident reports and identifying those cases where an individual in care is involved in three or more incidents of any type within a 30 day period. This system captures those incidents including those involving repeated use of restraint or seclusion. Under the system, the Risk Manager notifies the following individuals when the three or more trigger is reached: Clinical administrators, psychiatrists, nurse manager, and the Director of Psychiatry, Medical Director, Director of Psychology, PBS Team leader, Chief Nurse Executive and Assistant Directors of Nursing, and the Director and Deputy Directors of Clinical Operations. The Director of Psychiatric Services reviews the cases and writes a progress note in Avatar with recommendations. That information is then provided to the Risk Manager, who updates a spread sheet with the Director of Psychiatric Services' recommendations and the information is returned to the original recipients.

Facility's Findings:

	Mar	Apr	May	Jun	Jul	Aug
Number of individuals with 3 or more UIs in 30 day period	6	6	6	n/a	11	16
Documentation by Director of Psychiatric Services	6	6	3	n/a	10	10*

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n/a = not available * Not all available as of the writing of this report, due to timing of report. Should be available at site visit ***Tab # 56 Risk Indicator Event System: Tracking Reports for High Risk Indicators***
V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	**Recommendation:** 1. Maintain current level of practice. SEH Response: Current practice maintained.
V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Recommendations:** 1. Same as in V.E.3, V.E.4 and V.E.5. SEH Response: See V.E.3, V.E.4 and V.E.5 2. Same as in VIII. SEH Response: See VIII. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #5. Treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment,					65	63	**64**

N = All IRP reviews scheduled in the review month
n = number audited
Tab # 3, Clinical chart audit results

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 12 Is the subsection titled Medication Response accurately completed?	97	100	100	98	100	86	**97**	**98**
%C. #13 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	94	100	100	100	100	100	**93**	**99**

N = Census as of end of month, less month's admissions
n = number audited
Tab # 11 Psychiatric Update audit results

Analysis/Action Plans: Psychiatric Update audits show high levels of compliance. These audits will continue, and no other actions required for psychiatrists. However, the clinical chart audit's two months of data shows improvement is needed in ensuring plans are appropriately modified to reflect the individual's progress or lack thereof. The Hospital has provided extensive training and coaching to teams beginning in late July, 2010, (See V.A.3 and V.B.1); it is expected that the training should result in improved performance on this indicator. The trends will be monitored through the clinical chart audits.

V.B.8

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

Recommendations:

1. Monitor this requirement addressing both quality and accuracy of information based on at least 20% sample during the next review period.

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

2. Ensure the medical transfers address both emergency and non-emergency transfers.

SEH Response: The requirement of this cell only relates to inter-unit transfers, not transfers to medical facilities, so this recommendation will not be addressed.

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

SEH Response: See data below.

Facility's Findings:

INTER-UNIT TRANSFER AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P***	**Mean-C**
N	13	7	6	11	20	11		**11**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	7	5	6	4	5	5		5
%S	54	71	100	36	25	45		**47**
%C. #2.I.7.a Psychiatric transfer note present	71	60	33	25	20	25		**42**
%C #2.I.8.a Psychiatric acceptance note present	100	80	17	75	80	75		**71**
%C #2.I.7.b SW transfer note present	43	20	0	0	20	25		**19**
%C #2.I.8.b SW acceptance note present	71	20	0	0	0	0		**19**
%C #2.I.7.c Nursing transfer note present	57	100	17	75	100	50		**65**
%C #2.I.8.c Nursing acceptance note present	86	60	83	75	100	50		**77**
%C #2.I.7.d GMO transfer note present	57	40	67	50	60	75		**58**
%C #2.I.8.d GMO acceptance note present	43	60	33	100	40	50		**52**
%C #2.I.12.b Rationale for transfer	71	60	50	100	80	100		**66**
%C #2.I.12.c Current behavior, tx and response	71	40	50	100	60	75		**65**
%C #2.I.12.e Anticipated benefit of tx	71	60	50	100	60	100		**71**
%C #2.I.12.g Brief course of tx	71	60	50	75	60	75		**65**
%C # 2.I.12.h Risk factors	71	60	50	50	60	100		**68**
%C #2.I.12.i Current dx	71	60	50	100	80	100		**74**
%C #2.I.12.j Discharge barriers	71	40	50	100	80	100	*	**71**
%C #2.I.12.k Recommended plan of care	57	40	50	50	80	100	*	**61**
%C 2.II.2 IRP completed within 7 days of transfer	57	60	50	50	60	75	*	**58**

N= number of inter-unit transfers in the month
n= population monitored
* Not available
Tab # 61 Transfer Audit results, March through August

Analysis/Action Plans: The above data shows that the Hospital's performance in completing its transfer notes or in fully documenting information about the individual in making or receiving the transfer is declining, and further shows that it is meeting the standard around treatment planning only half the time. Based upon this data, the Director of Clinical Operations designated an individual to review transfers immediately after they occur to ensure the appropriate documentation and treatment planning are occurring.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and	**Recommendation:** 1. Present specific summary information regarding any changes/revisions in the auditing tools and corresponding sample sizes that were presented in the current Audit Plan. SEH Response: The Hospital is currently monitoring through a variety of tools. Audits continuing or beginning during this review period include IRP observation audits, clinical chart audits, therapeutic progress note audits, CIPA audits, Psychiatric Update audits, TD audits, IPA (Psychology) audits, Psychology Risk Assessment audits, Psychology Evaluation audits, PBS audits, Initial Rehabilitation Services Audits, SWIA audits, SW update audits, Medication Monitoring Audits (Pharmacy), CINA audits, Nursing Update audits, Seclusion and Restraint audits, Discharge record review audits,

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	Transfer audits, Substance Abuse Intervention audits, and the Post discharge services audits completed by MHA. Tools were developed for an Emergency Involuntary Medication audit and for audits of groups facilitators, both of which will begin in September. Below is a summary table.

AUDIT RESULTS	AUDIT STATUS	CHANGES IN AUDIT RESULTS SINCE LAST REVIEW
IRP observation audits	Ongoing throughout review period. Target is 2 per unit per month	New tool introduced in July, 2010 to more closely align with requirements of settlement agreement. IRP data are presented in two charts given differences in indicators.
Clinical chart audit	Began for IRPs completed in July, 2010. No data for March through June, 2010. Target is 2 per unit per month	New tool introduced in July, 2010 to more closely align with requirements of settlement agreement.
Therapeutic progress note audit	Ongoing for May through August, 2010 for psychology, psychiatry (2 months), social work (3 months) and rehabilitation. None for nursing. Target is 1 note per group leader and individual therapist per month.	No change in tool at this time. Tool was slightly modified in September 2010 to clarify instructions but indicators are the same. Does not affect audits during this review period.
CIPA audit	Ongoing for March through August, 2010. Target is 20%.	Tool changed to track each subsection of mental status examination section (Indicator #17) and risk assessment section (indicator #18) per DOJ request.
Psychiatric Update audit tool	Ongoing for March through August, 2010. Target is 2 reviews per unit psychiatrist	Tool changed to track each subsection of mental status examination section (Indicator #5); new indicator 14a added (does dx reflect current clinical data) per DOJ request. New tool will be required once psychiatric update is in Avatar. Does not affect this review period.
Psychiatry TD audit tool	Ongoing for March through August, 2010. Target is 6 per month	No change to tool
Psychology IPA audits	Ongoing for March through August, 2010. Target is 20%.	No change to tool
Psychology Risk Assessment	Ongoing for March through August, 2010. Target is 1 per psychologist who completes them	No change to tool. Tool however, is being revised beginning for Sept, 2010 audits.
Psychology Evaluation	Ongoing for March through August, 2010. Target is 1 per psychologist who completes them	No change to tool. Tool however is being revised beginning for Sept, 2010 audits

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		PBS audit tool	May 2010 through August, 2010. Target is 100% of plans and guidelines.	New tool created to more closely align with Settlement Agreement. Tool may be modified slightly for IIRPBIs for next review period.
		Initial Rehabilitation Assessment audit tool	Ongoing for March through August, 2010. Target is 20%.	No change in tool. Small changes in tool and instructions are being beginning with September 2010 audits. Does not affect this review period.
		SWIA audit tool	Ongoing for March through August, 2010. Target is 20%.	No change in tool. Small changes in tool and instructions are being implemented beginning with September 2010 audits to include tracking of whether family was invited to IRP conference. Does not affect this review period
		SW Update audit tool	Ongoing for March through August, 2010. Target is 1 per social worker	No change in tool. Small changes in tool and instructions are being implemented with September 2010 audits to include tracking of whether family was invited to IRP conference. Does not affect this review period
		Medication Monitoring audits (Pharmacy)	Ongoing for March through August, 2010. Target is to review 50% of the inpatient population during each 6 months	No change in tool
		Emergency Involuntary medication audits	Target is 20%. No audits completed during review period	Tool created. Not yet used.
		CINA audits	Ongoing for March through August, 2010. Target is 20%.	No change to tool
		Nursing Update audits	Ongoing for March through August, 2010. Target is 4 per unit.	New tool was created.
		Seclusion and restraint audit	Target is 50% of cases	Tool was modified to reflect policy changes or to add missing indicators. Section 1.1b (updated to reflect policy); 1.2c; 2.1a (clarifying language added); 2.1 (sensory based moved from moderate to low level intervention); 2.2a (clarifying language added); 2.2b (added offer of medication); 3.1 b and c added to clarify questions and better track policy; 3.2 b added to clarify face to face assessment by physician; 3.2d (duration of r/s order included); 3.4 amended to add additional questions around nursing documentation; 4.1 (revised question around use for staff convenience to clarify it)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT		
		Discharge record audit tool	Ongoing since March. Target is 10%	New tool used beginning in April 2010. Data from March 2010 using old tool will not be presented as it tracks wholly different indicators.
		Inter-unit transfer audit tool	Ongoing since March. Target is 20%	No change in tool during this review period.
		Group facilitator observation audit tool	No audits during review period. Goal each 1observation per group leader each quarter	New tool.
		DMH post discharge audits	Monthly	Tool modified beginning for September audits to include whether DMH received discharge plan of care.
V.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:			
V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Recommendations:** 1. Ensure that IRP Manual provides sufficient instruction, with adequate examples, regarding the IRP team's review of the social skills/functional status. SEH response: This recommendation is not aligned with the requirements of this cell. 2. Develop and provide a training module for the IRP team core members regarding the Interdisciplinary Case Formulation. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions. SEH response: The revised IRP Manual contains specific instructions for developing adequate case formulations. The manual provides the basis for all training. ***See IRP Manual*** 3. Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content. SEH Response: See V.A.3 and V.B.1 for training information and data. ***See Tab # 1 for IRP training materials and data.*** 4. Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.		

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

5. Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.

SEH Response: Completed. ***See Tab # 3 Clinical chart audit tool/instructions and results***

6. Monitor this requirement using the Clinical Chart Audit tool based on at least 20% sample during the review period.

SEH Response: This requirement is being monitored using the Clinical Chart Audit, with the sample size as determined in V.B.9. ***See Tab# 3 Clinical chart audit tool/instructions and results***

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

Facility's Findings:

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #6. The clinical formulation should be derived from analyses of the information gathered including diagnosis and differential diagnosis					67	75	**71**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
See Tab# 3 Clinical chart results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (training begun in August 2010) as well as the development of focus areas, objectives and interventions (training begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included a didactic portion as well as hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised clinical formulation will not be used however, until changes can be made in Avatar which is expected to occur in late September or early October 2010. Until then, the current format will be used.
V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Recommendations**: 1. Same as above. SEH Response: Same as above. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #7. The clinical formulation includes a review of clinical history; predisposing, precipitating and perpetuating factors; present status and previous treatment history					61	39	**49**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
See Tab# 3 Clinical chart audit tool/instructions and results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (begun in August 2010) as well as the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic and hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.

Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised clinical formulation will

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		not be used however, until changes can be made in Avatar, which is expected to occur in late September or early October. Until then, the current format will be used.
V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	**Recommendations**: 1. Same as above. SEH Response: Same as above **Facility's Findings:** (see Psychiatric Update Audit Results table below) N = Last day monthly census less month's admissions n = number audited-target is 2 per unit psychiatrist (Audit sample plan) ***Tab # 11, Psychiatric Update audit results*** **Analysis/Action Plans:** The Hospital's audit of psychiatric updates shows high performance on this requirement and no additional steps are required. The Hospital will continue to audit the psychiatric update.
V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Recommendations**: 1. Same as above. SEH Response: See above. **Facility's Findings:** (see Clinical Chart Audit Results table below) N = All IRP reviews scheduled in the review month

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 23 Does the psychopharmacological plan of care reflect the diagnoses, mental status assessment, and individual's response to treatment?	100	83	100	100	100	86	**94**	**99**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #8. The clinical formulation considers biochemical and psychosocial factors as clinically appropriate					94	79	**85**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n = number audited * Data not available ** Sample size 2 per unit (26) ***See Tab # 3 Clinical chart results*** **Analysis/Action Plans:** The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (begun in August 2010) as well as the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic as well as hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised clinical formulation will not be used however, until changes can be made in Avatar. Until then, the current format will be used.
V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	**Recommendations**: 1. Same as above. SEH Response: Same as above **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #9. The clinical formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions					84	67	**74**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
See Tab # 3 Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (begun in August 2010) as well as the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic and hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised form will not be used however, until changes can be made in Avatar, anticipated for the end of September or early October. Until then, the current format will be used.
V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Recommendations**: 1. Same as above. SEH Response: Same as above **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #10. The clinical formulation enables the interdisciplinary team to reach determinations about each individual's treatment needs					45	30	**37**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
See Tab # 3 Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (begun in August 2010) as well as the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic and hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		and may identify additional actions during the upcoming review period if indicated. Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised form will not be used however, until changes can be made in Avatar. Until then, the current format will be used.
V.C.7	make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.	**Recommendations**: 1. Same as above. SEH Response: Same as above **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #11. The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge, whenever possible					50	54	**52**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
See Tab# 3 Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on preparing the clinical formulation (begun in August 2010) as well as the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic and hands on assistance in developing clinical formulations and IRPs. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the clinical formulation is being modified to reflect the new IRP manual. The revised form will not be used however, until changes can be made in Avatar. Until then, the current format will be used.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.D.	By 24 months from the Effective Date hereof, SEH shall establish policies and/or	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	protocols 'to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	
V.D.1	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on, the individual's strengths and address the individual's identified needs;	**Recommendations:** 1. Revise the IRP Manual to ensure the following: a) The IRP teams adequately address the individuals' functional/social skills needs. b) The focus statements clearly delineate the individuals' needs but are not confused with objectives. c) The objectives adequately and consistently utilize learning outcomes and are attainable and measurable and/or behavioral. d) The interventions clearly specify the name of the provider, the frequency of the intervention and what staff will do to assist the individual in achieving objectives. e) There is a mechanism to document the individual's progress in Mall interventions and link these interventions to the IRP objectives. f) The strengths are linked to interventions. g) The foci, objectives and interventions are modified, in a timely and appropriate manner, in response to the changing needs of the individuals and h) Interventions are developed and updated to overcome lack of individuals' adherence to the IRP. SEH response: The IRP Manual has been revised to include these recommendations. ***See IRP Manual*** 2. Provide training to IRP core members focused on the development of Foci, Objectives and Interventions. The training should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions. SEH response: This recommendation is not aligned with the requirements of this cell. However, see V.A.3 and V.B.1 for summary training information and data. ***See Tab #1 IRP training outlines and data*** 3. Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content. SEH response: This recommendation is not aligned with the requirements of this cell. However, see V.A.3 and V.B.1 for summary training information and data. ***See Tab #1 IRP training outlines and data*** 4. Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions. SEH response: This recommendation is not aligned with the requirements of this cell. However, see V.A.3 and V.B.1 for summary training information and data. ***See Tab #1 IRP training outlines and data*** 5. Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least 20% sample

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		during the review period. SEH response: A Clinical Chart Audit was developed and implemented effective July, 2010. The sample is based on the requirements delineated in V.B.9. See data below. 6. Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates and weighted average compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. 7. Ensure that the self-report contains a summary outline of the following: a) Number and types of Cognitive remediation interventions that are currently provided and plans to increase these interventions and b) Specific information regarding the assignment of Mall groups to individuals based on initial cognitive screening of the individuals. SEH Response: The TLCs continue to evolve, and revised programming was implemented effective September 20, 2010. The new programming has four key components. These include more comprehensive cognitive programming, which includes an online cognitive skill building program for those with mild cognitive impairments, a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for those with mental retardation or dementia. In addition, there will be far more dosing of groups, which will allow for material to be presented in a more in depth manner. There will also be TAMAR groups and more basic social skills/living with people groups that will include videotaping and role playing. Schedules are built based upon the individual's diagnosis, level of functioning, IRP group guide and the needs and choices of the individual. ***See Tab # 163 Cognitive Groups Capacity comparison.*** Overall, the capacity has increased from 79 group sessions to 130 group sessions, with sessions per week increasing from 109 to 254 and total patient capacity from 557 to 1004. 8. Finalize and implement the Emergency Medical Response Policy #116.1-09. SEH Response: This recommendation is not aligned with the requirements of this cell. 9. Provide information regarding any systemic reviews by the facility of the code blue emergencies and drill emergencies, any performance improvement issues that were identified and corrective actions that were initiated during these reviews. SEH Response: This recommendation is not aligned with the requirements of this cell.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

10. Finalize and implement policy #209-1, General Medical Services.

SEH Response: This recommendation is not aligned with the requirements of this cell.

11. Finalize and implement policy #208-1, Seizure Management.

SEH Response This recommendation is not aligned with the requirements of this cell.

12. Finalize and implement policy #111.2-08, Transfers of Individuals in Care and address/improve the format of documentation of the assessment of individuals upon their return transfer from outside facilities.

SEH Response This recommendation is not aligned with the requirements of this cell.

13. Ensure adequate mechanisms regarding the following:
    a) Timely availability of Discharge Assessments from outside facilities;
    b) Communications of needed data to consultants;
    c) Timely review and filing of consultation and laboratory reports; and
    d) Follow-up on consultant's recommendations.

SEH Response: This recommendation is not aligned with the requirements of this cell.

Facility's Findings:

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #12. The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs					65	71	**68**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
Tab # 3, Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		week of September 13, 2010 and included didactic and hands on assistance in developing and writing goals and objectives. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the Hospital modified the format of the IRP effective mid September, 2010. This is also expected to improve the quality of the goals and objectives.
V.D.2	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	**Recommendations:** 1. Same as above. SEH Response: Same as above. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #13. The goals/objectives address treatment (e.g., for a disease or disorder), and rehabilitation (e.g., skills/supports and quality of life activities)					70	88	**80**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
Tab # 3, Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included hands on assistance in developing and writing goals and objectives. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the Hospital modified the format of the IRP effective mid September, 2010. This is also expected to improve the quality of the goals and objectives.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.D.3	write the objectives in behavioral and	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	measurable terms;	1. Same as above. SEH Response: Same as above **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #14. The IRP includes objectives written in behavioral and measurable terms					55	67	**61**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
Tab # 3, Clinical chart audit results

Analysis/Action Plans: The data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included hands on assistance in developing and writing objectives. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the Hospital modified the format of the IRP effective mid September, 2010. This is also expected to improve the quality of the goals and objectives.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Recommendations:** 1. Same as above. SEH Response: Same as above. 2. Provide additional data using the therapeutic progress notes self-audit based on least 20% sample during the review period. SEH Response: The Hospital's target sample is to review one note per group leader per month. 3. Ensure that the self-report includes an aggregated monitoring data regarding the therapeutic monthly progress

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		notes, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted averages of %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. 4. Determine the barriers currently existing to proper and timely completion of Therapeutic Mall Progress Notes. SEH Response: The Hospital has reviewed the issue of staff failure to complete the monthly therapeutic progress notes and has found that practice around completion is improving for most disciplines, although nursing continues to lag behind. Several barriers were identified and addressed. First, on-line training and a tip sheet on completing the therapeutic progress note is now available, and 224 nursing staff have completed the training (other disciplines received the training previously). This provided additional guidance to staff in how to complete the note. Second, the changes to the TLCs effective in mid September, 2010 are also expected to improve the completion of notes. By dosing of many of the groups, staff will have fewer notes to write each month. In addition, nursing staff are being given time during the TLC hours when they do not have groups or supervision and thus will be able to complete their notes during mall hours. Finally, the therapeutic progress note audits will continue, and trends among disciplines or staff will be identified and addressed - - in the past, prior to the audits, staff were able to miss completion of notes as there was no systemic way to determine if notes were being entered. 5. Improve Therapeutic Mall Progress Note template to prompt specifically for the name of the group. SEH Response: As configured in Avatar, two steps are required for the group name to automatically populate. First, the group name must be specified in the IRP by the clinical administrator in the intervention section of the IRP. Second the individual completing the progress note must also select the specific intervention listing the group. If either of these two things don't happen, the group name will not populate. Staff have been advised to include the group name in the body of the note in the event the IRP did not include the group name. Also, additional training was done on completing the therapeutic progress note and a tip sheet was developed and is available on the intranet. 6. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%S					12	13	**13**
%C. #15. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective					80	88	**84**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
Tab # 3, Clinical chart audit results

THERAPEUTIC PROGRESS NOTE AUDIT RESULTS (ALL DISCIPLINES)*							
	Mar	Apr	May	Jun	Jul	Aug	**Mean**
N	289	283	273	274	277	276	**279**
n total notes audited	39	81	27	26	36	36	**41**
Psychiatry	0	0	0	0	6	8	**2**
Psychology	15	7	11	6	13	11	**11**
Nursing*	0	72	0	0	0	0	**12**
Social work	9	0	0	3	5	4	**4**
Rehab/chaplain	15	2	16	17	12	13	**13**
%S	13	29	10	10	13	13	**15**
%C. #0 Completed timely (all disciplines)	100	11	100	92	92	92	**67**
%C. #2 Objective documented from most recent IRP (all disciplines)	73	89	93	96	86	86	**87**
%C. #3 Intervention documented from most recent IRP (all disciplines)	68	50	81	90	74	84	**79**
%C. #5 Number of sessions attended/scheduled indicated appropriately (all disciplines)	97	100	100	100	100	100	**99**
%C. #6 Reason for discrepancy between missing attendance indicated (all disciplines)	100	100	92	100	86	100	**96**
%C. #7 Individual's participation level recorded (all disciplines)	100	100	96	96	97	100	**98**
%C. #8 Individual's participation level present and informative (all disciplines)	95	89	93	96	100	94	**95**
%C #9 Appropriate progress level noted for the objective targeted (all disciplines)	97	100	93	92	92	92	**94**
%C #10 Description supports progress level (all disciplines)	95	100	93	96	100	94	**96**

N= 90% of average daily sample
n= total therapeutic progress notes audited
*Not all disciplines completed audits in each month. Nursing attempted audits in April but found no therapeutic

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		progress note in Avatar to audit; Social work completed audits in June through August; Rehab completed audits March through Aug; Psychology completed audits March through August; Psychiatry completed audits July and August. See tab 41 for discipline specific results. ***Tab #41 Therapeutic Progress Notes audit results*** **Analysis/Action Plans:** The clinical chart audit data reflected in the chart reflects only two months of audits, and the practice reflected therein largely predates the comprehensive IRP training that included modules on the development of focus areas, objectives and interventions (begun in July, 2010). Additional intensive competency based training occurred during the week of September 13, 2010 and included didactic and hands on assistance in developing and writing goals, objectives and linking interventions. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the Hospital modified the format of the IRP effective mid September, 2010. This is also expected to improve the quality of the goals and objectives. The therapeutic progress note audit data shows overall high levels of compliance with most indicators, including those relating to the quality of the note although nursing has not been completing therapeutic progress notes. Data around timeliness, inclusion of intervention and whether where services are delivered suggests improvement is needed. Training described in response to recommendation number 5 has been provided to nursing, and they now will have time during the TLC hours for documentation; these should improve compliance with this requirement.
V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and	**Recommendations:** 1. Track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. SEH Response: There was some delay in implementing this recommendation due to lack of capacity to enter group data or attendance data. That issue was resolved in August, and data was entered for both groups and attendance at groups for August. In addition, the new catalogue of TLC and ward based groups that began in mid September, 2010 is being entered into Avatar, and staff are being identified to serve as data entry specialists to ensure that groups, the participants and their attendance data are entered. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See data below.

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

SEH Response: Not completed.

Facility's Findings: The Hospital during this review period created a management report that tracks hours scheduled and hours attended based upon information in Avatar. The system was piloted during August and September, 2010, focusing only on TLC group scheduling and attendance (i.e., unit based treatment was not part of the pilot). Issues around the complexity of data entry and work flow processes were identified and largely resolved as they developed but these affected the timely entry of data. Consequently, the data available reflect only partial hours of treatment scheduled and attended but will serve as a baseline. Data show:

Hours of Mall Groups SCHEDULED					
Hours	Week Beginning 8/15/2010	Week Beginning 8/22/2010	Week Beginning 8/29/2010	Week Beginning 9/5/2010	Mean
N	318	318	318	318	318
0 Hours	68	61	64	67	65
0.1-5 Hours	30	29	37	39	34
6-10 Hours	37	32	22	19	27
11-15 Hours	128	119	78	83	102
16-19 Hours	34	55	85	84	65
20+ Hours	21	22	32	26	25

N = Number of individuals in the Report (census)

Hours of Mall Groups ATTENDED					
Hours	Week Beginning 8/15/2010	Week Beginning 8/22/2010	Week Beginning 8/29/2010	Week Beginning 9/5/2010	Mean
N	N	318	318	318	318
0 Hours	0 Hours	76	70	76	85
0.1-5 Hours	0.1-5 Hours	71	74	78	94
6-10 Hours	6-10 Hours	116	100	82	101
11-15 Hours	11-15 Hours	32	51	56	16
16-19 Hours	16-19 Hours	4	6	9	5

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

20+ Hours	20+ Hours	19	17	17	17

N = Number of individuals in the Report (census)

Tab # 46 TLC Hours report

As mentioned, in mid September, new programming, reflecting a more "dosed groups approach" was introduced. The Hospital is working to enter all treatment activity data into Avatar (both TLC and unit based treatment interventions) that reflects the new TLC and unit based programming. It is possible that an updated report reflecting a few weeks of treatment hours may be available during the site visit.

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

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #15. The IRP has interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective					80	88	**84**

N = All IRP reviews scheduled in the review month
n = number audited
* Data not available
** Sample size 2 per unit (26)
Tab # 3, Clinical chart audit results

Analysis/Action Plans: The data from the pilot show generally that most individuals are not scheduled and receiving 20 hours of treatment each week. It should be noted that in general the data does not reflect treatment groups that occur on the units, but the Hospital is working to include this in the next report.

Improvement is needed in formulating objectives and in tying the interventions to objectives, but training underway should continue to strengthen performance on this requirement.

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

V.D.6	provide that each treatment plan integrates	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	Same as in V.D.1 through V.D.5. SEH Response: Same as in V.D.1 through V.D.5.
V.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:	
V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Recommendations:** 1. Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals. SEH Response: Completed. ***See Tab #1 for training outline relating to development of foci, objectives and interventions.*** 2. Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least 20% sample during the review period. SEH Response: IRP observations continued throughout the review period, but a new IRP observation tool that is more closely aligned with the Settlement Agreement was developed and implemented in July, 2010. The clinical chart audit tool was revised as well to more closely align with the Settlement Agreement and was implemented for July, 2010 clinical chart audits. ***See Tab # 8 IRP Observation Monitoring tools/instructions) and Tab # 10 (Clinical chart audit tool/instructions.*** The Hospital's monitoring target for both instruments is 2 per unit per month, not 20%. ***See Tab # 36 Audit Sample Plan.*** 3. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below. **Facility's Findings:** **CLINICAL CHART AUDIT RESULTS**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #16 The team revised the objectives as appropriate to reflect the individual's changing needs.					58	60	**59**

N = All IRP reviews scheduled in the review month
n = number audited
* Not available
** Sample size is two per unit
Tab # 3, Clinical chart audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	Mean
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 7c review progress on objectives	75	60	66	92			**73**
#7d Individual had input into development of objectives	94	80	66	69			**77**

N = All IRP reviews scheduled in the review month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. # 7 Team bases progress reviews/revisions recommendations on clinical observation and data.					100	74	**86**

N = IRP reviews scheduled
n = number audited
* Data collected using different tool
Tab # 9 IRP Observation Audit results

Analysis/Action Plans: The data shows improvement is needed in revising objectives as an individual's needs changes. To improve performance, using classroom, observation and coaching methods, the Hospital in August and September provided intensive training to treatment teams around developing and revising objectives,.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. Finally, the Hospital modified the format of the IRP effective mid September, 2010. This is also expected to improve the quality of the objectives.
V.E.2	monitor, at least monthly, the goals; objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Recommendations:** 1. Same as in V.E.1 SEH Response: Same as in V.E.1 2. Ensure proper implementation of this requirement as part of the Psychiatric Updates. SEH Response: The Psychiatric Update audit tool, indicator # 13, addresses this requirement; the Instruction for indicator # 13 was modified and now reads as follows (highlighted in bold and italics are new parts of the instruction): " This item reviews the five subsections of the psychiatric update relating to response to treatment, including medication response, psychiatric condition generally, patient progressing toward treatment goals, overall assessment about the patient's condition and the identification of specific behavioral or psychodynamic issues affecting patient's progress since the prior psychiatric update. The reviewer should review the pertinent five subsections of the psychiatric update as well as the medical record and IRP for the most recent period. This item should be rated as *Adequate* if 1) each subsection is completed accurately, 2) the relevant subsections of the psychiatric update address specifically and accurately how the individual is progressing toward meeting his or her IRP goals and ***objectives***, including identifying/describing all specific areas of progress and specific areas in which progress has not been made or is lagging, ***as well as interventions that have been effective or not effective*** and 3) includes a discussion of specific behavioral and/or psychodynamic issues that are affecting the individual's lack of clinical progress (none could be noted if that is the case). For example, the psychiatric update should describe with specificity barriers (i.e. refusal to take medication), delusions, cognitive barriers, or defenses that are impacting progress toward IRP goals. These items should be rated as *Adequate* if these subsections fully address the complete picture of the individual's progress toward meeting IRP goals. This item should be rated as *Inadequate* if ***any*** of the five subsections are not completed, if they are not individual specific and comprehensive or if they are not supported by the record. For example, the item should be rated as *Inadequate* if the record only speaks of delusions but does not describe them or does not relate progress to IRP goals, objectives or interventions." ***See Tab # 17 Psychiatric Update Form and Instructions.*** 3. Provide data regarding the implementation of the monthly review of the IRPs as part of the Psychiatric Update Audit. SEH Response: See data below.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Facility's findings

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 13 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	94	100	100	100	100	100	**93**	**99**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: Data shows high performance on this indicator. The Hospital is providing extensive training around assessing the effectiveness of treatment. Using classroom, observation and coaching methods, the Hospital in August and September provided intensive training to treatment teams, including psychiatrists, around developing and revising goals, objectives, and interventions. The Hospital will continue the audits to identify areas and or units in which additional training or coaching may be needed. Finally, the Hospital is about to launch the psychiatric update in Avatar (it should be live prior to the next site visit) and this area is included as a mandatory field, which is also expected to improve compliance.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
V.E.3	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;	**Recommendations:** 1. Same as in V.E.1. SEH Response: See V.E.1 **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #17. Review the goals, objectives and interventions more frequently if there are clinical relevant changes in the individual's functional status or risk factors.					80	100	**86**

N = All IRPs due in the review month
n = number audited
* Not available
** Sample size target is 2 per unit per month
Tab # 3, Clinical chart audit results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: The data shows good performance on this requirement, although it is only a two month sample. The Hospital has provided classroom, observation and coaching training to all treatment teams during this review period around developing and revising goals, objectives, and interventions based upon changes in status and risk factors. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the now monthly clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. The Hospital is also monitoring change in risk factors through its high risk indicators, where treatment teams and the Medical Director and the Director of Psychiatric Services, among others, are advised when an individual has three or more unusual incidents in a thirty day period. The Director of Psychiatric Services consults with the treatment team, reviews the chart, and makes recommendations in the chart concerning actions for the team to consider.
V.E.4	provide that the review process includes an assessment of progress related to discharge; and	**Recommendations:** 1. Ensure that the IRP Manual provides adequate clinical examples to facilitate the individualization of discharge criteria. SEH Response: Completed. ***See IRP Manual.*** 2. Ensure that the IRP Manual/training includes strategies to increase the motivation of individuals to participate in their IRPs. SEH Response: Completed. ***See IRP Manual and Tab # 1 IRP training outlines.*** 3. Implement a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions. SEH Response: Completed in September, 2010, for all treatment teams. 4. Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content. SEH Response: ***See Tab #1 for training outline and data.*** See also V.A.3 and V.B 1 for summary. 5. Provide aggregated data regarding results of competency-based training of all core members of the treatment

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

team.

SEH Response: See V.A.3 for training data. ***See Tab #1 for training outline and data.***

6. Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample during the review period.

SEH Response: The Hospital is electing to monitor this through the IRP Observation audits and not through both the IRP observation audits and the clinical chart audits. Further, the Hospital target for auditing is two IRP observations per unit per month per the audit sample plan. ***See Tab # 36 Audit sample plan.***

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

SEH Response: See below

Facility's Findings:

IRP OBSERVATION MONITORING RESULTS (EFFECTIVE JULY 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #6. The review process includes an assessment of progress toward discharge					83	75	**79**

N = All IRPs scheduled
n = number audited
Tab # 9 IRP Observation Audit Results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C #5h Discuss in phase I discharge plans or step down at S E H	94	100	100	100			**99**
# 7h Individual participated in discharge planning/step down discussions	100	100	50	100			**88**

N = All IRP reviews scheduled in the review month

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital ***Tab # 9 (IRP Observation Audit results)*** **Analysis/Action Plans:** The data show that this area continues to need improvement, although only two months of data are available that directly relate to this requirement. This was an area in which all teams received training in August and September. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the IRP observation audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated. It should also be noted that a joint training with community case managers and Hospital social workers is scheduled for October 5, 2010 which will focus on roles in discharge planning as well as on available services among other topics. The October 5, 2010 training is open to all clinical staff.
V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Recommendations:** 1. Same as in Section V.A.1 to V.A.1.5. SEH Response: See Section V.A.1 to V.A.1.5. 2. Same as in V.B.1. SEH Response: See Section V.B.1 3. Same as V.E.4. SEH Response: See Section V.E.4 **Facility's Findings:**

IRP OBSERVATION MONITORING AUDIT RESULTS (EFFECTIVE JULY 2010)							
	Mar*	Apr*	Mar*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #7. Team bases progress reviews and revision recommendations upon clinical observation and data					100	74	**86**

N = All IRPs scheduled in the review month
n = number audited
Tab # 9 IRP Observation audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table below)

	Mar	Apr	Mar	Jun	Jul*	Aug*	Mean
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 5g Did team discuss if individual benefitting from therapies?	100	86	75	92			**88**
#5h If not benefitting, did team revise pertinent interventions?	100	50	75	80			**76**

N = IRPs scheduled in the audit month
n = number audited (Sample audit plan provides for 2 audits per unit per month). Observations were not conducted to the extent planned for in April and May due to the move to the new hospital
Tab # 9 (IRP Observation Audit results)

Analysis/Action Plans: The data shows that performance is not consistent for this requirement. To improve performance, using classroom, observation and coaching methods, the Hospital in August and September provided intensive training to treatment teams around evaluating the individual's progress and developing and revising goals, objectives, and interventions. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the monthly IRP observation audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.	**MENTAL HEALTH ASSESSMENTS**	
	By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible' for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	
A	**Psychiatric Assessments and Diagnoses**	
VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Recommendations:** 1. Ensure the revised policy regarding Assessments contain the same time frames for completion of weekly psychiatric updates (reassessments) that are outlined in the policy regarding Medical Records. SEH Response: Completed. The revised Assessment policy requires monthly reassessments and weekly progress notes for the first 60 days, consistent with the Medical records policy. ***See Tab # 12 Assessment policy and Tab # 13 Medical Records policy*** 2. Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. SEH Response: See VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7 3. Provide monitoring data regarding both timeliness and content of psychiatric assessments based on at least 20% sample and reassessments (based on two updates by each psychiatrist per month) during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures. SEH Response: The Hospital is completing monthly audits of the Comprehensive Initial Psychiatric Assessment (CIPA) and the Psychiatric Update, consistent with its Audit Sample plan of 20% of CIPA and 2 Psychiatric updates per ward based psychiatrist. ***See Tab # 36 Audit Sample Plan, Tab # 15 CIPA Audit Tool/instructions and Tab # 18 Psychiatric Update Audit Tool/instructions.*** Both audit tools were revised as reflected in section V.B.9. 4. Ensure that the progress report includes a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S),

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # Data fields -CIPA completed within 24 hours of admission	100	100	100	100	100	100	**95**	**100**
%C #2 Legal status correctly noted	100	100	100	100	86	100	**100**	**98**
%C #6 Psychiatric History reviewed	100	100	100	83	100	100	**88**	**98**
%C #7 Information from prior treatment setting	75	75	100	83	71	100	**62**	**84**
%C #8 History includes adverse reactions to medications	75	50	83	80	57	100	**46**	**74**
%C # 9 History of presenting illness	100	100	100	100	100	100	**88**	**100**
%C # 10 Medical History obtained	88	88	100	100	71	100	**90**	**91**
%C #12 Information about current medication obtained	50	63	83	67	43	38	**79**	**56**
%C #13 Completion of substance abuse history	100	100	100	100	86	100	**83**	**98**
%C # 14 Substance abuse assessment reflects stage of change	100	86	100	100	86	100	**67**	**95**
%C #15 Family history completed	50	57	100	83	86	100	**67**	**79**
%C # 16 Social and developmental history	75	50	100	83	71	100	**77**	**79**
%C #17 MSE completed	100	100	100	100	100	100	**91**	**100**
%C #17a MSE section completed (physical appearance)	100	100	100	100	86	100	*****	**98**
%C #17b MSE section completed (eye contact)	100	100	100	100	86	100	*****	**98**
%C #17c MSE section completed (psychomotor activity)	100	100	100	100	86	100	*****	**98**
%C #17d MSE section completed (attitude/behavior)	100	100	83	100	100	100	*****	**98**
%C #17e MSE section completed (speech)	100	100	100	100	100	100	*****	**100**
%C #17f MSE section completed (Mood)	88	100	100	100	100	100	*****	**98**
%C #17g MSE section completed (Affect)	100	100	100	100	100	100	*****	**100**
%C #17h MSE section completed (Perception)	88	88	100	67	86	100	*****	**88**
%C #17i MSE section completed (Thought Processes)	100	100	100	100	86	100	*****	**98**
%C #17j MSE section completed (Thought Content)	100	100	100	83	86	100	*****	**95**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #17k MSE section completed (Sensorium)	100	100	100	100	100	100	*****	**100**
		%C #17l MSE section completed (Orientation)	100	100	100	100	86	100	*****	**98**
		%C #17m MSE section completed (Memory)	88	100	100	83	86	100	*****	**93**
		%C # 21 Consistency between diagnosis and clinical presentation	100	88	100	83	71	100	**98**	**91**
		%C # 22 Individual's strengths noted	75	63	83	100	100	100	**74**	**86**
		%C # 25 Risk associated with medication regimen addressed	88	75	83	83	86	100	**68**	**86**
		%C # 26 AIMS test administered	63	50	83	83	86	100	**68**	**77**

N = Admissions during the month
n = number audited- target is 20% sample per month
* Data not available for subsections in prior review
Tab # 16 CIPA audit results

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C. #Data fields. Psychiatric update completed every 30 days	100	57	97	98	100	100	**93**	**97**
%C #5a MSE section completed (physical appearance)	100	100	100	100	100	100	**n/a**	**100**
%C #5b MSE section completed (eye contact)	100	100	100	100	100	100	**n/a**	**100**
%C #5c MSE section completed (psychomotor activity)	100	100	100	100	100	100	**n/a**	**100**
%C #5d MSE section completed (attitude/behavior)	100	100	100	100	100	100	**n/a**	**100**
%C #5e MSE section completed (speech)	100	100	93	100	100	100	**n/a**	**98**
%C #5f MSE section completed (Mood)	75	100	97	100	97	100	**n/a**	**97**
%C #5g MSE section completed (Affect)	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**	**n/a**
%C #5h MSE section completed (Perception)	72	100	100	90	100	71	**n/a**	**94**
%C #5i MSE section completed (Thought Processes)	100	71	97	98	97	100	**n/a**	**96**
%C #5j MSE section completed (Thought Content)	100	100	100	100	100	100	**n/a**	**100**
%C #5k MSE section completed (Sensorium)	100	100	100	100	100	100	**n/a**	**100**
%C #5l MSE section completed (Orientation)	100	86	93	95	97	100	**n/a**	**95**
%C #5m MSE section completed (Memory)	100	71	100	100	93	86	**n/a**	**96**
% C # 7 Use of STAT meds or restraint or seclusion addressed (standing order)	80	50	78	67	60	50	**68**	**68**
%C # 9 Adverse reactions noted as appropriate	96	100	100	78	81	83	**86**	**88**
%C # 10 Adequate justification for > than two anti-psychotics	95	80	100	89	50	0	**89**	**89**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT							
		%C # 11 Risk assessment sections accurately completed	94	100	97	98	93	86	**91**	**95**
		%C #13 Psychiatric update reflects response to treatment/progress	94	100	100	100	100	100	**93**	**99**
		%C #14a Diagnosis reflects current clinical data	67	100	97	100	100	100	**n/a**	**98**
		%C # 17 Documented justification for R/O or NOS diagnosis	82	100	86	82	71	n/a	**72**	**82**
		%C #19 Current medication regimen accurately described.	97	100	100	100	100	100	**98**	**99**
		%C #20 Rationale for use of anti-cholinergics with person with cognitive disorder	43	100	92	100	100	n/a	**81**	**84**
		% C # 22 Addressing abnormal lab levels	90	67	100	100	96	80	**75**	**95**
		%C #23 Pharmacological plan of care reflects diagnosis, MS assessment and response to treatment	100	83	100	100	100	86	**94**	**99**
		%C # 26 Rationale for use of benzodiazepines in person with substance abuse disorder.	71	50	100	91	80	n/a	**82**	**88**
		%C #29a Note by attending doctor if update completed by trainee	14	50	100	93	84	100	**n/a**	**85**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: Data shows that the CIPA and the Psychiatric Updates are timely. In the CIPA audits, August data shows significant improvement across all indicators, other than indicator #12 in which there was a significant decrease. In addition, for the CIPA, other than indicator #12, the weighted mean either improved from the prior review period or are above 90% on all indicators. Similarly, the audits show improvement in the content of Psychiatric Update. Other than ensuring the update provides an explanation for use of STAT meds or restraint and seclusion, deferring an Axis II diagnosis, and including an explanation for use of emergency medication, all indicators are over 80% compliance and most are over 90%. Of 47 indicators, 33 are rated as over 90% compliance, 10 are rated as between 80% and 90%, and the remaining range from 68% to 78%.

In an effort to sustain high performance and continue improving performance where needed, the Hospital will continue its monthly audits of the CIPA and the Psychiatric Update. In addition, as previously mentioned, the Psychiatric Update has been revised to improve the clinical flow as part of the form's Avatar development, and it is expected to "go live" prior to the next site visit. Ward psychiatrists as well as the Medical Director and Director of Psychiatry were part of the design team and tested the form; they also were involved in identifying "required" fields. These changes to the form, combined with the audits are expected to continue the positive trend in the content of the forms.

VI.A.2	By 24 months from the Effective Date	**Recommendations**:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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;	1. Same as VI.A.1. SEH Response: See VI.A.1. 2. Monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on at least 20% sample during the review period. SEH Response: Ongoing. Risk Assessment is monitored through the CIPA audits and the IPA audits, consistent with the Audit Sample plan presented (20% for CIPA and IPA). ***See Tab # 36, Audit Sample plan; Tab # 15 CIPA Audit tool, indicator # 18 a-e; Tab # 20, IPA Audit tool/Instructions, indicators # 7a, #7b, #8a, #8b.*** 3. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 18 Were the following specific subsections of the risk assessment completed	100	100	100	100	100	100	**86**	**100**
a. risk of self injury	88	100	100	100	100	100	*	**98**
b. risk of completed suicide	88	100	100	100	100	100	*	**98**
c. risk of physical aggression	100	100	100	100	100	100	*	**100**
d. risk of sexual aggression	100	100	100	100	100	100	*	**100**
e. risk of elopement	100	100	100	100	100	100	*	**100**
%C # 19 Were appropriate precautions noted for each type of risk identified	100	100	100	100	100	75	**63**	**95**

N = Number of admissions in the month
n = number audited- target is 20% sample per month
* Subsections not collected in prior review period
Tab # 16 CIPA audit results

INITIAL PSYCHOLOGY ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table below)

n	7	5	2	4	5	4	**7**	**5**
%S	21	12	6	13	11	10	**20**	**12**
%C #A8a Assess violence risk	100	100	100	100	100	100	**95**	**100**
#A8b Assess suicide risk	100	100	100	100	100	75	**95**	**96**
#A9a Findings violence risk	100	100	100	100	67	50	**91**	**86**
#A9b Findings suicide risk	100	100	100	100	67	75	**89**	**89**

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

Analysis/Action Plans: CIPA audits show excellent performance on completion of risk assessments with a mean above 90 for all sub-indicators. The dip in August performance in the identification of precautions will be monitored but is not believed to be the beginning of an adverse trend. Similarly the audits show high levels of performance around assessing risk in the IPA, with a mean in all categories above or near 100%. There was a decline in performance in August in the completion of the risk findings section, however. The involved psychologists were reminded that all parts of the risk assessment section of the IPA must be completed. Further, two psychologists assigned to the most active admissions unit were relieved of providing all but one group intervention in the TLC to allow more time for completion of the IPA and the related documentation.

VI.A.3 — By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics an Statistics Manual ("DSM") for reaching psychiatric diagnoses;

1. Same as in VI.A.1 and VI.A.6.

SEH Response: See VI.A.1 and VI.A.6

2. Implement the revised Psychiatric Update (Reassessments) audit to assess if diagnosis was properly updated in response to a review of new clinical data.

SEH Response: Completed. The Psychiatric Update audits are being completed monthly and the audit tool includes a new indicator, indicator #14a - - “Does diagnoses reflect current clinical data or was it changed or updated based upon change in current clinical data”. ***See Tab # 18 Psychiatric Update Audit Tool and Instructions, Tab # 11 Psychiatric Update audit results.***

3. Provide data regarding diagnostic accuracy in psychiatric assessments (20% sample) and reassessments (two per psychiatrist per month) during the review period.

SEH Response: See data below. The Hospital is reviewing 20% sample of CIPA. It is close to completing two psychiatric updates per ward-based psychiatrist in accordance with the Audit Sample Plan but is not consistently meeting that standard. ***See Tab # 36 Audit Sample Plan.***

4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

SEH Response: See data below

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 20 Are all axes completed	88	100	67	100	100	100	**68**	**93**
%C #21 Does the diagnosis reflect the clinical presentation	100	88	100	83	71	100	**98**	**91**

N = Number of admissions

n = number audited- target is 20% sample per month

Tab # 16 CIPA audit results

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 14 Is the diagnosis section accurately updated and completed	97	86	97	98	100	86	**98**	**97**
%C #14a Diagnosis reflects current clinical data	67	100	97	100	100	100	**n/a**	**98**
%C #15 Are all axes completed in the diagnosis section	97	100	100	98	100	71	**96**	**97**
%C #16 If there is a deferred Axis II diagnosis, is there an adequate justification	80	100	100	64	50	0	**67**	**76**
%C # 17 If there is a R/O or NOS diagnosis, is there an adequate justification	82	100	86	82	71	n/a	**72**	**82**

N = Census as of end of month, less month' admissions

n = number audited-target is 2 per unit psychiatrist (Audit sample plan)

Tab # 11 Psychiatric Update Audit results

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

5. Provide a summary of findings by the facility's Medical Director regarding internal survey of diagnostic accuracy, including, but not limited to, diagnosis listed as deferred , R/O and/or not otherwise specified, including any corrective actions.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: The following chart compares the major diagnostic categories from the last review period to the current review period.

Type	March 18, 2010	September 23, 2010
Total individuals in care	333	314
With Axis I diagnosis	333	313
R/O diagnosis	27	20
R/o for more than 90 days	7	4
NOS diagnosis	100	82
NOS for more than 90 days	46	34
Deferred diagnosis longer than 90 days	7	0
Mood Disorder	41	29
Depressive Disorder	13	9
Psychotic Disorder	305	279
Dementia	38	44
Impulse Control Disorder	8	7
Cognitive Disorder	54	65
Substance abuse disorder	145	152
Personality Disorder	93	86
Mental retardation	27	30

The Medical Director and Director of Psychiatric Services continue to monitor cases for diagnostic accuracy and appropriate use of DSM-IV through periodic reviews of management reports that track individuals with NOS and Deferred diagnoses. When a case is found where the NOS or deferred diagnosis exceeds 90 days, the Director of Psychiatric Services contacts the treating psychiatrist and prompts a review of the case to ensure it is meeting the DSM-IV requirements.

During this review period, the Office of Medical Affairs also conducted a special study of those with diagnoses of Dementia NOS and Amnesia Disorder NOS, which carry the same code in Avatar. Fourteen cases were identified and all were sent to the Neurology and Neuropsychology Departments to determine if the individuals had been seen by either clinic and if not, a referral for a review of the diagnosis was made. Of the 14, three had not been seen by neuropsychology, and those three are currently undergoing assessment by neuropsychology. See ***Tab # 157, Dementia NOS review***

Analysis/Action Plans: CIPA audit data shows the means across both indicators as above 90%. The Psychiatric Update audit shows good performance generally around diagnosis, but suggests improvement is needed in documenting the basis for rule/out , NOS and deferred diagnoses. However, it is clear that the Hospital continues to make good progress on diagnosis – improvement is seen in the number of individuals with a R/O diagnosis for more than 90 days, from 7 to

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		4; in the number with NOS diagnoses for more than 90 days (from 46 to 34) and in Axis II deferred for more than 90 days (from 7 to 0). The Hospital will continue to monitor these indicators through CIPA and the Psychiatric Update.
VI.A.4	By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;	**Recommendations:** 1. Same as above. SEH Response: Same as above. See V.A.3 for related data. **Analysis/Action Plans:** Same as above.
VI.A.5	By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;	**Recommendations**: 1. Same as in VI.A.1 to VI.A.3. SEH Response: See VI.A.1 to VI.A.3. 2. Develop and implemented corrective actions to address the deficiencies outlined in findings above. SEH Response: See VI.A.1 to VI.A.3. **Analysis/Action Plans:** See VI.A.1 to VI.A.3.
VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	
VI.A.6.a	Clinically supported, and current assessments and diagnoses are provided for each individual	**Recommendations:** 1. Same as in VI.A.1, VI.A.3 and VI.A.6. SEH Response: Same as in VI.A.1, and VI.A.3. See those subsections for related data. **Analysis/Action Plans:** See VI.A.1 to VI.A.3
VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments:	**Recommendations:** 1. Provide documentation of competency-based training of all trainees, including students and residents regarding issues of patient abuse/neglect. SEH Response: This is beyond the scope of the requirement and thus will not be addressed. 2. Provide self-assessment data regarding implementation of this requirement. SEH Response: **COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 27 Was the CIPA signed by the attending psychiatrist?	100	100	100	100	100	100	**79**	**100**
%C #28 Is the assessment was completed by the resident, is there a note from the attending psychiatrist?	100	67	100	100	86	38	*****	**72**

N = Number of admissions each month
n = number audited- target is 20% sample per month
* Data not available
Tab # 16 CIPA audit results

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 29 If completed by a resident, is there documented evidence that the Psychiatric Update was reviewed by the attending psychiatrist?	57	50	100	85	100	86	**47**	**83**
%C #29a Is there a note by the attending psychiatrist?	14	50	100	93	84	100	**n/a**	**85**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: The data shows improving performance on this requirement overall, although in August's CIPA audit compliance with indicator #28 was very low. In contrast, the compliance with the review and notes by an attending of a trainee's completion of the Psychiatric Update improved steadily during this review period. The Medical Director will continue to monitor performance to ensure that August data from the CIPA are not indicative of a downward trend. Given the otherwise positive trend, the Medical Director will continue to monitor this through monthly audits of both the CIPA and Psychiatric Updates.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in	**Recommendations:** 1. Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4. SEH Response: See VI.A.1, VI.A.2, VI.3 and VI.A.4

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	certain cases where they may not need to be justified after initial diagnosis); and	2. Provide further CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders. SEH Response: The following Grand Rounds were held in 2010:

Grand Rounds	Presenter	# of Attendees
Schizophrenia: Treatment Resistance (1/6/2010)	Robert Conley, MD Professor Psychiatry and Pharmacy , U. of MD School of Medicine	Psychiatry – 34 Psychology-4 RN-2 Residents-3 GMOs-2
Psychiatric Disorders in HIV Clinic (3/3/2010)	Glen Treisman, MD Professor of Psychiatry, John Hopkins U.	Psychiatry – 27 Psychology-7 Residents-6 GMOs-3 Social work-1
The Enduring Value of Psychoanalytic Survival and Healing in a Quick Fix Culture (4/7/2010)	Elio Frattaroli Institute of Psychoanalytic Center Philadelphia	Psychiatry – 19 Residents-4
Recognizing and Exploring Dissociative Processes (5/5/2010)	Richard Chefetz MD	Psychiatry – 32 Psychology-6 Social work-5 Residents-6 GMOs-5
Paranoia and Violence (6/14/2010)	Phillip J Resnick MD	Psychiatry – 25 Psychology-9 Social work - 9 Residents-5 GMOs-4
Treatment and Management of Sex Offenders (6/2/10)	Judith Becker, Ph.D Dept of Psychology University of Arizona	Psychiatry – 35 Psychology-0 RN-2 Social workers- 2 Residents-4 GMOs-6

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(continued table) Psychiatric Roles in Treating Sex Offenders (7/7/10) — Bradley Johnson MD, Chief of Psychiatry, Arizona Community Protection and Treatment Center — Psychiatry – 25, Psychology-6, Social workers - 4, Residents-5

Psychiatric Roles in Treating Sex Offenders (7/7/10)	Bradley Johnson MD Chief of Psychiatry Arizona Community Protection and Treatment Center	Psychiatry – 25 Psychology-6 Social workers - 4 Residents-5

See Tab # 84, Grand Rounds Training Schedule

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

SEH Response: See above. ***See Tab # 84, Grand Rounds Training Schedule***

Facility's findings:

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C #16 If there is a deferred Axis II diagnosis, is there an adequate justification?	80	100	100	64	50	0	**67**	**76**
%C # 17 If there is a R/O or NOS diagnosis, is there an adequate justification?	82	100	86	82	71	n/a	**72**	**82**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: The Hospital needs to improve documentation concerning the rationale for deferring diagnoses or carrying a R/O or NOS diagnosis. See VI.A.6.b for action steps.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Recommendations:** 1. Same as in VI.A.1 through VI.A.6.a and VI.6.c SEH Response: See VI.A.1 through VI.A.6.a and VI.6.c **Analysis/Action Plans:** See VI.A.1 through VI.A.6.a and VI.6.c
VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to	**Recommendations:** 1. Develop and implemented corrective actions to address the deficiencies outlined in findings above, including

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	streamlining of the information in the updates to improve clinical flow; SEH Response: The Hospital continues its monthly audits of psychiatric updates using a slightly modified tool from the last review period. It also is tracking use of STAT and PRN medication through a management report, the Psychiatric Update audit and the Medication Monitoring audit. Late in this review period, the Hospital modified its method of completing the Medication monitoring audits - - rather than complete a review of one units medication records each month, Pharmacy, in August, began pulling a sample from each unit, so that the data is not skewed in any given month by special populations (i.e., geriatric units) but is more representative of the Hospital as a whole. In addition, the Psychiatric Update was modified somewhat as it is in the Avatar build phase. It is expected to be operational in Avatar by the November site visit and should reflect recommendations made during the last site visit. 2. Same as in VI.A.1. SEH Response: Same as in VI.A.1. **Facility's findings:**

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C Data fields Timeliness (every 30 days)	100	57	97	98	100	100	**93**	**97**
%C #3 Are all sections of the Subjective Findings section completed and consistent with the relevant progress notes?	100	100	100	100	100	100	**93**	**100**
%C #6 Is the section for targeted symptoms complete and accurate?	97	100	97	95	90	100	**95**	**95**
%C #7 Is there adequate explanation for the use of STAT medications, seclusion or restraint –specifically, if and how the benefits of these interventions outweigh their risks, triggers, frequency etc?	80	50	78	67	60	50	**68**	**68**
%C #12 Is the subsection titled Medication response generally completed?	97	100	100	98	100	86	**97**	**98**
%C # 13 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	94	100	100	100	100	100	**93**	**99**
%C #14a Does the diagnosis reflect current clinical data or was it changed or updated based upon in current clinical data	67	100	97	100	100	100	**n/a**	**98**
%C # 18 Is there an adequate justification for continued psychiatric hospitalization?	100	100	100	98	96	83	**91**	**98**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see tables below)

%C # 20 If the medication regimen includes use of anti-cholinergics in an individual with a dx of cognitive disorder, is there adequate justification	43	100	92	100	100	n/a	**81**	**84**
%C # 24 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects	97	83	90	81	96	83	**79**	**90**
C% #25 Does the psychopharmacological plan of care adequately address the use of >2 antipsychotics and/or 3 or more psychotropics?	64	100	100	100	56	50	**68**	**88**
C% # 26 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse dx	71	50	100	91	80	n/a	**82**	**88**

N = Census as of end of month, less month' admissions
n = number audited-target is 2 per unit psychiatrist (Audit sample plan)
Tab # 11 Psychiatric Update Audit results

MEDICATION MONITORING AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	387	362	346	348	360	362	**385**	**358**
n	63	5	8	20	27	13	**41**	**23**
%S	17	1	2	6	8	4	**11**	**6**
%C #G.1a % Patients with psychiatric/psychotropic PRN medication orders during the review period	0	0	0	0	11	0	**0**	**2**

N = Number of individuals served for at least one day in the month
n = number audited- 20-30 per unit per month (Audit sample plan)
Tab # 66 Medication Monitoring Audit results

Analysis/Action Plans: The data shows generally improving performance during this review period, although documentation continues to be a challenge for the Hospital. The Hospital took a number of actions to address deficient findings from the prior review period. The Psychiatric Update was revised and reorganized to provide a better clinical flow as well as to identify all key mandatory fields. In addition, the Psychiatric Update is expected to "go live" in Avatar by late October, 2010. Further, the audits are now occurring each month, and the Medical Director and the Director of Psychiatric Services are able to address deficiencies on an individual basis if needed. Psychiatrists also participated in each module of the IRP training, which provided a better framework for their assessments and the relationship to the development of the clinical formulation and IRP. Finally it should be noted that there were three cases identified during the review period where there was a PRN order for psychiatric medications. Two were discontinued before they were discovered, and the other one was discontinued once discovered.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
B	Psychological Assessments (these assessment may be completed by psychologists or	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	graduate students, in psychology under the supervision of psychologists.)	
VI.B.1	By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	**Recommendations:** 1. Determine the barriers to the timely completion of IPAs, both Part A and Part B and implement appropriate corrective action plan. SEH Response: Currently, the civil admissions unit is staffed with two psychologists, and each admissions unit serving forensic admissions have a psychologist. Psychologists are reporting that at times they have not been able to complete their documentation in a timely matter because of other responsibilities such as leading groups in the TLCs or because they are providing support for behavioral or emergency interventions on their assigned units. To address this, the Director of Psychology has reduced the number of groups that the civil admissions psychologists lead in the TLCs and will continue to monitor this issue. A half time neuropsychologist has been assigned to complete neuropsychological exams. 2. Implement the audit of all other psychological assessments including neuropsychological assessments according to the instructions in Cell V.B.9. SEH Response: Completed. Psychology is currently reviewing the IPAs (Part A and B) (peer review), risk assessments (peer review), neuropsychological evaluations (audit), behavioral interventions (audit) and general psychological evaluations (peer review). ***See Tab #20 IPA Peer Review tool; Tab # 21 IPA Peer Review results; Tab # 22 Psychology tools - - Psychology Risk Assessment and Psychology Evaluation; Neuropsychology Audit Tool; Tab # 30 Peer Review results, Psychology Evaluation and Risk Assessment; Neuropsychology Audit Results***. The tools for the Risk Assessment and Psychological Evaluation reviews are being modified effective October 1, 2010 (for September reviews) based upon the experience over the last five months. 3. Continue to present auditing data in trended format. SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response

INITIAL PSYCHOLOGICAL ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	7	5	2	4	5	4	**7**	**5**
%S	21	12	6	13	11	10	**20**	**12**
%C # 1 (Part A) Is Part A completed within 5 days of admission?	86	60	0	50	33	25	**50**	**50**
%C # 1 (Part B) If Part B completed within 12 days of admission?	57	60	100	75	67	50	**59**	**64**

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

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C # 1 Completed within 30 days of receipt of referral?	n/a	n/a	100	50	0	0	**0**	**40**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Results

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	11	2	7	5	5	3	**2**	**33**
n	1	1	0	2	1	3	**1**	**8**
%S	9	50	0	40	20	100	**50**	**24**
%C # 1 Completed within 30 days of receipt of referral?	n/a	100	n/a	100	100	100	**100**	**100**

N= Number of referrals in the month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

NEUROPSYCHOLOGICAL AUDIT RESULTS

	Mar*	Apr*	Mar	Jun	Jul	Aug	**Mean**
N			11	9	5	3	**7**
n			2	2	2	2	**2**
%S			18	22	40	67	**2**
%C # 1 Completed within 45 days of receipt of referral?			0	50	50	0	**33**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation Peer Review, Neuropsychological Audit and Risk Assessment Peer Review Results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: The Hospital is providing the full range of psychological evaluations and the quality remains high. See VI.B generally for additional data reflecting other indicators from audits. Some modifications to the audit tools for the Risk Assessment and the Psychological Evaluations peer review tools will be introduced in October, 2010, as a result of the audit experience. The primary issues in meeting this requirement is not quality, but are in the timely completion of the risk assessment evaluations and neuropsychological evaluations, and in ensuring that completed evaluations remain in the medical record. The Hospital has undertaken several steps to address these issues. Upon implementation of FILENET, all completed psychological evaluations will be forwarded to Medical Records for scanning into the medical record; as scanned records, the evaluations will not be able to be removed. There are multiple strategies around improving the timeliness of psychological evaluations. First, the Hospital reviewed the current 30 day requirement in its policy for completion of psychological evaluations and concluded that the time frame needed to be extended in order to ensure high quality evaluations continue. Under the revised time frame psychology will have 30 days to assign the referral, and the staff will have 60 days from assignment to complete the evaluation. Second, three additional psychology positions have been identified, and the District is working to identify funding. Finally, as noted, some reassignments of therapy groups have been made to free up psychologists from the civil admissions unit to complete the IPAs more timely. It should be noted however, that this issue is likely to continue for some months as several staff will be out on maternity leave.
VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments, shall:	
VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Recommendations:** 1. Maintain current level of practice. SEH Response. Level of practice maintained. 2. Begin auditing process according to instructions in Cell V.B.9. SEH Response: Ongoing. See VI.B.1. 3. Present auditing data in trended format. SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C # 3c. Referral question, purpose of evaluation and what information is to be provided is clearly stated?	n/a	100	100	100	100	50	**100**	**86**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	11	2	7	5	5	3	**2**	**33**
n	1	1	0	2	1	3	**1**	**8**
%S	9	50	0	40	20	100	**50**	**24**
%C # 3a Referral question, purpose of evaluation and what information is to be provided is clearly stated?	0	100	n/a	50	100	67	**100**	**63**

N= Number of referrals during the month
n = number audited-target is 1 per psychologist who completes them (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.B.2.b	be based on current, and accurate data;	**Recommendations:** 1. Maintain current level of practice. SEH Response: Level of practice maintained. 2. Begin auditing process according to instructions in Cell V.B.9. SEH Response: Auditing underway 3. Present auditing data in trended format.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats

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

SEH Response:

RISK ASSESSMENT PEER REVIEW RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C # 6a Lists psychological tests, specific risk assessment tools, interview and duration and collateral interviews?	n/a	100	100	50	100	100	**100**	**86**
%C # 6b Lists records reviewed?	n/a	100	100	100	100	100	**100**	**100**
%C # 6c Uses multiple sources of information from each area that is being assessed?	n/a	100	100	100	100	100	**100**	**100**
%C # 6e Provides comment on sufficiency and reliability of available data?	n/a	100	100	100	0	100	**100**	**86**

N= Number of risk assessment referrals in month

n = number audited-target is 1 per psychologist (Audit sample plan)

Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	11	2	7	5	5	3	**2**	**33**
n	1	1	0	2	1	3	**1**	**8**
%S	9	50	0	40	20	100	**50**	**24**
%C #6a Lists interviews, record reviews, structured clinical inventories, observational methods and tests administered?	100	100	n/a	100	100	100	**100**	**100**
%C # 6b Tests chosen are appropriate to referral question and patient characteristics	0	100	n/a	50	100	67	**100**	**63**

N= Number of referrals in month

n = number audited-target is 1 per psychologist (Audit sample plan)

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Tab # 30 Psychological Evaluation and Risk Assessment Audit Results **Analysis/Action Plans:** Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations. No other actions required.
VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Recommendations:** 1. Maintain current level of practice. SEH Response: Level of practice maintained. 2. Begin auditing process for Risk Assessments according to instructions in Cell V.B.9. SEH Response: Risk Assessments audits are occurring. 3. Present auditing data in trended format. SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C # 13c Conclusions about the patient's risk status are stated?	n/a	100	100	100	100	100	**100**	**100**
%C #13d Clinician distinguishes between strategies for addressing stable and acute risk factors?	n/a	100	100	100	100	100	**100**	**100**
%C # 13e Recommendations on overall level of risk and risk management targets are provided?	n/a	n/a	100	50	100	50	**50**	**67**
%C # 13f Recommendations should be individualized and personalized to the patient?	n/a	n/a	100	50	100	100	**100**	**83**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N= Number of risk assessment referrals in month n = number audited-target is 1 per psychologist (Audit sample plan) ***Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results*** **Analysis/Action Plans:** Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations. No other actions required.
VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment, and	**Recommendations:** 1. Revise the guidelines for Recommendations section of IPA to include recommendation of specific groups from the Mall Catalogue for both parts A and B. SEH Response: Guidelines for the IPA have been revised, effective October 1, 2010, to coincide with the revised TLC curricula. ***Tab # 19 IPA Form.*** 2. Begin auditing process for non-IPA psychological evaluations according to instructions in Cell V.B.9. SEH Response: Risk Assessment, neuropsychological and psychological evaluation audits are ongoing. 3. Present auditing data in trended format. SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C #4a First sentence provides any bottom line recommendations	n/a	100	100	50	100	0	**100**	**67**
%C #4b Paragraph summarizes conclusions and recommendations sections	n/a	0	100	50	0	100	**100**	**50**
% C #13b Referral question is answered	n/a	100	100	100	100	100	**n/a**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N= Number of risk assessment referrals in month n = number audited-target is 1 per psychologist (Audit sample plan) ***Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results***

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	11	2	7	5	5	3	**2**	**33**
n	1	1	0	2	1	3	**1**	**8**
%S	9	50	0	40	20	100	**50**	**24**
%C #4a First sentence provides any bottom line recommendations	0	0	n/a	0	0	0	**0**	**0**
%C #4b Paragraph summarizes conclusions and recommendations sections	0	0	n/a	0	0	0	**0**	**0**
%C # 11j Referral question is directly answered	100	100	n/a	100	100	100	**100**	**100**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Recommendations:** 1. Maintain current level of practice. SEH Response: Level of practice maintained 2. Begin auditing process for non-IPA psychological evaluations according to instructions in Cell V.B.9. SEH Response: Risk Assessment and psychological evaluation audits are ongoing. 3. Present auditing data in trended format. SEH Response: Data is being presented in format requested by DOJ lead consultant. The Hospital is not agreeable to presenting data in multiple formats. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See VI.B.2.b

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: Audits will continue and psychology will monitor data and trends. Psychologists are being reminded of the standards for completion of the evaluations and the Chief Psychologist will also work with staff in selecting the appropriate tests and instruments. No other actions required.
VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	**Recommendation:** 1. None needed. SEH Response: None needed.
VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Recommendations:** 1. Present data on the timeliness of psychological assessments as the percentage of assessments per month that were completed within the 30-day time limit. SEH Response: See V.B.1 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See V.B.1 **Analysis/Action Plans:** See V.B.1
VI.B.5	By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.	**Recommendations:** 1. Begin auditing process according to instructions in Cell V.B.9. SEH Response: Audits and peer reviews are underway. The Hospital is considering moving the auditing of this requirement to the clinical chart audit. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(tables below)

RISK ASSESSMENT PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	3	2	7	2	3	3	**4**	**3**
n	0	1	1	2	1	2	**1**	**1**
%S	0	50	14	100	33	67	**29**	**35**
%C # 16c.i Acknowledgement of receipt of report and recommendations is signed by psychologist	n/a	100	n/a	0	100	100	**0**	**75**
%C # 16c.ii Acknowledgement of receipt of report and recommendations is signed by clinical administrator	n/a	100	0	0	100	0	**0**	**40**

N= Number of risk assessment referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

PSYCHOLOGICAL EVALUATION PEER REVIEW RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	11	2	7	5	5	3	**2**	**33**
n	1	1	0	2	1	3	**1**	**8**
%S	9	50	0	40	20	100	**50**	**24**
%C #14c.i Acknowledgement of receipt of report and recommendations is signed by psychologist	0	0	n/a	0	100	50	**n/a**	**33**
%C #4c.ii Acknowledgement of receipt of report and recommendations is signed by clinical administrator	0	0	n/a	0	100	50	**n/a**	**33**

N= Number of referrals in month
n = number audited-target is 1 per psychologist (Audit sample plan)
Tab # 30 Psychological Evaluation and Risk Assessment Peer Review Results

Analysis/Action Plans: Upon completion of each psychological assessment, the psychologist should meet with the clinical administrator to review the results, and the clinical administrator should be signing the acknowledgement of receipt of the report and recommendations. In addition, each treatment team is supported by a psychologist who is available on an ongoing basis to provide further guidance to teams about the results of various assessments. The Chief of Psychology will meet with his staff to remind them of these expectations, and will continue to audit this to assess if other actions should be taken.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.C	Rehabilitation Assessments	
VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with	**Recommendations:** 1. Maintain current level of practice in those areas where significant progress has been achieved, and develop a corrective action plan for those areas of the RSA that clinicians are having more trouble completing in the expected manner.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	2. SEH Response: The Director of Rehabilitation Services is planning two refresher trainings on 9/30 and 10/7with rehabilitation services staff on completing the rehab assessment using updated instructions. ***See Tab # 23 for current and revised RSA instructions.*** The instructions are designed to provide more clarity around completion of the assessment, and the training will focus on those areas with which the audits suggest staff struggle. It should be noted that during the current review period, 22 of 226 admissions did not have an initial rehabilitation services assessment; all 22 individuals have been discharged. An initial rehabilitation services assessment has been completed for all individuals currently in care. The Director of Rehabilitation Services has redeployed staff to ensure every individual admitted over 5 days has a rehabilitation services assessment completed and will be monitoring this regularly. 3. Present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below

REHABILITATION ASSESSMENT AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**
3	12	13	14	14	14	14	**9**	**14**
%S	35	32	41	44	30	36	**25**	**36**
%C # Completed within 5 days of admission	92	92	86	71	86	79	**82**	**84**
%C # 2 Level of functioning - leisure	100	100	100	100	100	100	**98**	**100**
%C # 3 Level of functioning - perceptual	100	100	100	100	100	100	**100**	**100**
%C # 4 Level of functioning – cognitive	100	100	100	100	100	100	**98**	**100**
%C # 5 Level of functioning - psychosocial	100	100	100	100	100	100	**100**	**100**
%C # 6 Level of functioning – motor skills	100	100	100	100	100	100	**100**	**100**
%C # 7 Level of functioning - behavior	83	100	100	100	100	100	**100**	**98**

N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 25 Rehabilitation Services Audit Results

Analysis/Action Plans: Staff have been redeployed to ensure timely completion of the initial rehabilitation assessment. Training is being held with rehabilitation services staff on new guidelines that are expected to improve the quality of the assessments. Audits will continue, and if trend appear (i.e. specific staff struggle with portions of the Assessment), additional support will be provided. See also Corrective Action Plan submitted with this report .

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.C.2.a	be accurate as to the individual's functional abilities;	**Recommendation:** 1. Maintain current level of practice. SEH Response: Level of practice maintained. See data in VI.C.1.
VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Recommendation:** 1. Determine what obstacles prevent RS staff from accurately completing this section of the RSA and institute appropriate corrective action plan. SEH Response

REHABILITATION ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
3	12	13	14	14	14	14	**9**	**14**
%S	35	32	41	44	30	36	**25**	**36**
%C 9 Assessment reflections: Were the individual's life skills perspectives prior to and over the course of mental illness/disorder identified?	83	100	100	100	100	100	**88**	**98**

N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 25 Rehabilitation Services Audit Results

Analysis/Action Plans: The trend continues to show improvement with performance now at 98%. Audits will continue. No further actions required.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Recommendation:** 1. Continue current level of practice with attention to data trends and the development of corrective action plans if necessary. SEH Response:

REHABILITATION ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
3	12	13	14	14	14	14	**9**	**14**
%S	35	32	41	44	30	36	**25**	**36**
%C # 10 Does the assessment include the individual's self-reported interests and activities?	86	100	100	100	100	93	**80**	**96**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N= Number of admissions n = number audited-target is 20% of admissions (Audit sample plan) ***Tab # 25 Rehabilitation Services Audit Results*** See also VI.C.2.a. **Analysis/Action Plans:** The trend continues to show improvement with performance now at 96%. Audits will continue. No further actions required.
VI.C.2.d	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	**Recommendations:** 1. Maintain current level of practice. SEH Response: Practice maintained.

REHABILITATION ASSESSMENT AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**
3	12	13	14	14	14	14	**9**	**14**
%S	35	32	41	44	30	36	**25**	**36**
%C # 11 Were specific rehabilitative strategies identified to engage the individual in appropriate activities that are viewed as personally meaningful and productive?	100	85	100	100	93	93	**84**	**95**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 25 Rehabilitation Services Audit Results

2. Revise instructions for Recommendations section of SRA to include recommendations for specific groups from the Mall Catalogue.

SEH Response: Effective with the new TLC programming in September, staff will include recommendations for specific groups.

Analysis/Action Plans: The trend continues to show improvement with current compliance levels at 95%. Audits will continue. No further actions required.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VI.C.3	By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who	**Recommendation:** 1. None needed.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment.	
VI.D	By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.	**Recommendations:** 1. Identify barriers to acceptable completion of the SWIA and impairment corrective action plan. SEH Response: The Hospital identified several issues around social work practice generally and has taken several steps to resolve them. First, the Hospital increased the credentials required for social work practice at the Hospital, now requiring all social workers to hold a LICSW license to qualify for employment. Those individuals who did not hold that level of license were reduced in force. While this created short term vacancies, it is believed it will improve overall the quality of social practice. Next, the Hospital hired a second supervisory social worker, and filled all but one social work vacancy (an offer was made for the final vacancy but was not accepted.) Recruitment continues to fill that vacancy. The Hospital then reorganized the social work department under each supervisory social worker. There are two social workers on the one admission unit serving civil patients, and three social workers assigned to the three admission units serving the forensic admissions. Under the new structure, the social workers on the admission units and one other social worker report to one supervisor, and the social workers on more long term units report to the other supervisory social worker. Each supervisor will also specialize in specific areas. The supervisor leading the admission units will also provide linkages to DMH and to community services and lead initiatives around discharge planning, and the supervisor heading the long term units will focus on training and related issues. With two supervisors, supervisors will be meeting with each individual social worker weekly to provide coaching, individual support and identify any training needs. The supervisors also reviewed the guidelines for completion of the social work initial assessment and updates and, based in part upon audit data, made modifications that will provide more specific guidance on completion of certain sections of the assessments. These will be in place and training on the changes will occur by September 30, 2010, so that initial assessments and updates beginning in October will be completed using the new guidelines. In addition the audit tools/instructions were reviewed and updated to correspond to the changes in the guidelines. ***Tab #31 Social Work Initial Assessment and Guidelines; Tab # 32 Social Work Initial Assessment Audit Tool; Tab # 34 Social Work Update and Guidelines; Tab # 35 Social Work Update Audit Tool.*** Finally audit results are being shared with all department social workers during reinstituted monthly meetings, as well as individual social workers, and supervisors are assessing if there are additional training needs, either for social workers as a whole or on an individual basis. See Chapter VII for additional information about actions involving discharge planning and social work training. 2. Present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See below.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	7	9	6	6	9	8	**8**	**8**
%S	21	22	18	19	20	21	**21**	**20**
%C # Completed within 5 days of admission	100	44	33	50	67	63	**85**	**60**
%C # 2 Discrepancies in social history and efforts to resolve them	n/a	50	100	n/a	50	0	**94**	**50**
%C # 3 Explanation for conclusion about discrepancies	n/a	50	0	n/a	100	n/a	**87**	**50**
%C # 4 Treatment goals and discharge plans reflect strengths and limitations	100	78	83	100	56	75	**93**	**80**
%C # 5 Assessment includes discussion of individual's goals and whether they are realistic/achievable.	71	67	83	50	78	100	**74**	**76**
%C # 6 Social work interventions are specific and individualized, reflect frequency and are related to treatment goals and discharge planning	100	78	83	83	67	63	**94**	**78**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 33 Social work audit results

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**292**	**280**
n	11	10	9	11	7	12	**18**	**10**
%S	4	4	3	4	3	4	**6**	**4**
%C # 1 Progress note(s) indicate contact with family, significant others, and their support towards individual's progress and discharge plan.	82	90	78	82	86	75	**85**	**82**
%C # 2 Documentation of objective/focus of intervention is descriptive	100	90	89	82	86	83	**90**	**88**
%C # 3 Individual's expressed goals, concerns and perception of progress related to treatment and discharge goals (in individual's own words)	100	100	100	100	100	92	**96**	**98**
%C # 4 Description of progress toward discharge	91	100	78	100	100	58	**94**	**87**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C # 5 Description of case manager's involvement in discharge planning and contact with individual	100	89	100	91	67	67	**99**	**86**
		%C #6 Status of discharge barriers	100	90	100	100	57	67	**89**	**87**
		%C # 7 Assessment of services needed for discharge planning	73	80	78	73	71	25	**91**	**65**
		%C Timely completions	100	100	100	100	100	100	**100**	**100**

N= Census at end of month less admissions
n = number audited-target is 1 per social worker (Audit sample plan)
Tab # 33 Social work audit results

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

Analysis/Action Plans: The social work initial assessment audits show a decline in performance in many key indicators, including timeliness, identifying and resolving discrepancies in social history, identification of treatment goals and discharge plans that reflect the individual's strengths and limitations, and developing interventions that are specific, individualized and relate to goals and discharge planning. In addition, the social work update audit also shows in most indicators a decline in performance. This in both instances is likely due to social work vacancies for a number of months during the review period, but now that all but one vacancy is filled, that issue should be addressed. As noted, the Hospital also hired a second social work supervisor which will provide increased opportunities for coaching and training. Finally, on October 5, 2010, an all day workshop (required for social workers and community case managers, optional for others) will focus on issues around discharge planning. Rather than just be a one-time event, the plan is to have 3-4 workshops of this kind throughout the year.

See also response to recommendation # 1.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.	**DISCHARGE PLANNING AND COMMUNITY INTEGRATION**	
	Taking into account the limitations of court-imposed confinement and public safety, SER, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	
VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Recommendations:** 1. Previous recommendations must be implemented immediately. SEH Response: The Hospital will not respond to this recommendation specifically. See corrective action plan submitted with this report at Section VII. 2. The hospital must develop and implement training for clinical staff with regard to how to develop effective discharge plans. SEH Response: Completed as part of IRP training. ***See Tab # 1 IRP training materials and training data.*** Data Source: Training DB, 9/29/2010

Discharge Planning - IRP Module IV					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Clinical Administrator	12	10	10	83%	83%/100%
Medical	n/a	n/a	n/a	n/a	n/a
Nurse Manager	8	8	8	100%	100%/100%
Psychiatry	22	21	20	95%	95%/95%
Psychology	14	12	12	86%	86%/100%
Social Work	13	12	12	92%	92%/100%
Total	**69**	**63**	**62**	**91%**	**91%/98%**

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

3. The hospital must develop monitoring guidelines to ensure that the training occurs.

SEH Response: The Hospital does not understand this recommendation.

4. The hospital must provide coaching to ALL unit staff with regard to how to develop appropriate discharge plans.

SEH Response: Ongoing as part of IRP training. ***See Tab # 1 IRP training materials and training data.***
See also V.A.3 and V.B.1 for description of training. In addition, the Hospital hired a second supervisory social worker which provides enhanced supervisory capacity. The social workers on the admission units and one other social worker report to one supervisor, and the social workers on more long term units report to the other supervisory social worker. Each supervisor will also specialize in specific areas. The supervisor leading the admission units will also provide linkages to DMH and to community services and lead initiatives around discharge planning, and the supervisor heading the long term units will focus on training and related issues. With two supervisors, supervisors will be meeting with each individual social worker weekly to provide coaching, individual support and identify any training needs.

Facility's findings:

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	7	9	6	6	9	8	**8**	**8**
%S	21	22	18	19	20	21	**21**	**20**
%C # 7 All areas of discharge criteria are described in detail as to what is needed	86	89	100	83	78	88	**85**	**87**
%C # 8 Community support needs are addressed in all areas and are individualized	100	100	100	100	89	100	**89**	**98**
%C # 9 Description of discharge barriers	100	100	100	83	100	100	**96**	**98**
%C # 10 Identification of skills needed for discharge	100	100	83	100	67	88	**98**	**89**
%C # 11 Descriptive identification of discharge needs, i.e. housing, medical, financial, day program, employment, and aftercare needs	86	100	100	100	78	100	**93**	**93**

N= Number of admissions
n = number audited-target is 20% of admissions (Audit sample plan)
Tab # 33 Social work audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n					20	23	**22**
%S					10	10	**10**
%C # 8 SEH shall provide the individual the opportunity beginning at the time of admission and continuously throughout the individual's stay, to be an active participant in the discharge planning process, as appropriate					100	74	**86**

N = All IRP reviews scheduled in the month
n = number audited
* Audits during this period used different tool
** Sample size target is 2 per unit (Audit Sample plan)
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 7h Individual participated in discharge/step down planning	100	100	50	100			**88**

N = All IRPs scheduled in the review month
n = number audited
* Audits completed using a different tool
** Sample size target was 20%
Tab # 9 IRP Observation Audit results

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C # 9 The clinical formulation considers such factors as age, gender, culture, treatment adherence and medication issues that may affect the outcomes of treatment and rehabilitation interventions.					84	67	**74**
%C. # 11 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?					50	54	**52**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C # 12 The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.					65	71	**68**

N = IRP reviews scheduled during month
n = number audited
* No audits conducted
** Sample size target is 2per unit (Audit sample plan)
Tab # 3 Clinical Chart audit results

DISCHARGE MONITORING AUDIT RESULTS							
	Mar*	Apr	Mar	Jun	Jul	Aug	**Mean**
N		30	15	14	20	25	**21**
n		7	4	4	4	5	**5**
%S		23	27	29	20	20	**23**
%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?		n/a	n/a	n/a	75	80	**78**
%C # 21 Identified individual to assist with interventions.		n/a	n/a	n/a	75	100	**89**
%C # 22 Timeframes and duration for completion of interventions							

N = All discharges in the month
n = number audited
* March audits were excluded because findings were based upon prior audit tool that was substantially different than the current tool. A mean from the prior review period is not available due to the change in the tool.
n/a –These indicators were added to tool beginning for July audits
Tab # 68 Discharge audit results

Analysis/Action Plans: As the various audit results suggest, the Hospital is continuing to struggle with effective discharge planning from the time of admission. In an effort to improve, the Hospital hired consultants to provide intensive training for the treatment teams around discharge planning. The training began in earnest in late July and August, and in September, included a weeklong training involving didactic, observation and coaching of all treatment teams. Because the training occurred late in the review period, there is not yet data to assess its effectiveness. However, training is continuing for all teams. See also VI.D.

In addition, the social work department is partnering with the DMH Division of Integrated Care on a full day workshop for social workers and community case managers/clinical directors. That training will include information about roles and responsibilities, available community services and joint planning, among other things. ***See Tab # 164 "Working Together: A Partnership for Community Integration".*** Similarly workshops will occur at least three times per year.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		improvement.
VII.A.1	those factors that likely would result in successful discharge including the individual's strengths, "preferences, and personal goals;	**Recommendation:** 1. See VII.A SEH Response: See VII.A **Analysis/Action Plans:** See VII.A
VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Recommendation:** 1. See VII.A. and VII.A.1 SEH Response: See VII.A. See also additional data below. **Facility's findings:**

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C. # 13 Does the psychiatric update accurately reflect the individual's response to treatment/progress	94	100	100	100	100	100	**93**	**99**
%C # 28 Does the psychiatric update reflect the current and accurate list of barriers to discharge	100	100	100	100	93	100	**89**	**99**

N = Census minus monthly admissions
n = number audited
Tab # 11 Psychiatric Update Audit results

Analysis/Action Plans: See VII.A,, VII.A.1 and VII.A.3

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Recommendations:** 1. Implement previous recommendations. SEH Response: The Hospital will not respond to this recommendation specifically. See corrective action plan at Section VII. 2. SEH and DMH must focus on: housing placement issues; resistive to discharge and nursing home barriers. SEH Response: The Hospital is working with DMH to improve the discharge process. A key focus during this review

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		period has been to strengthen social work staff at the Hospital through increasing their knowledge of availability of community services and their roles vis-a-vis community case managers. To this end, the supervisory social worker leading discharge related improvements and DMH's Director of Integrated Care have developed an all day workshop, (scheduled for October 5) with Hospital social workers and community case managers to review best practice guidelines, housing options, ACT services, Community Integration (New Directions program), DMH 101, access to services, roles and responsibilities of hospital social workers and community case managers, and treatment provided at the Hospital. With respect to nursing home placements, lack of capacity was identified as an issue. Five individuals were placed in nursing homes in August/September, and the list of those awaiting nursing home placements was updated. The placements are being prioritized; teams have been given deadlines for applications, social work supervisors will review the social histories prior to submission to ensure all information is provided and accurate. Additionally, the Hospital is working with two nursing homes to identify capacity. With respect to the resistive to discharge individuals (6 have been placed off the list), and in addition to the training described above to address possible staff resistance, New Directions is working closely with individuals to ease the transition, such as frequent visits on the units short visits to coffee shops, neighborhood stores etc. In addition, additional groups around community integration for resistive individuals have been added to the TLC catalogue. DMH is also renting an apartment close to the Hospital for individuals to visit with peer specialists to work on transition issues. Finally, DMH is working on evaluating whether housing availability matches need. 3. DMH must advocate with DDS/DMR to accelerate discharges of individuals with mental retardation. SEH Response: The Hospital and DDS are meeting on a bi-weekly basis to place those individuals who should be receiving services from DDS. DDS is committed to identifying services for this population. In fact in a recent case, when a jointly served client required rehospitalization, DDS provided 1:1 supervision at the Hospital. Seven DDS clients have been placed this calendar year. 4. SEH must specifically identify "resistive to discharge" issues including but not limited to: staff ambivalence, family ambivalence, disagreement between the community and hospital, client reluctance and identify specific strategies for addressing each issue. A monitoring tool must be developed to ensure appropriate resolution of each individual consumer issue. SEH Response: The Hospital is not agreeable to creating an additional monitoring tool and thus will not implement this portion of the recommendation. All members of all treatment teams were provided training related to discharge planning, which included identifying the source of resistance and interventions to address these. See V.A.3 and ***Tab # 1*** for additional information. A new single log has been created in which all barriers to discharge are monitored.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

5. The Community Integration meeting must clarify membership/attendance, chairmanship, maintain minutes and follow up processes with specific staff roles and timelines. This meeting should serve as the forum to identify clinical disagreements and barriers to placement between the community and SEH regarding discharge plans.

SEH Response: There have been some changes to the community integration meeting. A sign in sheet is maintained, and the new combined discharge log will serve as the minutes. The week prior to the meeting, social workers are notified of which agencies will be at the meeting, and are asked to identify any issues. Those are then presented to the provider. After the meeting, the log is updated, and all workers are updated with the results. Social workers are now acting as links to the treatment team in terms of identifying issues and relaying feedback from the meeting. The Hospital disagrees with the remaining recommendations.

6. The multiple lists of consumers ready for discharge, discharge logs and barriers to discharge must be consolidated into one log utilized by all relevant parties with discharge barrier identified, action steps, timelines and staff identified.

SEH Response: Completed. See ***Tab #72 Ready for Discharge summary log.***

7. SEH Hospital Discharge Planning process must be finalized immediately, implemented and agreed to by DMH, its certified community providers and SEH staff.

SEH Response: The Discharge planning process was finalized and is an attachment to the DMH continuity of care procedure. It will be discussed at the October 5 training. ***See Tab 83, Discharge Process Protocol that is attached to DMH Continuity of Care procedure.***

Facility's findings:

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 28 Does the psychiatric update reflect the current and accurate list of barriers to discharge	100	100	100	100	93	100	**89**	**99**

N = End of the month census less month's admissions
n = number audited
See Tab # 11 Psychiatric Update Audit Results

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(continued below)

n	7	9	6	6	9	8	**8**	**8**
%S	21	22	18	19	20	21	**21**	**20**
%C # 9 Description of discharge barriers	100	100	100	83	100	100	**96**	**98**

N= Number of admissions in the month

n = Target is 20% of admissions

Tab # 33 Social work audit results

SOCIAL WORK UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**292**	**280**
n	11	10	9	11	7	12	**18**	**10**
%S	4	4	3	4	3	4	**6**	**4**
%C # 6 Description of discharge barriers	100	90	100	100	57	67	**89**	**87**

N= Census at end of month less month's admissions

n = number audited-target is 1 per social worker(Audit sample plan)

Tab # 33 Social work audit results

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. # 11 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?					50	54	**52**
%C # 12 The team developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.					65	71	**68**

N = All IRPs scheduled in the review month

n = number audited. Target sample is 2 per unit

Tab # 3 Clinical Chart audit results

Analysis/action steps: See VII.A.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.A.4	the skills necessary to live in a setting in	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	which the individual may be placed.	1. See VII.A , VII.A.1, VII.A.2 and VII.A.3 SEH Response See VII.A , VII.A.1, VII.A.2 and VII.A.3 2. SEH must promptly identify the specific treatment and/or rehabilitation goals for each activity/program provided at the TLC. Each and every program must correspond to a specific, individual skill, behavior or symptom. SEH Response: Implemented. ***See Tab # 69 TLC Catalogue.*** 3. Working with DMH and community agencies, SEH must identify and implement transitional activities for individuals considered discharge ready.. These activities must include transportation to and from SEH and community programs. SEH Response: ***See Tab # 69 TLC Catalogue*** for new TLC groups that expand services and include groups that undertake community transitional activities. Among the new groups are several groups that focus on social skill building, and appropriate social interactions. Curricula includes videotaping and role playing. The Hospital also has a living skills lab, and the DMH has rented an apartment near the hospital for peer specialists to take individuals in care for visits of increasing lengths to experience the community and apartment living. There are also numerous activities on weekend and evenings that expand opportunities for individuals to interact to with the community. ***See Tab # 85 Evening and Weekend activities***

SOCIAL WORK INITIAL ASSESSMENT AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	7	9	6	6	9	8	**8**	**8**
%S	21	22	18	19	20	21	**21**	**20**
%C # 10 Identification of skills needed for discharge	100	100	83	100	67	88	**98**	**89**
%C # 11 Descriptive identification of discharge needs, i.e. housing, medical, financial, day program, employment, and aftercare needs	86	100	100	100	78	100	**93**	**93**

N= Number of admissions
n = number audited-target is 20% of admissions(Audit sample plan)
Tab # 33 Social work audit results

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table continued below)

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
%C. # 11 The clinical formulation enables the interdisciplinary team to reach a preliminary determination as to the setting to which the individual should be discharged and the changes that will be necessary to achieve discharge, whenever possible?					50	54	**52**

N = All IRPs scheduled in the review month
n = number audited. Target sample is 2 per unit
Tab # 3 Clinical Chart audit results

Analysis/Action Steps: See VII.A.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	See below

Recommendations:

1. Coaching on how to actively engage the consumer in the discharge planning process must be extended to all treatment teams and must focus on individual engagement.

SEH Response: Ongoing. See V.A.3 and V.B.1 for descriptions of training and coaching. Additionally the updated TLC curricula include groups around strengthening the individual's participation in discharge planning. See ***Tab # 69 TLC Catalogue***

2. Treatment teams must encourage the individual to actively participate in the team process.

SEH Response: See response to Recommendation #1. See also V.A.3, V.A. 4 and V.B.1

3. Treatment teams must actively solicit the engagement of relevant and identified stakeholders, including family, community agencies and peer specialists in this process.

SEH Response: Insofar as the recommendation includes anyone beyond the individual it is beyond the requirements of the cell and will therefore not be addressed.

Facility's Findings:

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C. #8. SEH shall provide the individual the opportunity beginning at the time of admission and continuously throughout the individual's stay, to be an active participant in					100	74	**86**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(continued below)

the discharge planning process, as appropriate							

N = All IRPs scheduled in the review month
n = number audited
Tab # 9 IRP Observation Audit results

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**
%C # 7h Individual participated in discharge/step down planning	100	100	50	100			**88**

N = All IRPs scheduled in the review month
n = number audited
Tab # 9 IRP Observation Audit results

Analysis/Action Plans: Data shows in general, individuals are involved in discharge planning. However to improve the quality of the involvement, all treatment teams and their members were provided additional training on engagement, and are being provided coaching on an on-going basis. ***See Tab # 1 IRP training materials and data.*** This will continue for the next six months, at least. Further, there are groups in the TLC that assist the individual in being more involved in treatment planning. ***See Tab # 69 TLC Catalogue.*** The Hospital will continue to monitor this through audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Recommendations:** 1. See all of section VII.A. and VII.B recommendations SEH Response: See all of section VII.A. and VII.B.
VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Recommendations:** 1. See VII.A, VII.A.1 and VII.C SEH Response: See all of section VII.A. and VII.B 2. The TLC activities need to clearly identify the learning, skill building or treatment goals for each activity in order for SEH staff to appropriately identify the individuals to attend which activities and for what purpose. SEH Response: Completed. ***See Tab # 69 TLC Catalogue.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(continued below)

DISCHARGE MONITORING AUDIT RESULTS

	Mar*	Apr	Mar	Jun	Jul	Aug	**Mean**
N		30	15	14	20	25	**21**
n		7	4	4	4	5	**5**
%S		23	27	29	20	20	**23**
%C. #20 Were there measurable interventions regarding the individual's particular discharge considerations?		n/a	n/a	n/a	75	80	**78**

N = All discharges in the month
n = number audited
* March audits were excluded because findings were based on an older audit tool that did not include comparable indicators. A mean from the prior review period is not available due to the change in the tool.
n/a - Indicators #20-23 were added in July, 2010
Tab # 68 Discharge audit results

Analysis/Action Plans: The audit tool was modified effective with July, 2010 audits to monitor this specific requirement, so it is too early to identify a trend, although early results support identifying this as an area in need of some improvement. As previously noted, extensive training around IRP development and individual engagement began in late July, 2010, and included modules on both discharge planning (September 2010) and development of focus statements, objectives and interventions. See V.A.3 and ***Tab #1*** for information about the training. It is expected that the training will improve performance on this requirement, especially beginning with the audits for October, 2010. Audits will continue to monitor performance on this requirement.

VII.C.2 — the persons responsible for accomplishing the interventions; and

Recommendation:

1. Treatment interventions and rehabilitation services must be implemented in response to specific treatment goals. See earlier recommendations around IRP processes.

SEH Response: This recommendation exceeds the scope of the requirement and will not be addressed.

.

Facility's findings:

DISCHARGE MONITORING AUDIT RESULTS

	Mar*	Apr	Mar	Jun	Jul	Aug	**Mean**
N		30	15	14	20	25	**21**
n		7	4	4	4	5	**5**
%S		23	27	29	20	20	**23**
%C. # 21 Was there an identified person(s) responsible for accomplishing the interventions?		n/a	n/a	n/a	75	100	**89**

N = All discharges in the month
n = number audited
* March audits were excluded because findings were based on an older audit tool that did not include comparable

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		indicators. A mean from the prior review period is not available due to the change in the tool. n/a - Indicators #20-23 were added in July, 2010 ***Tab # 68 Discharge audit results*** **Analysis/Action Plans:** The audit tool was modified effective with July, 2010 audits to monitor this specific requirement, so it is too early to identify a trend, although early results support identifying this as an area of good performance. As previously noted, extensive training around IRP development and individual engagement began in late July, 2010, and included modules on both discharge planning (September 2010) and development of focus statements, objectives and interventions. See V.A.3 and ***Tab #1*** for information about the training. It is expected that the training will improve performance on this requirement, especially beginning with the audits for October, 2010. As indicated in the training, however, the individual who is providing the intervention will be identified for groups or individual therapy, but not for day-to-day unit based interventions (i.e., taking vital signs as those will be assigned by nursing managers). Audits will continue to monitor performance on this requirement.
VII.C.3	the time frames for completion of the interventions.	**Recommendations:** 1. The IRP format must include specific timeframes for completion of interventions. SEH Response: The Hospital disagrees with this recommendation. Unless otherwise indicated in the IRP itself, the time frame is the period covered by the IRP. Plans are either 7 days, 14 days, 30 days or every 60 days. Therefore to require a specific time frame is unnecessary. 2. A monitoring tool must be developed to monitor the implementation of time specific interventions. SEH Response: The discharge audit tool was modified to assess if there is a timeframe for completion of the interventions.

DISCHARGE MONITORING AUDIT RESULTS

	Mar*	Apr	Mar	Jun	Jul	Aug	**Mean**
N		30	15	14	20	25	**21**
n		7	4	4	4	5	**5**
%S		23	27	29	20	20	**23**
%C. # 22 Were there time frames for the completion of the interventions?		n/a	n/a	n/a	75	100	**89**

N = All discharges in the month
n = number audited
* March audits were excluded because findings were based on an older audit tool that did not include comparable indicators. A mean from the prior review period is not available due to the change in the tool.
n/a - Indicators #20-23 were added in July, 2010.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>Tab # 68 Discharge audit results

Analysis/Action Plans: The audit tool was modified effective with July, 2010 audits to monitor this specific requirement, so it is too early to identify a trend, although early results support identifying this as an area of good performance. As previously noted, extensive training around IRP development and individual engagement began in late July, 2010, and included modules on both discharge planning (September 2010) and development of focus statements, objectives and interventions. See V.A.3 and Tab #1 for information about the training. It is expected that the training will improve performance on this requirement, especially beginning with the audits for October, 2010.

Audits will continue to monitor performance on this requirement.</td></tr>
<tr><td>VII.D</td><td>By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or.DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.</td><td>Recommendations:
1. See all of section VII.A

SEH Response: See all of section VII.A.

2. The hospital must focus on creating psychosocial rehabilitation services that facilitate an individual’s successful discharge to the community.

SEH Response: The TLC programming was revised effective September 20, 2010. There is now comprehensive cognitive programming that includes online cognitive skill building for those with mild impairments, paper/pencil cognitive skill building for those with moderate impairments and sensory enhancement/reminiscence/remotivation for those with mental retardation or dementia. In addition, there is dosing of groups, TAMAR groups, and basic social skills/living with people. In addition, there are numerous community integration groups that include readiness development, Stress Management, Money management, communication skills, communication skills and sexual issues for men, living skills lab, STAMP program, employee expectations/rights, resume writing/application completion, job seeking skills/interviewing techniques, education/vocational assessments, library appreciation group, consumer math, community awareness/reentry: exploring the community (weekly trips into the community); Takoma Park socialization; travel training; making friends/making connections; transitions; discharge planning; sexual issues and communication skills for women; and day programs. Tab # 69 TLC Catalogue; Tab # 85 Weekend and Evening Activities.

3. These services must be linked to specific, individual skills that are delineated in the IRP.

SEH Response: This is being monitored through a revised discharge monitoring tool.

<table>
<tr><th colspan="8">DISCHARGE MONITORING AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar*</td><td>Apr</td><td>Mar</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Mean</td></tr>
<tr><td>N</td><td></td><td>30</td><td>15</td><td>14</td><td>20</td><td>25</td><td>21</td></tr>
<tr><td>n</td><td></td><td>7</td><td>4</td><td>4</td><td>4</td><td>5</td><td>5</td></tr>
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<tr><td></td><td></td><td>
<table>
<tr><td>%S</td><td></td><td>23</td><td>27</td><td>29</td><td>20</td><td>20</td><td>23</td></tr>
<tr><td>%C. # 23 Is there evidence of adequate assistance in transitioning prior to discharge?</td><td></td><td>n/a</td><td>n/a</td><td>n/a</td><td>25</td><td>20</td><td>22</td></tr>
</table>
N = All discharges in the month
n = number audited
* March audits were excluded because findings were based on an older audit tool that did not include comparable indicators. A mean from the prior review period is not available due to the change in the tool.
n/a - Indicators #20-23 were added in July, 2010
Tab # 68 Discharge audit results

Analysis/Action Plans: The audit tool was modified effective with July, 2010 audits to monitor this specific requirement, so it is too early to identify a trend, although early results support identifying this as an area in need of significant improvement. As previously noted, extensive training around IRP development and individual engagement began in late July, 2010, and included modules on both discharge planning (September 2010) and development of focus statements, objectives and interventions. See V.A.3 and Tab #1 for information about the training. It is expected that the training will improve performance on this requirement, especially beginning with the audits for October, 2010. Further, as indicated above, the revised TLC curricula have far more robust offerings to address transition issues, and many of the groups include community visits to learn how to manage shopping, public transportation etc.

The Hospital will continue with monthly audits.
</td></tr>
<tr><td>VII.E</td><td>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.</td><td>
Recommendations:
1. SEH social work department must have a sufficient level of staffing to meet the clinical needs, including discharge planning of individuals. The hospital must clarify the organizational structure, number and roles of social work in the new hospital setting.

SEH Response: All but one social work staff vacancy has been filled, and that position is in recruitment. A second supervisory social worker has been hired and organization structure was finalized. Each supervisor will supervise 6-7 social workers, and one supervisor will be also responsible for training and the other for systemic discharge issues and linking with DMH. This ratio will allow for weekly supervision of the individual workers. To this end, the supervisory social worker leading discharge related improvements and DMH’s Director of Integrated Care have developed an all day training, (scheduled for October 5) with Hospital social workers and community case managers. See VII.A. for description of the workshop. Tab # 164.

2. SEH’s Hospital Discharge Planning Process (draft 4/2010) must immediately be reviewed, revised and implemented. SEH, DMH and its certified providers must be in agreement with each respective role.

SEH Response: Completed. This is part of the continuity of care guidelines and will be reviewed at the October 5th workshop. Tab # 83 Discharge Planning process.
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		3. SEH Social Work Department must incorporate orientation to community services and develop (or receive) written materials describing the range of community services and supports available for individuals as well as the skills and clinical appropriateness of individuals for each service type. SEH Response: Completed. This will be reviewed at the October 5th workshop. It will be included in new employee orientation. 4. Under the leadership of DMH, a process for resolving clinical (and administrative disputes) between its community agencies and SEH must be developed immediately. A quality assurance mechanism must be developed and implemented to identify systemic or individual issues. SEH Response: This is part of the process of the Monday community integration meetings. The Hospital is not agreeable to implement an additional audit, but the new log will serve as a mechanism to identify systemic or individual issues.

DISCHARGE MONITORING AUDIT RESULTS

	Mar*	Apr	Mar	Jun	Jul	Aug	**Mean**
N		30	15	14	20	25	**21**
n		7	4	4	4	5	**5**
%S		23	27	29	20	20	**23**
%C. # 6 Is there documented evidence of active collaboration with a CSA?		67	50	0	25	60	**43**
%C. # 7 Was the outpatient psychiatrist identified?		67	100	75	75	80	**78**
%C. #8 Was the outpatient/community support worker identified?		100	100	67	75	80	**87**
%C. # 9 Was the next outpatient (medication or therapy) appointment date indicated?		86	75	25	50	100	**71**
%C. # 10 Was the outpatient medical appointment date indicated?		100	33	0	0	20	**40**
%C. # 11 Was the specific role of medication completed?		86	75	75	25	20	**58**
%C. # 12 Was the exact type of day services or employment indicated?		86	100	25	50	80	**71**
%C. # 13 Were the type and location of substance abuse/addiction services indicated?		67	NA	NA	50	0	**50**
%C. # 14 If the individual has an active Axis III diagnosis, were ongoing medical needs identified?		67	67	50	75	40	**59**
%C. # 15 Was housing secured?		71	75	75	50	80	**71**
%C. # 16 Was the individual's benefit information completed?		86	100	75	50	100	**83**
%C. # 17 Were any other specialized services identified?		67	100	50	33	80	**68**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C. # 18 Was the discharge plan of care signed by the individual or his/her legal representative? | | n/a | n/a | n/a | n/a | n/a | n/a %C. # 19 Was a copy of the Discharge plan of care given to the individual or the individual's family or legal representative? | | n/a | n/a | n/a | n/a | n/a | n/a N = All discharges in the month n = number audited * March audits were excluded because findings were based on an older audit tool that did not include comparable indicators. A mean from the prior review period is not available due to the change in the tool. n/a - Could not verify signatures in avatar-predated provision of signature pads. ***Tab # 68 Discharge audit results*** **Analysis/Action Plans:** See VII.A. Discharge audits will continue. Social work supervisors, as well as the Director of Medical Affairs will review data monthly to identify systemic issues or trend among individual practitioners.
VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	
VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at· discharge; and	**Recommendations:** 1. The monitoring tool must include a check off that confirms that the discharge plan of care was submitted to DMH. SEH Response: Completed. ***See Tab # 67 Discharge Audit Tool.*** The Discharge plan of care is sent to the Director of Integrated Care and the Discharge plan of care is in Avatar which is accessible to DMH. 2. The monitoring tool for the discharge plan of care must be implemented on a very timely basis for all records in order to ensure that there is follow up on all discharges. A process for ensuring compliance must be developed. SEH Response: Do not agree the monitoring tool for the discharge plan of care must be implemented for all records. That is overly burdensome, and is not required by the Settlement Agreement. The Hospital will complete the Discharge Monitoring tool each month and review a minimum 10% of discharges per the Audit Plan submitted in May, 2010. DMH will review a minimum of 20% of discharges for up to 90 days to assess implementation of outpatient services. ***See Tab # 73 Post discharge audit results*** 3. SEH must review and finalize promptly the pilot monitoring tool for discharge plan of care (adopted March 2010) and the Discharge/Outplacement Quality Assessment tool to ensure consistency, eliminate any redundancies and/or to achieve any efficiency in implementation.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Tools were combined and audits underway. ***See Tab # 67 Discharge Audit Tool.*** **Analysis/Action Plan:** The DMH and Hospital continue to work closely to improve effective discharge planning. The weekly meetings are continuing, and a series of trainings are underway around discharge planning.
VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Completed.**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.	**SPECIFIC TREATMENT SERVICES**	
VIII.A	Psychiatric Care	
	By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	
VIII.A.1	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	
VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Recommendations:** 1. Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. SEH Response: See VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. 2. Same as in VI.A.7. SEH Response: See in VI.A.7
VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;	**Recommendations:** 1. Same as in VI.A.7. SEH Response: See VI.A.7. **FACILITY'S FINDINGS**

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 7 Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and how the benefits of these interventions outweighed their risks, triggers, frequency, etc?	80	50	78	67	60	50	**68**	**68**
%C # 8 If standing medication is being administered involuntarily is there adequate explanation why?	89	75	88	92	100	75	**77**	**88**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #9 Are the appropriate adverse reactions noted in the appropriate subsection with respect to FGA or SGA antipsychotics	96	100	100	78	81	83	**86**	**88**
		%C # 11 Were the risk assessment subsections of the psychiatric update fully and accurately completed?	94	100	97	98	93	86	**91**	**95**
		%C # 13 Does the psychiatric update accurately reflect the individual's response to treatment/progress	94	100	100	100	100	100	**93**	**99**
		%C # 14 Is the diagnosis section accurately updated and completed?	97	86	97	98	100	86	**98**	**97**
		%C # 22 If abnormal labs are indicated, is there evidence of appropriate follow up and response?	90	67	100	100	96	80	**75**	**95**
		%C # 23 Does the pharmacological plan of care reflect the diagnosis, mental status assessment and individual's response to treatment?	100	83	100	100	100	86	**94**	**99**
		%C #24 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	97	83	90	81	96	83	**79**	**90**
		%C #28 Does the psychiatric update reflect a current and accurate list of barriers to discharge?	100	100	100	100	93	100	**89**	**99**
		%C # 29 If completed by a resident, is there documented evidence that the psychiatric update was reviewed by attending psychiatrist and issues noted?	57	50	100	85	100	86	**47**	**83**

N = End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 11 Psychiatric Update Audit Results

Analysis/Action Plans: Performance improved on all but one indicator (# 14, completion of diagnosis section), which fell from 98% to 97% . Indicators with significant improvement include # 4 (vital signs indicated, rising from 76% to 88%); completion of mental status section (indicator # 5) which improved from 93% to 99%; explanation for medication administered involuntarily (# 8) which improved from 77% to 88%; psychiatric update reflects response to treatment (# 13) up from 93% to 99%. Even two indicators for which additional improvement is needed (#16 and # 17) around documented rationale for deferred Axis II or R/O or NOS diagnosis, showed marked gains of 9% to 10%.

Audits monitoring performance of this requirement will continue. The Director of Medical Affairs will monitor for changes in trends or issues around a particular practitioner's performance and will address them with the individual practitioner as appropriate.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Recommendations:** 1. Same as in VI.A.7.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: See VI.A.7 **FACILITY'S FINDINGS**

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C #13 Does the psychiatric update accurately reflect the individual's response to treatment/progress?	94	100	100	100	100	100	**93**	**99**
%C # 14 Is the diagnosis section accurately updated and completed?	97	86	97	98	100	86	**98**	**97**
%C # 14a Does the diagnosis reflect current clinical data or was it changed or updated based upon change in current clinical data?	67	100	97	100	100	100	**n/a**	**98**
%C #23 Does the pharmacological plan of care reflect the diagnoses, mental status assessment and individual's response to treatment?	100	83	100	100	100	86	**94**	**99**
%C #27 Does the psychiatric update include an appropriate plan that includes integration of behavioral and psychiatric interventions?	97	100	100	100	90	100	**84**	**97**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 11 Psychiatric Update Audit Results

Analysis/Action Plans: Performance improved, most significantly around ensuring the update includes a plan that integrates behavioral and psychiatric interventions. Audits to monitor this requirement will continue. The Director of Medical Affairs will monitor for changes in trends or issues around a particular practitioner's performance.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Recommendations:** 1. Same as in VI.A.7. SEH Response: See VI.A.7 **FACILITY'S FINDINGS**

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 25 Are the risks associated with the medication regimen addressed?	88	75	83	83	86	100	**68**	**86**

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

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 7 Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and how the benefits of these interventions outweighed their risks, triggers, frequency, etc?	80	50	78	67	60	50	**68**	**68**
%C #9 Are the appropriate adverse reactions noted in the appropriate subsection with respect to FGA or SGA antipsychotics	96	100	100	78	81	83	**86**	**88**
%C # 20 If the medication regimen includes use of anti-cholinergics in an individual with diagnosis of cognitive disorder, is there an adequate justification?	43	100	92	100	100	n/a	**81**	**84**
%C # 22 If abnormal labs are indicated, is there evidence of appropriate follow up and response?	90	67	100	100	96	80	**75**	**95**
%C #24 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	97	83	90	81	96	83	**79**	**90**
%C # 25 Does the psychopharmacological plan of care adequately address the use of > than 2 anti-psychotics and/or 3 or more psychotropics?	64	100	100	100	56	50	**68**	**88**
%C # 26 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse diagnosis?	71	50	100	91	80	n/a	**82**	**88**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 11 Psychiatric Update Audit Results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: Despite a positive trend, the audits suggest that improvement is still needed in documenting the rationale underlying medication choices and the risks/ benefits; this is especially true around use of STAT medications and use of benzodiazepines. The Medical Director will continue audits and will identify practitioner issues. In addition, the medication guidelines were modified and he will review the documentation expectations during his monthly meetings with psychiatrists.
VIII.A.1.e	assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Recommendations:** 1. Same as in V.B.5, VI.A.7.and VI.A.2 SEH Response: See V.B.5, VI.A.7.and VI.A.2

FACILITY'S FINDINGS

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C #18 Were the following components of a risk assessment completed?*	*	*	*	*	*	*	**86**	**100**
%C #18a Risk of self injury	88	100	100	100	100	100	*	**98**
%C # 18b Risk of completed suicide	88	100	100	100	100	100	*	**98**
%C # 18c Risk of physical aggression	100	100	100	100	100	100	*	**100**
%C # 18d Risk of sexual aggression	100	100	100	100	100	100	*	**100**
%C # 18e Risk of elopement	100	100	100	100	100	100	*	**100**
%C #19 For each type of risk that was identified as mild or above, were appropriate precautions identified?	100	100	100	100	100	75	**63**	**95**

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

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 7 Is there adequate explanation for use of STAT medications, seclusion or restraint-specifically if and	80	50	78	67	60	50	**68**	**68**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table continued below)

how the benefits of these interventions outweighed their risks, triggers, frequency, etc?								
%C # 8 If standing medication is being administered involuntarily is there adequate explanation why?	89	75	88	92	100	75	**77**	**88**
%C # 11 Were the risk assessment subsections of the psychiatric update fully and accurately completed?	94	100	97	98	93	86	**91**	**95**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
Tab # 11 Psychiatric Update Audit Results

Analysis/Action Plans: The audit results suggest high or improving performance around completion of risk assessments and addressing use of involuntary medication, but reflect a need to improve performance in addressing use of STAT medications and use of restraint or seclusion. The Medical Director will share audit results with the psychiatrists; however, the revised psychiatric update will be in Avatar in October, 2010, and addressing the use of STAT medication will be a required field. He will continue to work with psychiatrists around the quality of documentation.

In addition, the Hospital is tracking high risk through the High Risk Indicator Event System. Here, if an individual in care is involved in 3 or more UIs in a 30 day period, the Medical Director is notified. Either he or the Director of Psychiatric Services are reviewing the record, talking with member of the team and making recommendations, documented through a progress note in the record. ***See Tab # 56, Risk Indicator Event System.*** This will continue.

VIII.A.1.f — documentation of, and responses to, side effects of prescribed medications;

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

SEH Response: See VI.A.1 and VI.A.7, VIII.A.1.e.

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 25 Are the risks associated with the medication regimen addressed?	88	75	83	83	86	100	**68**	**86**

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

PSYCHIATRIC UPDATE AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table below) N= End of month census less monthly admissions n = Number audited. (Target is two per unit psychiatrist per audit sample plan ***Tab # 11 Psychiatric Update Audit Results*** **Analysis/Action Plans:** The audits suggest performance is improving. The Hospital will continue monitoring through the audits.
VIII.A.1.g	documentation of reasons for complex pharmacological treatment;	**Recommendations:** 1. Same as in VI.A.7. SEH Response: See VI.A.7. 2. Provide monitoring data based on the Medication Monitoring Form (items related to intra and interclass polypharmacy) during the review period. SEH Response: Pharmacy continues its medication monitoring auditing, and the methodology changed in August. Prior to that time, pharmacy was conducting its audits by reviewing all records on a particular ward, then moving to another one the next month. Beginning in August, Pharmacy began reviewing a sample of records on multiple wards, still with the goal of an audit of each individual's medication regimen at least once per year. See below for findIngs. 3. Ensure that the progress report includes a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 9 Are the appropriate adverse reactions noted in the appropriate subsection with respect to treatment with FGA or SGA anti-psychotics?	96	100	100	78	81	83	**86**	**88**
%C # 21 Does the Psychiatric Update reflect that lab levels were obtained?	86	100	100	98	87	71	**83**	**92**
%C # 22 If abnormal results are indicated, is there evidence of appropriate follow up and response?	90	67	100	100	96	80	**75**	**95**
%C # 24 Does the pharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	97	83	90	81	96	83	**79**	**90**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Facility's findings:

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 20 If the medication regimen includes use of anti-cholinergics in an individual with diagnosis of cognitive disorder, is there an adequate justification?	43	100	92	100	100	n/a	**81**	**84**
%C # 24 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	97	83	90	81	96	83	**79**	**90**
%C # 25 Does the psychopharmacological plan of care adequately address the use of > than 2 anti-psychotics and/or 3 or more psychotropics?	64	100	100	100	56	50	**68**	**88**
%C # 26 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse diagnosis?	71	50	100	91	80	n/a	**82**	**88**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
Tab # 11 Psychiatric Update Audit Results

MEDICATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	387	362	346	348	360	362	**385**	**358**
n	63	5	8	20	27	13	**41**	**23**
%S	17	1	2	6	8	4	**11**	**6**
%C B2a Was there any use of 3 or more psychotropic medications within the same class at the same time during the review period?	0	0	0	0	0	0	**2**	**0**
%C B2c If so, is there physician-documented evidence of rationale for the use of three or more intra-class medications?	n/a	n/a	n/a	n/a	n/a	n/a	**80**	**n/a**
%C B3a Was there any use of 4 or more psychotropic medications from different classes at the same time during the review period?	2	0	0	0	0	0	**1**	**1**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see table and analysis below)

%C B3c If so, is there physician documented evidence of rationale for the use of 4 or more inter-class medications?	0	n/a	n/a	n/a	n/a	n/a	**67**	**0**
%C B3d If not, has the pharmacist taken any follow-up action, such as making recommendations to the attending psychiatrist?	0	n/a	n/a	n/a	n/a	n/a	**0**	**0**

N= Number of individuals served
n= number audited
Tab # 66 Medication Monitoring Audit results

Analysis/Action Plan: This requirement is being audited through the Psychiatric Update audit as well as the Pharmacy audits. Pharmacy is continuing its monthly audits, however the sampling method changed somewhat in August, 2010 The data of audited cases shows improvement in some categories (i.e. no cases audited in 3 or more intra-class medications of the 137 cases reviewed) but in July, there was 1 cases of 4 or more inter-class psychotropic medications which did not have a rationale documented for their use. The Director of Psychiatry is regularly pulling reports involving cases of complex pharmacology and is monitoring its usage; he follows up as necessary with individual doctors.

Further the Hospital is continuing to track other key data. The number of individuals receiving three or more anti-psychotics within the same class was 14 as of February 28, 2010, and 15 as of September 20, 2010. The number of individuals taking 4 or more interclass medications is 27. The number of individuals with a cognitive impairment diagnosis who are on benzodiazepines longer than 90 days is 10 (8 in February 2010) , and the number of individuals with a substance abuse diagnosis who are on benzodiazepines longer than 90 days is 8 (9 in February). Twenty four individuals (all diagnoses) have been on benzodiazepines longer than 90 days. Finally, the number of individuals on anti-cholinergics longer than 90 days is 30; of those, only one individual (23 in February) with a cognitive impairment has been on anti-cholinergics longer than 90 days. It should be noted that it is likely that the individuals currently on these medications may not be the same as who were on them in the February time period.

The Hospital will continue with audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	**Recommendations:** 1. Same as in VI.A.7. SEH Response: See VI.A.7. 2. Implement corrective actions to ensure the adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval. SEH Response: The Hospital is monitoring use of STAT medications through Psychiatric Update audits as well as the high risk indicator process. See psychiatric update audit data below. Under the UI policy an unusual incident report is

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		completed when a STAT medication is administered. Further, the high risk indicator process captures 3 or more UIs of any type within a thirty day period, so that an individual with three or more STAT medications, or with two STAT administrations and one other UI, or one STAT and two other types of UIs within a thirty day period will be “flagged”. The Director of Psychiatry then reviews the record, and speaks with treatment team members as needed; he documents his recommendations in a progress note in Avatar. As noted in prior reports, PRN orders for psychotropic medications are not permitted by policy although during this review period, three instances were identified. Two were remedied immediately when the medications were discontinued, and the third was remedied once it was identified. 3. Provide monitoring data based on the Psychiatric update Audit. SEH Response: See data below. 4. Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 7 Is there an adequate explanation for the use of STAT medications, seclusion/restraint- specifically if and how the benefits of these interventions outweighed their risks, any triggers, frequency, etc. ?	80	50	78	67	60	50	**68**	**68**
%C #8 If standing medication is being administered involuntarily is there adequate explanation why?	89	75	88	92	100	75	**77**	**88**
%C #23 Does the pharmacological plan of care reflect adequately address the diagnoses, mental status assessment and individual’s response to treatment?	100	83	100	100	100	86	**94**	**99**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan)
Tab # 11 Psychiatric Update Audit Results

Analysis/Action Plan: See response to recommendation #2. The Hospital will continue its monthly audits. The Medical Director is reminding staff about the importance of including rationales in the Psychiatric Updates.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.A.2	By 18 months from the Effective Date	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	
VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	
VIII.A.2.a.i	clinically justified;	**Recommendations:** 1. Same as in VIII.A.2.b.i (individualized medication guidelines) and VIII.A.2.b.iv (drug utilization evaluation). SEH Response: Medication guidelines were updated and in the appendix include a monitoring cue card for many medications. ***See Tab # 87 Medication Guidelines.*** The Hospital completed a DUE relating to the "Effect of Atypical Antipsychotic Agents on the Hemoglobin A1C of Patients in the Care of Saint Elizabeths Hospital". ***Tab #86, Drug Utilization Review.*** 2. Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications. SEH Response: The Hospital is utilizing several strategies to improve performance in these areas. The medication guidelines were updated and now include more specific monitoring guidelines as well as monitoring cue card that should assist physicians in perfecting their practice. It also continues to use the various audits to track its performance. See response to VIII.A.1.d, VIII.A.1.f and g as well. See below for analysis of audit results. Data from these audits generally show progress. 3. Provide monitoring data regarding high risk medication uses, based on at least 20% sample during the review period. SEH Response: See data below. The Hospital does not accept this recommendation insofar as it requires a 20% sample, but will continue audits per the Audit Sample Plan. ***Tab # 36 Audit Sample plan.*** 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response;

PSYCHIATRIC UPDATE AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 20 If the medication regimen includes use of anti-cholinergics in an individual with diagnosis of cognitive disorder, is there an adequate justification?	43	100	92	100	100	n/a	**81**	**84**
%C # 24 Does the psychopharmacological plan of care adequately address the monitoring of FGA or SGA for adverse reactions/side effects?	97	83	90	81	96	83	**79**	**90**
%C # 25 Does the psychopharmacological plan of care adequately address the use of > than 2 anti-psychotics and/or 3 or more psychotropics?	64	100	100	100	56	50	**68**	**88**
%C # 26 Does the psychopharmacological plan of care adequately address the use of benzodiazepines if the individual carries substance abuse diagnosis?	71	50	100	91	80	n/a	**82**	**88**

N= End of month census less monthly admissions

n = Number audited. (Target is two per unit psychiatrist per audit sample plan

Tab # 11 Psychiatric Update Audit Results

MEDICATION MONITORING AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	387	362	346	348	360	362	**385**	**358**
n	63	5	8	20	27	13	**41**	**23**
%S	17	1	2	6	8	4	**11**	**6**
% C # A- 5 Are there any medications that should have been considered as an alternative relative to the individual's age or other risk factors?	2	0	0	0	4	0	**1**	**1**
%C #A-6a Does the individual have conditions or indications for which medication may be appropriate but are not being used?	3	0	13	0	0	0	**4**	**2**
%C # A-7. Does the patient's medication have a current and valid indication?	94	100	100	1000	96	92	**n/a**	**96**
%C #B-2a Individuals prescribed three or more psychotropic medications within the same class at the same time during the review period?	0	0	0	0	0	0	**2**	**0**
%C # B-2c If 3 or more intra-class medications were used at the same time, is there psychiatrist documented evidence of rationale consistent with hospital medication guidelines?	n/a	n/a	n/a	n/a	n/a	n/a	**80**	**n/a**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #B-3a Was there use of 4 or more psychotropic medications from different classes at the same time during the review period.	2	0	0	0	0	0	**1**	**1**
		%C #B-3c If 4 or more psychotropic medications from different classes were used at the same time, is there a physician documented evidence of rationale for use of 4 or more psychotropic medications?	0	n/a	n/a	n/a	n/a	n/a	**67**	**0**
		%C # C-2 Is a geriatric patient on a medication that can cause delirium?	22	0	0	11	0	0	**26**	**13**
		%C # C-3a Is the geriatric individual's creatinine clearance being monitored?	94	0	80	67	50	100	**93**	**83**
		%C #C-5a Geriatric individual prescribed medication on the BEERS list	67	n/a	80	22	50	40	**23**	**53**
		%C # D-3 Does the individual have a valid and current indication for use of anti-cholinergics?	0	n/a	0	0	0	100	**100**	**6**
		%C # D-5a Is there evidence the individual experienced side effects that support use of anti-cholinergics?	44	n/a	0	25	11	50	**27**	**32**
		%C # D-6a Is there evidence that the individual experience side effects caused by anti-cholinergics?	0	n/a	0	0	0	0	**n/a**	**0**
		%C #D-6c Is there documentation that the psychiatrist is aware of side effects from use of anti-cholinergics but considers benefits to outweigh risks.	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**	**n/a**
		% #D-7a Use of anti-cholinergics in individuals with TD	6	n/a	100	0	0	0	**8**	**6**
		%C #D-8a Use of anti-cholinergics in individuals with cognitive disorder dx	0	n/a	0	0	11	0	**6**	**3**
		%C # D-8b If the individual has a cognitive disorder is there documented evidence that the psychiatrist has evaluated risks against the benefits of use of an anti-cholinergic?	n/a	n/a	n/a	n/a	100	n/a	**40**	**100**
		%C # E-2 Duration of therapy with SGA exceeds 90 days	75	100	100	80	47	82	**72**	**74**
		%C # E-3 Does the use of SGA have a valid and current indication?	98	100	100	100	94	100	**98**	**98**
		%C # E-6a Has the individual receiving SGA been diagnosed with diabetes?	20	25	25	20	12	18	**17**	**19**
		%C #E-6b Is there documented evidence that the psychiatrist has evaluated diabetes risk associated with this medication?	56	100	0	100	50	0	**25**	**56**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT								
		%C #E-7 BMI is 30 or greater	43	50	25	67	35	9	**35**	**41**
		%C # E-8 Is there documented evidence that the treatment team is monitoring BMI for individual on SGA?	95	100	100	93	94	73	**64**	**93**
		%C #E- 9a Are appropriate labs being ordered and reviewed per the medication guidelines for SGA?	95	100	100	87	94	100	**88**	**95**
		%C # E-9b If no labs completed, has the pharmacist taken follow up actions	0	n/a	n/a	0	100	n/a	**13**	**20**
		%C #F -2a Benzodiazepines prescribed for more than 90 days	74	n/a	100	75	60	67	**73**	**74**
		%C #F-3 Is there current and valid indication for use of benzodiazepines	100	n/a	100	100	80	100	**98**	**97**
		%C # F-6 Does individual being prescribed benzodiazepines have current of history of substance abuse/dependence disorder?	17	n/a	0	0	0	33	**19**	**13**
		%C # F-7 Does the individual being prescribed benzodiazepines have a diagnosed cognitive disorder?	13	n/a	0	25	0	33	**11**	**13**
		%C #F-8a Is there documented evidence that psychiatrist evaluated risk of medication regimen (benzodiazepines) against benefits?	74	n/a	0	25	20	33	**24**	**53**
		%C # J-4a Have the appropriate examinations/tests been completed and documented prior to Clozapine being started?	n/a	n/a	n/a	100	100	100	**93**	**100**
		%C #J-4b Has any of the labs or exams produced abnormal results	n/a	n/a	n/a	0	0	0	**7**	**0**
		%C # J-6a Has the individual been monitored appropriately while on clozapine according to SEH medication guidelines	n/a	n/a	n/a	100	100	100	**93**	**100**

N=Number of individuals served
n=number audited
Tab # 66 Medication Monitoring Audit results

Analysis and Action The data from the medication monitoring audits by pharmacy suggest areas in which improvement continues but also some areas in which performance is declining. The data from the Psychiatric Update audits suggest overall improving performance.

Polypharmacy: Areas of improvement in polypharmacy include the percentage of individuals prescribed 3 or more intra-class psychotropic medications (from 2% to 0%). There were only 2% of cases in one month that included four or more inter-class psychotropic medications being prescribed to an individual, but in that case there was not a documented rationale. Benzodiazepines: The medication monitoring audits showed improvement in several

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		prescribing practices around benzodiazepines, including a decrease in use for individuals with substance abuse/dependence disorders (19% to 13%), and documentation that the psychiatrist evaluated the risks of the medication regimen against the benefits, from 24% to 53% of cases. However, the percentage of individuals prescribed benzodiazepines for more than 90 days in the sample increased slightly, from 73% to 74%, the percentage of those with a cognitive disorder diagnosis being prescribed benzodiazepines increased from 11% to 13% of the sample, and the percentage with a valid and current indication decreased very slightly from 98% to 97%. While the percentages increased the numbers actually decreased. Anticholinergics: Here performance improved in all indicators measured in the medication monitoring audit. Documentation of side effects that support use of anticholinergics improved from 27% to 32%, the use of anticholinergics in individuals with a TD diagnosis decreased from 8% to 6% of cases reviewed as did their use in individuals with a cognitive disorder diagnosis (from 6% to 3%) and documentation that the doctor has evaluated risks and benefits of anticholinergics in a person with a cognitive diagnosis improved from 40% to 100% of cases reviewed. However, only 6% of individuals prescribed antu-cholinergics had a valid and current indication compared with 100% during the last review period. Geriatric: The medication monitoring audits showed improvement in the prescribing practices around use of medications that cause delirium in geriatric individuals which dropped from 26% during the last period to 13% during this review (it had been 56% at the Sept 2009 review). Of concern however is that the creatinine level monitoring for geriatric individuals dropped from 93% to 83% in this review period. These cases are being referred to the Supervisory General Medical Officer for follow up. SGA and metabolic risks: There was a slight increase in the percentage of individuals prescribed SGAs and diagnosed with diabetes during the review period, from 17% in the last review period to 19% during this review period and those with a BMI of 30 or more increased from 35% to 41%. Some of this increase may be attributable to better tracking of BMI or those with diabetes diagnoses that predated the medication regimen, so it is not clear if it is a true increase or simply reflects what has been the case in the past but for which data was not being captured. The medication monitoring audits also show, however, improvement around documentation that the treatment team is monitoring the BMI, from 64% during the prior review period to 93% during this review period and continued high performance (95%) in the ordering of appropriate labs. The number of individuals receiving three or more anti-psychotics within the same class was 14 as of February 28, 2010, and 15 as of September 20, 2010. The number of individuals taking 4 or more interclass medications is 27. The number of individuals with a cognitive impairment diagnosis who are on benzodiazepines longer than 90 days is 10 (compared with 8 in February) , and the number of individuals with a substance abuse diagnosis who are on benzodiazepines longer than 90 days is 8 (compared with 9 in February). Twenty four individuals (all diagnoses) have been on benzodiazepines longer than 90 days. Finally, the number of individuals on anti-cholinergics longer than 90 days is 30; of those, only one individual (compared with 23 in February) with a cognitive impairment has been on anti-cholinergics longer than 90 days. It is important to note that these numbers do not reflect a cohort comparison, in that these are not necessarily the same individuals as were on the medications at the time of the last review period. In addition, a DUE was completed during this review period which focused on the relationship between atypical antipsychotics and new onset diabetes. That study revealed several key findings: 1) 25% (57 individuals) of those on AAPs had a diabetes diagnosis; 2) that of the 57 individuals with a diabetes diagnosis, 72% (41) had the diagnosis before the AAP regimen was begun, and 28% developed it after beginning AAPs. The DUE included several

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		recommendations which will be presented to Pharmacy and Therapeutics Committee during its October 2010 meeting. ***See Tab # 86 Drug Use Evaluation.***
VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.v	evaluated for side effects; and	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.a.vi	documented.	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	**Recommendations:** 1. Same as above. SEH Response: Same as above.
VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use	**Recommendations:** 1. Fully implement the revised guidelines and develop and implement individualized monitoring standards (frequency and type of testing) for each NGA medication on the formulary. SEH Response: Completed. Guidelines include baseline monitoring, periodic monitoring guidelines and a monitoring

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	of classes of medications in the formulary;	cue card for both FGA and new generation medications. ***See Tab # 87 Medication Guidelines (revised) and Appendices 5 and 6 to guidelines.*** 2. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. SEH Response: Completed and ongoing. ***See Tab # 87 Medication Guidelines (revised)*** **Analysis and Action Plan:** Continue medication monitoring audits.
VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of· PRN uses;	**Recommendations:** 1. Same as in VIII.A.1.h. 2. SEH Response: The Hospital protocol clearly provides that PRN orders may not be used for psychotropic medications. It is monitored through a report available daily in Avatar and through the medication monitoring audits. The psychiatric update audit also reviews use of STAT medications, which are also monitored through an Avatar report. **Facility's findings:**

MEDICATION MONITORING AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	387	362	346	348	360	362	**385**	**358**
n	63	5	8	20	27	13	**41**	**23**
%S	17	1	2	6	8	4	**11**	**6**
%C # G-1a Individuals with psychiatric/psychotropic PRN medication orders during review period	0	0	0	0	11	0	**0**	**2**
%C #G1-b Psychiatric PRN medication administered by injection	n/a	n/a	n/a	n/a	0	n/a	**0**	**0**

N= Total individuals served
n= number audited
Tab # 66 Medication Monitoring Audit results

PSYCHIATRIC UPDATE AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**

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

%C # 7 Is there an adequate explanation for the use of STAT medications, seclusion/restraint- specifically if and how the benefits of these interventions outweighed their risks, any triggers, frequency, etc. ?	80	50	78	67	60	50	**68**	**68**

N= End of month census less monthly admissions
n = Number audited. (Target is two per unit psychiatrist per audit sample plan
Tab # 11 Psychiatric Update audit results

Analysis and Action Plan: The Hospital identified three cases in which a PRN order was written for psychiatric medication. Of the three cases, two orders were discontinued prior to being discovered. The order for one individual was still active at the time of the review but has been discontinued. In an effort to minimize the likelihood of this occurring again, Pharmacy will review this as part of the order verification process and notify the physician of the policy that prohibits such orders.
</td></tr>
<tr><td>VIII.A.2.b.iii</td><td>establish a system for the pharmacist to communicate drug alerts to the medical staff; and</td><td>

Recommendations:

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

SEH Response: See data below.

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

SEH Response: Drug alerts are present to the P and T Committee. See ***Tab #90 Pharmacy and Therapeutics Committee Minutes, (March through Jul 2010)*** There was one drug alert for the medication Lamictal during the review period (March 2010 – August 2010).
</td></tr>
<tr><td>VIII.A.2.b.iv</td><td>provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.</td><td>

Recommendations:

1. Adverse Drug Reactions (ADRs): Ensure that the self-report contains summary information to address the following:
2.

a) Corrective actions to increase reporting of ADRs;

SEH Response: The Hospital continues to monitor ADR reporting through it Pharmacy and Therapeutics Committee and through medication monitoring audits and continues to work with physicians around the importance of reporting ADRs but admittedly strategies to date have not proven to be effective. As the data shows, there still is significant underreporting of ADRS as the medication audits during this review found 0% compliance with reporting ADRs in those categories reviewed.

MEDICATION MONITORING AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

N	387	362	346	348	360	362	**385**	**358**
n	63	5	8	20	27	13	**41**	**23**
%S	17	1	2	6	8	4	**11**	**6**
%C # D-5 d If the individual experience side effects from medication that are considered to be an adverse drug reaction is there evidence it was reported as an ADR?	0	n/a	n/a	n/a	0	0	**n/a**	**0**
%C #E-5c If the individual experienced side effects from SGA, is there evidence it was reported as an ADR	0	n/a	n/a	n/a	0	n/a	**0**	**0**

N= Total individuals served
n= number audited
Tab # 66 Medication Monitoring Audit results

Beginning in September, 2010, a new strategy was added - - the Chief Pharmacist is now getting the 24 hour nursing report which allows him to review transfers or medical calls to units for possible ADRs. When he identifies a possible ADR, he contacts the relevant physician for information and requests that the ADR be filed if appropriate. This latter mechanism will only capture the more serious ADRs, but it is expected to increase physician awareness of ADR reporting requirements. In addition, this issue is reviewed regularly with medical staff at the monthly meetings with the Medical Director.

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

Total Number of Reported ADRs by Month								
Previous Review Period	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Total**	**Mean**
Current Review Period	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**		
Previous	**12**	**1**	**1**	**2**	**11**	**3**	**30**	**5.0**
Current	**10**	**0**	**11**	**8**	**3**	**10**	**42**	**7.0**

Tab # 93 Pharmacy and Therapeutics Committee Data

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

Probability of ADRs									
Probability	**Previous Period**	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Total**	**Mean**
	Current Period	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**		
Doubtful	**Previous**	n/a	n/a	n/a	1	2	1	**4**	**1.3**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Current	2	0	0	0	0	0	**2**	**0.3**
Possible	Previous	n/a	n/a	n/a	0	5	1	**6**	**2.0**
	Current	6	0	3	3	2	7	**21**	**3.5**
Probable	Previous	n/a	n/a	n/a	1	3	1	**5**	**1.7**
	Current	2	0	6	5	1	3	**17**	**2.8**
Definite	Previous	n/a	n/a	n/a	0	1	0	**1**	**0.3**
	Current	0	0	2	0	0	0	**2**	**0.3**

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

Severity of ADRs									
Severity Level	Previous Period	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Total	Mean
	Current Period	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10		
Mild (0)	Previous	n/a	n/a	n/a	0	2	0	**2**	**0.7**
	Current	2	0	0	1	0	1	**4**	**0.7**
Moderate (1~2)	Previous	n/a	n/a	n/a	8	0	11	**19**	**6.3**
	Current	8	0	11	7	3	9	**38**	**6.3**
Severe (3~5)	Previous	n/a	n/a	n/a	0	1	0	**1**	**0.3**
	Current	0	0	0	0	0	0	**0**	**0.0**

Outcome of Reaction								
Result	Mar	Apr	May	Jun	Jul	Aug	Total	Mean
Recovered/resolved Completely	3	0	5	2	0	0	**10**	**1.7**
Recovered/resolved with sequelae	0	0	0	0	0	0	**0**	**0.0**
Recovering/resolving	0	0	0	0	0	0	**0**	**0.0**
Not recovered/not resolved	3	0	4	3	0	3	**13**	**2.2**
Fatal	0	0	0	0	0	0	**0**	**0.0**
Unknown	4	0	2	3	3	7	**19**	**3.2**

Reporter Discipline								
Result	Mar	Apr	May	Jun	Jul	Aug	Total	Mean
Nurse	0	0	0	0	0	0	**0**	**0.0**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Pharmacist	1	0	0	1	0	1	**3**	**0.5**
Medical	2	0	2	1	0	0	**5**	**0.8**
Psychiatrist	7	0	9	6	3	9	**34**	**5.7**

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

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

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

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

g) Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns. See above discussion in a).

SEH Response: See response to a) above.

3. Drug Utilization Evaluation (DUE): Ensure that the self-report contains summary information about the following:
4.
a) Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.

SEH Response: See c) below.

b) Completed DUEs, with a summary outline of the following:
   i) Date of each DUE;
   ii) Description of each DUE including methods used;
   iii) Outline of each DUE's recommendations; and
   iv) Outline of actions taken in response to the recommendations.

SEH Response: See c) below.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

c) Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns.

SEH Response: The Hospital undertook one DUE during this review period. The DUE looked at the effect of atypical antipsychotic agents on the hemoglobin of Hospital patients with schizophrenia. The method used included the development of a report of all patients receiving treatment with at least one atypical antipsychotic agent. Avatar and WORx systems were then used to provide other necessary information. The study found that of the 237 individuals on AAPs, 96% had glucose lab data, and the mean A1C level as 5.5% and the median level was 5.3%. The study also found that 90% of individuals had a A1C level of less than 7%, and that 12% had a A1C level greater than or equal to 6.5%. Recommendations included screening individuals in care for diabetes and metabolic syndrome before initiation of AAP; continue close monitoring of individuals receiving AAP for metabolic changes; those that have developed diabetes should either be switched to an anti-psychotic medication with less risk of metabolic adverse events, treated to achieve glycemic control or a combination thereof; those with A1C level greater than 7 should have their glycemic control therapy reevaluated and modified in necessary and finally, all individuals treated with AAP should have regularly scheduled blood glucose levels. The report is to be presented to the Pharmacy and Therapeutics Committee in its October meeting for review and approval of recommendations made in the DUE report.

5. Medication Variance Reporting (MVR): Ensure that the self-report includes a summary information of the following:

6.

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

Total Number of Reported Medication Variances by Month								
Previous Review Period	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Total**	**Mean**
Current Review Period	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**		
Previous	3	18	19	29	40	32	141	**23.5**
Current	14	12	7	14	12	11	70	**11.7**

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

Number of Medication Variances by Type								
	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Total**	**Mean**
Total MVs	**14**	**12**	**7**	**14**	**12**	**11**	**70**	**11.7**
Administering	4	3	2	4	4	3	**20**	**3.3**
Dispensing	4	4	0	0	2	3	**13**	**2.2**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Monitoring	0	0	0	0	0	0	**0**	**0.0**
Prescribing	5	4	5	6	4	3	**27**	**4.5**
Procurement	1	0	0	0	2	0	**3**	**0.5**
Transcribing/Documenting	1	0	0	3	1	1	**6**	**1.0**
Other/NA	1	1	0	3	1	3	**9**	**1.5**

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

Actual/Potential Medication Variances in Previous and Current Review Period		
Potential vs. Actual	**Previous Review Period (Sep-2009 ~ Feb-2010)**	**Current Review Period (Mar-2010 ~ Aug-2010)**
# Potential	71	41
# Actual	70	29

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

Number of Medication Variances by Critical Breakdown Point								
	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Total**	**Mean**
Administering	3	3	2	4	4	3	**19**	**3.2**
Dispensing	4	4	0	0	1	1	**10**	**1.7**
Monitoring	0	0	0	0	0	0	**0**	**0.0**
Prescribing	5	4	5	6	4	3	**27**	**4.5**
Procurement	0	0	0	0	2	0	**2**	**0.3**
Transcribing/Documenting	1	0	0	1	0	1	**3**	**0.5**
Other/NA	1	1	0	3	1	3	**9**	**1.5**

Number of Medication Variances by Outcome Category (A~I)								
	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Total**	**Mean**
Potential - A	7	4	0	3	0	1	**15**	**2.5**
Potential - B	2	5	2	6	6	5	**26**	**4.3**
Actual - C	5	3	4	3	6	4	**25**	**4.2**
Actual - D	0	0	1	2	0	1	**4**	**0.7**
Actual - E	0	0	0	0	0	0	**0**	**0.0**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see table and text below)

Actual - F	0	0	0	0	0	0	**0**	**0.0**
Actual - G	0	0	0	0	0	0	**0**	**0.0**
Actual - H	0	0	0	0	0	0	**0**	**0.0**
Actual - I	0	0	0	0	0	0	**0**	**0.0**
# of ICA Complete*	*0*	*0*	*0*	*0*	*0*	*0*	***0***	***0.0***

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

d) Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved;

SEH Response: None fits this category.

e) Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; Also provide summary outline of each analysis including the following:
- i) Date of the variance;
- ii) Brief Description of the variance;
- iii) Outline of ICA findings and recommendations; and
- iv) Outline of actions taken in response to the recommendations

SEH Response: None fits this category.

f) Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances;

SEH Response: ***See Tab # 90 Pharmacy and Therapeutics Committee minutes.*** The Committee reviews each month the Medication Variance Reporting data as well as a synopsis of each reported medication variance. The information is summarized in the minutes, and a more full description is handed out and reviewed at each meeting.

g) Evidence of corrective actions to address patterns and trends identified in medication variances.

SEH Response: The Hospital continues to focus on medication variances involving missing medication administration documentation. Each month, a report is prepared by the Office of Patient Statistics and Reporting concerning missing medication administration documentation. During this review period, the percentage of missing documentation has fallen from 1.2% in February, 2010, to 0.57% in August. The percentage of nurses with no missing documentation improved from 33% in February 2010 to 48% in August, 2010. Information is tracked by unit and by nurse. ***See Tab # 102 Medication Administration Documentation data report.***

7. Mortality review: Ensure that the facility integrates results of the independent external medical mortality review in the final level interdisciplinary review.

SEH Response: The DMH Mental Health Authority continues to act as the independent external review of mortalities.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Its recommendations are presented to the Performance Improvement Committee and are tracked by the Performance Improvement Department. During this review period, there were two deaths. We also received the autopsy report from the death of RH in the prior review period as well as the final mortality report from the external reviewer. ***See Tab # 152 Mortality reports.***
VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units	**Recommendation:** 1. Maintain compliance with this requirement in all acute care and long-term care units in the facility. SEH Response: Compliance maintained.
VIIII.A.4	SEH shall ensure that individuals in need are -provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Recommendations:** 1. Same as in V.A.2.e and VI.A.7. SEH Response: See V.A.2.e and VI.A.7
VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	**Recommendations:** 1. Same as in V.A.2.e and VI.A.7. SEH Response: See V.A.2.e and VI.A.7.
VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	**Recommendations:** 1. Same as in V.A.2.e and VI.A.7. SEH Response: See V.A.2.e and VI.A.7.
VIII.A.4.c	integrate psychiatric and behavioral treatments.	**Recommendations:** 1. Same as in V.A.2.e and VI.A.7. SEH Response: See V.A.2.e and VI.A.7.
VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.	**Recommendations:** 1. Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. SEH Response: See VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.
VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Recommendations:** 1. Provide monitoring data (to address the above mentioned indicators) based on at least 20% sample during this review period. The data should address initial screening and the IRP management of substance use disorders.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

SEH Response: See data below.

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

SEH Response: The substance abuse screening occurs as part of the Comprehensive Initial Psychiatric Assessment and is monitored through the CIPA audits. The Hospital, beginning in April, 2010 , also starting auditing IRP interventions for those individuals with substance abuse diagnoses. See data below.

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 13 Was a substance abuse assessment completed, and if not, was the reason clearly provided?	100	100	100	100	86	100	**83**	**98**
%C #14 Did the assigned stage of change level reflect the results of the substance abuse assessment?	100	86	100	100	86	100	**67**	**95**

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

CO-OCCURRING DISORDERS SELF AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	*	141	144	148	151	*	**n/a**	**146**
n	*	15	15	15	10	*	**n/a**	**14**
%S	*	11	10	10	7	*	**n/a**	**9**
%C #1 IRP addresses both the identified mental illness and substance use disorder.	*	86	87	67	80	*	**n/a**	**80**
%C #2 IRP reflects the individual's stage of change with respect to SUD	*	92	47	71	78	*	**n/a**	**70**
%C #3 If #2 is yes, TLC interventions appropriately link with documented stage of change	*	55	67	40	86	*	**n/a**	**59**
%C #4 IRP has discharge criteria on SUD	*	33	0	100	33	*	**n/a**	**23**
%C #5 If #4 is yes, criteria are individualized and written properly.	*	100	n/a	100	100	*	**n/a**	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		N = Individuals with substance use diagnoses n = number audited- target is 10% sample per month n/a = not available ***Tab # 57 Substance use IRP audit results*** 3. Same as in V.D.1 and VI.A.5. SEH Response: Same as in V.D.1 and VI.A.5 **Analysis and Action Plan:** The data from the most recent six month review period around substance abuse screening and designation of the stage of change shows significant improvement in the Comprehensive Initial Psychiatric Assessment (CIPA) since the last review period. The completion of the substance abuse assessment in the CIPA rose from a mean of 83% during the prior review period to 98% in the current six month period. Similar improvement is noted in the assignment of level of stage of change in the CIPA, which rose from 67% to 95% during the current review period. In contrast the substance abuse IRP audits show improvement is needed across most indicators, especially around discharge criteria. Recently however, training was provided to medical staff and clinical administrators around stage of change during this review period in an effort to strengthen performance and to better identify appropriate IRP interventions. The Hospital expects this will be evident during the next six months data. Further, substance abuse-related offerings in the TLCs were enhanced and include "Double Trouble in Recovery", AA and NA, Anger Management for Individuals with Co-occurring Disorders, Substance Abuse Education, Sexual Safety and Sobriety, Principles of Recovery, Relapse Prevention, Recovery Process, and Relaxation and Stress Reduction. The increase in offerings relating to Substance abuse in the TLCs should also improve IRP linkages.
VIII.A.7	By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.	**Recommendations:** 1. Provide monitoring data based on a review of a 100% sample during the review period (March 2010 to August 2010). SEH Response: See data below. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See data below

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

TARDIVE DYSKINESIA AUDIT RESULTS

	2/25/2010	8/31/2010
P Target Population (# TD Patients)	39	**38**
S Population reviewed	39	**37**
%S	100	**97**
%C # 1 Is there evidence of at least a semi-annual AIMS	92	**95**
%C # 2 Is there evidence of a neurology consult?	72	**76**
%C #3 Is there evidence of consideration in medication choices?	87	**95**
%C #4 Are there interventions (i.e. patient education, medication) targeting TD on the IRP	69	**76**
%C #5 Are first generation anti-psychotic medications prescribed?	41	**41**
%C #6 If first generation anti-psychotic medications are prescribed, is there justification in the monthly notes?	75	**87**
%C #7 Are anti-cholinergics prescribed?	21	**51**
%C #8 Is there justification in the monthly notes?	63	**95**
%C #9 Discuss results of audit with psychiatrist	74	**95**

Tab # 64 TD Audit results

COMPREHENSIVE INITIAL PSYCHIATRIC AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	47	39	**37**	**38**
n	8	8	6	6	7	8	**7**	**7**
%S	24	20	18	19	15	21	**20**	**19**
%C # 26 AIMS test administered	63	50	83	83	86	100	**68**	**77**

N = Monthly Admissions

n = number audited- target is 20% sample per month

Tab # 16 CIPA audit results

Analysis/Action Plan: Data from the CIPA audits shows steady improvement in the completion of AIMS tests upon admission, reaching 100% in August 2010; the weighted mean improved from 68% during the last review period to 77% during the current review period. Similarly, significant improvement was noted in the tardive dyskinesia audits, particularly around the documentation of justification for use of first generation anti-psychotics (from 75% to 87%) anti-cholinergics (up from 63% to 95%). Given the positive trend, this will continue to be monitored through the two audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
B	Psychological Care	
	By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological support and	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	services to individuals who require such services.	
VIII.B.1	By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	
VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected. to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;[2]	**Recommendations:** 1. Complete the formation of the PBS team. SEH Response: The PBS team includes a PBS team leader (clinical psychologist), two PBS specialists, a data analyst and will include a half time registered nurse. The PBS team leader determined that a full time RN was not needed at this time. It is expected to be filled by the time of the site visit. It is expected that at least 1 additional plan and 1 additional guideline will be completed by the site visit. 2. Standardize the format for IIRPBIs. SEH Response: Completed. The format has been standardized, and it is being phased in for new IIRPBIs. Some IIRPBIs during the review period predated the new format. ***See Tab # 98 for IIRPBI format.*** In addition, the PBS consultant is working with staff to improve the quality of the IIRPBIs. 3. Provide specific instructions in policy for how the success or failure of an IIRPBI is to be documented in the medical record. SEH Response: The IIRBI format and operational instructions require criteria to be stated for determining the success of the IIRPBI. The operational instructions instruct the psychologist to document by his/her progress notes whether the criteria have been met. ***See Tab # 98 for IIRPBI format. Tab # 99, PBS Policy and Procedure*** 4. Develop a process for monitoring IIRPBIs. SEH Response: The IIRPBIs were audited by the Director of Psychology using the audit tool designed for behavioral guidelines and plans, but the Director of Psychology is evaluating whether the IIRPBIs should have a separate audit tool. If so, an audit tool for monitoring IIRPBIs specifically will be developed and may be completed by November 1.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		5. Determine how IPA assessment of the need for behavioral interventions is to be monitored and present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: Data is being compiled to determine if violence and suicide triggers from IPA risk assessment are good indicators for referral of individuals for behavioral interventions. To date however, sufficient data has not yet been compiled. **Facility's findings:**

INITIAL PSYCHOLOGICAL ASSESSMENT AUDIT RESULTS	Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	34	41	34	32	46	39	**37**	**38**
n	7	5	2	4	5	4	**7**	**5**
%S	21	12	6	13	11	10	**20**	**12**
%C #B- 2 (Part B) Behavioral intervention screening	100	100	100	100	83	100	**93**	**96**
%C # B- 3 (Part B) Behavioral observations	86	100	100	100	100	75	**98**	**93**
%C # B- 5b (Part B) Behavioral plan appropriateness	100	100	100	100	100	100	**95**	**100**

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

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the	**Recommendation:** 1. Complete the formation of the PBS team. SEH Response: The PBS team includes a PBS team leader (clinical psychologist), two PBS specialists, a data analyst and will include a half time registered nurse. The PBS team leader determined that a full time RN was not needed at this time. It is expected that the position will be filled by the site visit. An audit tool was modified, and audits were begun for the IIRPBIs, plans and guidelines. See ***Tab # 101.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	individual, had in their development, and the system for earning reinforcement;	**Facility's findings:**

BEHAVIORAL INTERVENTIONS AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Total**
N							**21**
n			2	2	2	2	**8**
%S							**38**
%C #1 The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms.			50	100	100	100	**88**
%C #4 A functional assessment is completed			n/a	n/a	n/a	n/a	**n/a**
%C #10 Appropriate interventions are developed if the target maladaptive behavior is to be made inefficient.			100	50	100	100	**88**

N = Referred for behavioral interventions
n = number audited- (Audit sample plan calls for 100% sampling)
Tab # 101 Behavioral Interventions Monitoring Form and Instructions and audit results.

Analysis/Action Plan: The Hospital will continue to work with the PBS consultant to improve the quality of the IIRPBIs, and will develop additional PBS plans and guidelines. The development of a format is expected to improve consistency and quality as will the individual work with the PBS consultant.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.B.1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not ,the use of aversive contingencies;	**Recommendation:** 1. Complete the formation of the PBS team. SEH Response: The PBS team includes a PBS team leader (clinical psychologist), two PBS specialists, a data analyst and will include a half time registered nurse. The PBS team leader determined that a full time RN was not needed at this time. It is expected that the position will be filled by the site visit. **Facility's findings:**

BEHAVIORAL INTERVENTIONS AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Total**
N							**21**
n			2	2	2	2	**8**
%S							**38**
%C # 12 Behavioral interventions do not use aversive contingencies.			100	100	100	100	**100**

N = Referred for behavioral interventions
n = number audited- (Audit sample plan calls for 100% sampling)
Tab # 101 Behavioral Interventions Monitoring Form and Instructions and audit results.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/action plan: The audits show that PBS plans and guidelines do not use aversive contingencies.
VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	**Recommendations:** 1. This cell repeats cell VIII.B.1.a SEH Response: See VIII.B.1.a
VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Recommendations:** 1. Begin to audit behavioral interventions according to instructions in Cell V.B.9. SEH Response: Audits of IIRPBIs, behavioral guidelines and PBS plans were begun. 2. Present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response: See below **Facility's Findings:**

BEHAVIORAL INTERVENTIONS AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	Total
N							**21**
n			2	2	2	2	**8**
%S							**38**
%C. #1. The target maladaptive behavior is defined in behavioral, observable, and/or measurable terms			50	100	100	100	**88**
#2. Appropriate data collection methods are used			0	50	50	100	**50**
#3. A structural assessment is completed			n/a	n/a	n/a	n/a	n/a
#4. A functional assessment is completed			n/a	n/a	n/a	n/a	n/a
#5. The target maladaptive behavior is described in terms of its predisposing, precipitating, and perpetuating factors			100	100	50	100	**88**
#6. A baseline estimate of the behavior is presented in terms			50	50	0	50	**38**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

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

N = Individuals referred for behavioral interventions
n = number audited
Tab # 101 Behavioral Interventions Monitoring Form and Instructions and audit results.

Analysis/Action Plans: The data above reflect audits of IIRPBIs, and the behavioral guideline and plan in place. Based upon the data, which reflects only a small sample, it appears that the behavioral plans generally are of good quality. For several of the indicators, however, especially the presentation of the baseline estimate of behavior being presented in objective measures, improvement is needed.

The Hospital has undertaken several steps designed to improve the quality of the various types of behavioral plans. The Hospital has finalized a format for the IIRPBIs, begun audits and will have the PBS consultant review IIRPBIs and work with psychologists on improving the quality of the IIRPBIs. Further, the PBS procedure policy was modified to specify documentation requirements for evaluating the effectiveness of the IIRPBIs. The PBS consultant is continuing to provide training and coaching with psychologists and the PBS team. These efforts will continue.

In addition, the PBS team is involved in providing ongoing training and consultation to teams relating to ten specific individuals who are exhibiting behavioral issues and appear on the High Risk Indicator Event list. Consultation include developing a PBS plan for one individual, assisting in developing IIRPBIs and in training staff (8 individuals in care) and in another case, the PBS plan is being developed.

VIII.B.1.f	ensure that there are adequate number	**Recommendation:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	of psychologists for each unit, where needed- with experience in behavior management, to provide adequate assessments and behavioral treatment programs.	1. Fill current psychology department vacancies. SEH Response: All but one position are filled, although two psychologists are on maternity leave. The Hospital is requesting three additional psychology positions for FY11, pending funding.
VIII.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.	**Recommendation:** 1. Assure that all initial assessments (RSA, IPA, SWIA and Nursing Assessment) specifically indicate recommended groups from the Mall Treatment Catalogue. SEH Response: Psychology, rehabilitation services and social work have modified their instructions to include this. Nursing is evaluating the recommendation. **Analysis/Action plan:** The Hospital continues to rework the TLCs to better meet the needs of individuals in care. Beginning September 20, 2010, the 4th Generation of the TLCs was introduced. The key improvements that were made include more comprehensive cognitive programming that includes online cognitive skill building for mildly impaired, cognitive skill building (paper/pencil) for the moderately impaired and sensory enhancement/reminiscence/remotivation techniques for individuals with mental retardation or dementia. Second, far more groups now are "dosed", and meet several times per week to allow for more depth in presenting the curricula. In addition there will be more TAMAR groups and new basic social skills groups that will include role playing and videotaping. ***Tab # 69 TLC Mall catalogue.*** See VIII.B.3 for additional information. In addition, the Hospital developed a group facilitator monitoring form and instructions to assess the performance of group leaders. ***See Tab # 124 Group Facilitator Monitoring Form and Instructions.*** Audits have not yet begun, but will begin in October, 2010, and be completed on a quarterly basis, as the revised TLC group offerings began on September 20, 2010. The monitoring form that will be used includes the following indicators:

GROUP FACILITATOR (GF) MONITORING FORM							
	Mar	Apr	May	Jun	Jul	Aug	Mean
N							
n							
%S							
%C. #1. The current session starts and ends on time							
#2. The group facilitator greets participants to begin the session.							
#3. GF briefly reviews the work from the prior session.							
#4. GF introduces sessions topics and goals.							

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>#5. GF shows familiarity with the lesson plan and materials</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#6. GF attempts to engage each participant in the session.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#7. GF keeps participants on task during the session.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#8. GF presentation style keeps the majority of participants attentive and interested.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#9. GF tests and evaluates the participants understanding through questions, role play or other means.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#10. GF presents information in a manner appropriate to the functioning level of the participants.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#11. At the conclusion of the session, the GF summarizes the work done in the session</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#12. The GF and/or co-GF used at least one effective teaching technique.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#13. GF ensures the lesson plan for the current session is available and follows it.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#14. GF uses the individual's strengths, preferences, and interests.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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See Tab # 124 Group Facilitator Monitoring Form and Instructions

In September, the Hospital restarted its training program for group leaders. Forty one staff previously completed training and 20 are now in training. See Tab # 153 for Group Training Information. It is a six week course and includes a specific curriculum for nursing. In addition there are currently 21 psychiatrists and 12 psychologists who lead groups in the TLCs.</td></tr>
<tr><td>VIII.B.3</td><td>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.</td><td>Recommendations:
1. Develop and maintain a process for certifying the competency of group treatment providers.

SEH Response: As noted in prior reports, the Hospital in December 2008 began implementing a 12 hour group leaders curricula. Between Dec 2008 and February 2010, 41 staff completed the program. Group leader training restarted in September, 2010, under the leadership of Michelle Marsh, a psychologist. Twenty individuals are enrolled. In addition there are currently 21 psychiatrists and 12 psychologists who lead groups at the TLCs.

2. Develop a monitoring tool to assure that clinicians involved in offered group treatment services in the malls are</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		providing those services according to accepted treatment manuals and protocols. SEH Response: See VIII.B.2. The audit tool was created, but quarterly audits will begin until October as the revised TLC programming was effective on September 20, 2010. **Analysis/Action Plans:** Implement the audits effective October, 2010.
VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	
VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	**Recommendations:** See cell VIII.B.1.c. SEH Response: See VIII.B.1.e

BEHAVIORAL INTERVENTIONS AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Total**
N							**21**
n			2	2	2	2	**8**
%S							**38**
#12. Behavioral interventions do not use of aversive contingencies			100	100	100	100	**100**

N = All new or revised behavioral interventions in the review month
n = number audited
Tab # 101 Behavioral Interventions Monitoring Form and Instructions and audit results.

Analysis/Action Plans: Continue with audits.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Recommendation:** Maintain current level of practice. SEH Response: Level of practice maintained. Substance abuse related offerings in the mall were enhanced and include multiple offerings of "Double Trouble in Recovery", AA and NA, Anger Management for Individuals with Co-occurring Disorders, Substance Abuse Education, Sexual Safety and Sobriety, Principles of Recovery, Relapse Prevention, Recovery Process, and Relaxation and Stress Reduction.
VIII.B.4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Recommendations:** 1. Ensure that the form developed to document the integration of psychological assessments into the IRP is used for neuropsychological evaluations as well. SEH Response: Ongoing.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		2. Provide a method to audit this process. SEH Response: The Hospital is not agreeable to additional audits. **Analysis/Action Plans:** The Hospital is working closely with the Department of Developmental Disabilities around discharge of 10 individuals with a diagnosis of mental retardation. In each of these cases, a community living plan has been developed or is in the process of being developed. Seven DDS clients have been discharged since March, 2010, through work with DDS.
VIII.B.4.d	programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;	**Recommendation:** Maintain current level of practice. SEH Response: Level of practice maintained.
VIII.B.4.e	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;	**Recommendations:** 1. Continue with training program and present data regarding how many clinical staff have been trained. SEH Response: IRP training continues. Staff have been trained on four modules (engagement, discharge planning, development of clinical formulation, and development of focus statements, objectives and interventions) and coaching is underway. See V.A.3 and V.B.1 for training information. 2. Present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. SEH Response:

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	Mean
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #5 Treatment and medication regimens are modified, as appropriate, considering such factors as the individual's response to treatment, significant developments in the individual's condition and the individual's changing needs.					65	63	**64**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		%C #16 The team revised the focus of hospitalization, objectives, as appropriate, to reflect the individual's changing needs. | | | | | 58 | 60 | **59** N = All IRP reviews scheduled, IRP database 9/23/10 n = number audited * No data available ***Tab #10 Clinical chart audit results.*** **Analysis/Action Plan:** The Hospital only has two months of data for this requirement. It is noteworthy that the treatment teams IRP training largely occurred in late July through September (and continues at this time). Given the timing of the training, the Hospital will monitor this over the next several months through clinical chart audits to determine if additional corrective steps are needed.
VIII.B.4.f	clinically relevant information remains readily accessible; and	**Recommendation:** Maintain current level of practice. SEH Response: Level of practice maintained.
VIII.B.4.g	staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.	**Recommendations:** 1. Fully staff the PBS team. SEH Response: The PBS team has one team leader, two PBS specialists, one data analyst and will have a half time nurse. The PBS team leader does not think a full time nurse is needed and the position of half time nurse is expected to be hired by the site visit. 2. Present data indicating how many clinicians have been trained in behavioral principles. SEH Response: Data Source: PBS Records DB, 9/30/2010

Positive Behavior Support					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	6	5	5	83%	83%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	13	1	1	8%	8%/100%
Dietary	4	1	1	25%	25%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table continued below)

Medical	11	10	10	91%	91%/100%
Nursing - Nurse Manager	18	18	18	100%	100%/100%
Nursing - RN	87	83	83	95%	95%/100%
Nursing - LPN	31	31	31	100%	100%/100%
Nursing - RA	203	195	191	96%	96%/98%
Psychiatry	67	50	39	75%	75%/78%
Psychology	29	29	29	100%	100%/100%
Rehabilitation	20	20	20	100%	100%/100%
Social Work	16	15	15	94%	94%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	10	5	4	50%	50%/80%
Total	**531**	**479**	**463**	**90%**	**90%/97%**

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

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

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

SEH Response: No data is available

Analysis/action plan: Now that the PBS team is in place, the team has started the monitoring of staff in performing behavioral treatment consistent with the guidelines or plan and the IIRPBIs. The team is using a monitoring form, but monitoring only began in September. Information will be available during the site visit.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
C	Pharmacy Services	
	By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.C.1	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	See below

Recommendations:

1. Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department.

SEH Response:

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

Significance of Issue							Sep-09 ~ Feb-10		Mar-10 ~ Aug-10	
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Total	Percent	Total	Percent
Major	4	4		4	2		19	16%	14	29%
Moderate	9	1	1	1	2	3	38	31%	17	35%
Minor	10	1		1			49	40%	12	25%
Unknown/NA				2	1	2	15	12%	5	10%
Grand Total	**23**	**6**	**1**	**8**	**5**	**5**	**121**	**100%**	**48**	**100%**

Drug Interventions by Intervention Category							Sep-09 ~ Feb-10		Mar-10 ~ Aug-10	
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Total	Percent	Total	Percent
ALLERGY	2			1		2	4	3%	5	10%
DOSAGE ISSUES					1		18	15%	1	2%
DRUG INFORMATION	3	1			1	1	7	6%	6	13%
INDICATION		1					0	0%	1	2%
INTERACTION	1	1					2	2%	2	4%
ON-CALL MED PROCUREMENT	4				1		0	0%	5	10%
ORDER CLARIFICATION	4	2	1	2	1		5	4%	10	21%
ORDER ENTRY	8	1		3			44	36%	12	25%
PATIENT MONITORING	1			1			10	8%	2	4%
POLYPHARMACY					1	2	2	2%	3	6%
PROVIDER CLINICAL CONSULT							26	21%	0	0%
SIDE EFFECTS				1			1	1%	1	2%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

OTHER							**2**	**2%**	**0**	**0%**
Grand Total	**23**	**6**	**1**	**8**	**5**	**5**	**121**	**100%**	**48**	**100%**

Expected Outcome							**Sep-09 ~ Feb-10**		**Mar-10 ~ Aug-10**	
	Mar-10	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Percent**	**Total**	**Percent**
ALLERGY INFO PROVIDED	1						**1**	**1%**	**1**	**2%**
AWAITING CALL/UNRESOLVED				1			**11**	**9%**	**1**	**2%**
CLINICAL CONSULT PROVIDED	8	1		3	4		**23**	**19%**	**16**	**33%**
COST SAVINGS							**1**	**1%**	**0**	**0%**
DOSAGE CHANGED	1						**3**	**2%**	**1**	**2%**
DOSAGE CLARIFIED							**5**	**4%**	**0**	**0%**
DOSAGE FORM CHANGED	1	2					**7**	**6%**	**3**	**6%**
DOSAGE REDUCED		1		1			**1**	**1%**	**2**	**4%**
DRUG INF PROVIDED	1						**0**	**0%**	**1**	**2%**
FREQUENCY CHANGED	1						**11**	**9%**	**1**	**2%**
LABS ORDERED							**4**	**3%**	**0**	**0%**
MEDICATION CHANGED	7	1		1		2	**9**	**7%**	**11**	**23%**
MEDICATION DISCONTINUED	1			1	1	2	**6**	**5%**	**5**	**10%**
ORDER RENEWED	2						**14**	**12%**	**2**	**4%**
ORDER UNCHANGED		1	1	1		1	**10**	**8%**	**4**	**8%**
Pt no longer in care and outcome couldn't be verified							**14**	**12%**	**0**	**0%**
Not Identified							**1**	**1%**	**0**	**0%**
Grand Total	**23**	**6**	**1**	**8**	**5**	**5**	**121**	**100%**	**48**	**100%**

Reason for Action							**Sep-09 ~ Feb-10**		**Mar-10 ~ Aug-10**	
	Mar-10	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Percent**	**Total**	**Percent**
ALLERGY/ADE ID OR PREVENTED	1			1		2	**7**	**6%**	**4**	**8%**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT										
		ALTERNATIVE MEDICATION RECOMMENDED	2	2					**5**	**4%**	**4**	**8%**
		DOSING ADJUSTMENT	1	2		1	1		**27**	**22%**	**5**	**10%**
		DRUG INFORMATION REQUEST		1			2		**1**	**1%**	**3**	**6%**
		DRUG-DRUG INTERACTION	1	1					**2**	**2%**	**2**	**4%**
		DUPLICATE ORDER	1			3	1	2	**6**	**5%**	**7**	**15%**
		EXCESSIVE DOSAGE	1				1		**0**	**0%**	**2**	**4%**
		INCORRECT FREQUENCY SELECTED			1	1			**0**	**0%**	**2**	**4%**
		LABS MISSING							**4**	**3%**	**0**	**0%**
		LABS NOT CURRENT							**1**	**1%**	**0**	**0%**
		LABS OUTSIDE OF REFERENCE RANGE							**2**	**2%**	**0**	**0%**
		MEDICATION NOT AVAILABLE	6						**10**	**8%**	**6**	**13%**
		NON FORMULARY MEDICATION FORM REQUIRED	1					1	**3**	**2%**	**2**	**4%**
		ORDER EXPIRED OR OMITTED	2			1			**21**	**17%**	**3**	**6%**
		PROVIDE DRUG INFORMATION							**1**	**1%**	**0**	**0%**
		REQUEST TO CHANGE TO FORMULARY MEDICATION							**1**	**1%**	**0**	**0%**
		ROUTE/DOSAGE FORM CHANGE	2						**4**	**3%**	**2**	**4%**
		SUBOPTIMAL DOSAGE							**6**	**5%**	**0**	**0%**
		TECHNICAL ASSISTANCE	5						**13**	**11%**	**5**	**10%**
		THERAPEUTIC DUPLICATION							**3**	**2%**	**0**	**0%**
		Not Identified				1			**4**	**3%**	**1**	**2%**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Grand Total | **23** | **6** | **1** | **8** | **5** | **5** | **121** | **100%** | **48** | **100%** 2. Provide clear operational definitions for all categories of the recommendations, including Drug Information, Formulary Issues and Provider Clinical Consult. SEH Response: Completed. See ***Tab# 103, Pharmacist/Physician communication data/definitions/data.*** 3. Develop and implement tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews. SEH Response: Completed. See ***Tab# 103, Pharmacist/Physician communication data/definitions/data.*** If the physician fails to respond within a reasonable time frame and the failure to do so is likely to have adverse consequences for the individual, the pharmacists will contact the Chief Pharmacist, who will address it with the physician or the Medical Director. 4. Provide summary information regarding each recommendation that was not followed by the physician without documented rationale. SEH Response: There was only one case during this review period where there was no response by the physician to a pharmacist recommendation. Upon investigation, it appears that case involved an individual whose labs were outside the normal limits. After it was brought to the attention of the physician, the doctor chose to monitor the patient more closely. Therefore the recommendation was accepted and updated in the system as such---the pharmacist was just late in updating the entry in the system.
VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Recommendations:** 1. Same as above SEH Response: Same as above.
D	Nursing and Unit-based Services	
	SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and 'therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	
VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-	**Recommendations:** 1. Select an approach i.e. policy, procedures, program description that will result in a clear description of the content and structure of nursing orientation and annual training, the methods to determine competency, the responsible

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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;	parties, and the process to assure that staff only perform functions for which they have been deemed competent. Assure that the associated competency assessment/validation tools are aligned, described/attached, and that they address the six categories of competency based training required by this agreement for all nursing staff. SEH Response: Completed. ***See Tab #116, Nursing Competency Plan.*** Nursing finalized and is implementing a new nursing competency plan procedure that provides that nursing competencies will measured at established periods during probation and at least annually thereafter or more frequently when indicated. The plan covers new employee training, maintenance of competencies for current employees and the role of each category of nursing staff in ensuring competencies. 2. Resolve barriers to nursing staff completion of required trainings. SEH Response: The Hospital continues to identify and resolve barriers that affect completion of required trainings. An additional nurse educator was hired which provides additional training opportunities, and nursing has varied some of the training techniques, to include self study. It is also working with the Hospital's training director to evaluate the feasibility of on-line training for some mandated nursing trainings. 3. Train all nursing staff on all mental health diagnoses and associated nursing interventions. SEH Response: See training data below 4. Report aggregate percentages of staff who achieved or maintained competency. SEH Response: See training data below and curricula outlines for scope of training. ***Tab # 119 (Course Outlines) and # 120 (Training data)***

Mental Health Diagnosis, Stages of Change & Therapeutic Communication

as of June 16th - Sept 20th, 2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
LPN	31	28	3	**90.00%**	10.00%	100.00%	10.00%
RN	87	72	15	**83.00%**	17.00%	100.00%	17.00%
RA	203	187	16	**92.00%**	8.00%	100.00%	8.00%
Sup. RN	18	17	1	**94.00%**	6.00%	100.00%	6.00%
Grand Total	339	**304**	35	**90.00%**	10.00%	**90.00%**	10.00%

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

June 16th - Sept 20th, 2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
RN	9	6	3	67.00%	0.00%	67.00%	33.00%
Educator, RN	1	0	1	0.00%	0.00%	0.00%	100.00%
RA	4	3	1	75.00%	0.00%	75.00%	25.00%
Sup. RN	1	1	0	100.00%	0.00%	100.00%	0.00%
Grand Total	15	**10**	5	**67.00%**	0.00%	**67.00%**	33.00%

SEH Nursing Staff - Total Compliance for Medication Training Data

as of March 5th, 2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
LPN	33	33	0	100.00%	0.00%	100.00%	0.00%
RN	72	72	0	100.00%	0.00%	100.00%	0.00%
Office Sup. RN	5	5	0	100.00%	0.00%	100.00%	0.00%
Sup. RN	11	11	0	100.00%	0.00%	100.00%	0.00%
Grand Total	121	**121**	0	**100.00%**	0.00%	**100.00%**	0.00%

SEH Nursing Staff - Total Compliance for Medication New Hires Training

May 3rd - Sept 20th, 2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
RN	9	6	3	67.00%	0.00%	67.00%	33.00%
Educator, RN	1	1	0	100.00%	0.00%	100.00%	0.00%
Sup. RN	2	1	1	50.00%	0.00%	50.00%	50.00%
Grand Total	12	8	4	67.00%	0.00%	67.00%	33.00%

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

SEH Nursing Staff – Vital Signs Annual Training

Sept 10th - Sept 24th, 2010

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(tables below)

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
RA Total	234	**85**	149	**36.00%**	0.00%		**64.00%**

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

SEH Nursing Staff – Vital Signs New Hires Training *As pf Sept 24th, 2010*							
Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
RA Total	4	**4**	0	**100.00%**	0.00%		0.00%

Tab # 120 Nursing training data

Analysis/Action plan: The Hospital has integrated related concepts of the required training areas and either has completed or is progressing toward completion of the required training areas. Ninety percent of experienced nursing staff have completed competency based training around mental health diagnosis and related symptoms, which includes identification and monitoring of symptoms and target variables. Training around psychotropic medications and identification of their side effects was completed as part of the medication administration training, and newly hired registered nurses have all been trained on these modules. Each of these trainings also included training on related documentation requirements. Training on taking of vital signs is underway.

A new nursing documentation procedure was developed and is being rolled out to staff. ***Tab # 106 Nursing procedure re documentation.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Recommendations:** 1. Identify barriers and take actions to reduce redundant documentation and increase the consistency with which required documentation is in the records. SEH Response: The Hospital continues to review documentation requirements to ensure staff are not duplicating documentation. Beginning mid-September, 2010, an unusual incident report is no longer required for medical transfers to other facilities or for restraint or seclusion incidents. Instead, the information will be on the 24 hour nursing report, and the relevant documentation in Avatar (i.e. the completed medical transfer form or doctor's order for seclusion or restraint) will serve as the UI. The data will be entered from these documents into the UI database for tracking and trending. In addition, as more forms are included in Avatar, it is expected documentation requirements can be further streamlined – for example, certain information from Avatar may automatically populate in various forms, reducing the time spent on documentation. Training on documentation is included in each subject matter training offered. In addition, a new nursing documentation policy was developed. ***See Tab #106. Nursing Procedure on Documentation.*** Training on the taking of vital signs is underway. See above data.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

2. Identify and take actions to assure integration of relevant assessment data into the IIRP.

SEH Response: Nursing will develop suggested IIRP interventions and the physician completing the IIRP is expected to incorporate those into the IIRP. There is also some consideration being given to link the CINA to the IIRP in Avatar, although that will require changes to the CINA form, which nursing is developing.

3. Monitor the effectiveness of actions taken.

SEH Response: The Hospital does not understand this recommendation and therefore will not respond. It is unclear if it relates to recommendation #1 or #2. Nursing audits of both the CINA and the Update are underway, so documentation is now being reviewed.

4. Train all nursing staff on all mental health diagnoses and associated nursing interventions.

SEH Response: See training data in VIII.D.1.

5. Develop a structure and process for nursing leadership to analyze various audit findings, document actions to address findings, and evaluate the effectiveness of those actions.

SEH Response: Nurse manager review the audit data at their meetings, held weekly, upon receipt of the data. At times, portions of more than one meeting are devoted to reviewing the audit data. Those areas of improving or high performance are highlighted and strategies are evaluated for effectiveness and applicability to other areas. Areas of lagging performance are also evaluated, issues are identified as either systemic or unit based, and follow-up is dependent on the classification. Nursing leadership is charged with addressing systemic issues, (i.e. Avatar, training) while nurse managers of specific units are expected to address unit specific issues.

FACILITY'S FINDINGS

IRP OBSERVATION MONITORING AUDIT RESULTS (effective July 2010)							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					199	225	**212**
n					20	23	**22**
%S					10	10	**10**
%C # Data fields Presence of RN in IRP meetings					85	91	**88**

IRP OBSERVATION MONITORING AUDIT RESULTS (for period of March through June 2010)							
	Mar	Apr	Mar	Jun	Jul*	Aug*	**Mean**
N	231	197	49	169			**162**
n	20	7	4	13			**11**
%S	9	4	8	8			**7**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

%C. Data Fields: Individual attends the IRP conference	100	100	100	92			98

N = All IRPs scheduled in the review month
n = number audited
* Not available. It should be noted that the IRP observation tool was modified in July 2010 ,which altered slightly the specific question reflected. For this reason, we have not calculated MEAN, but will do so for the next site visit.
Tab # 9 IRP Observation audit results

INITIAL NURSING ASSESSMENT AUDIT RESULTS

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
Completed within 8 hours	100	100	71	88	20	33	**92**	**72**
%C #9 If assessment identified risk in any risk screens, was nature of risk described sufficiently to develop adequate nursing interventions to address risk	75	80	50	20	40	60	**75**	**53**
%C #13 If prior medical history was noted was there appropriate description of the event so that interventions could be identified if needed?	100	80	56	20	75	50	**56**	**65**
%C # 16 Did the assessment include a physical assessment of all systems	71	80	43	50	80	100	**78**	**68**
%C #17 If a positive physical assessment is noted, is there a description of the symptoms or event sufficient to develop interventions and minimize risk to patient?	83	50	60	33	75	60	**83**	**60**
%C #25 Did the record overall support the findings in the mental status examination sections?	100	80	33	29	75	100	**72**	**69**
%C # 26 Were the MSE section findings consistent with the risk assessment findings?	100	80	33	38	80	100	**67**	**71**
%C #28 Was the recovery assessment section completed?	63	60	71	71	60	67	**78**	**66**
%C #30 Do the assessments in each domain of the functional rehabilitation screens accurately reflect the record?	100	80	43	75	60	83	**83**	**74**
%C #33 Were nursing interventions developed?	43	80	57	43	75	100	**61**	**64**
%C #34 Was a nursing intervention developed for each area of risk identified in the assessment?	25	60	33	43	25	100	**6**	**47**
%C #35 Were the nursing interventions specific and individualized and tailored to the individual's needs?	0	80	43	14	25	67	**17**	**35**
%C #36 Were the interventions appropriate to the	14	60	29	43	50	100	**17**	**46**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		functional level of the individual? N= Monthly Admissions n= Population monitored (target is 20% sample) ***Tab #4 Comprehensive Initial Nursing Assessment tool and results***

NURSING UPDATE ASSESSMENT AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N	289	270	284	284	276	274	**302**	**280**
n	32	7	29	41	30	7	**16**	**24**
%S	11	3	10	14	11	3	**5**	**9**
%C # 3 Are all sections of the MSE completed and consistent with the relevant progress notes	100	100	86	100	92	87	**100**	**94**
%C # 5 Does the update accurately reflect the individual's acceptance of medication- is it consistent with eMAR	93	100	100	100	92	100	**100**	**97**
%C #6 Is the section on co-morbidity completed accurately to include a specific and accurate description of the status of each condition supported by relevant data?	93	92	100	100	92	67	**78**	**89**
%C #7 Is the section on risk completed accurately and fully based upon a review of the record?	93	85	86	100	75	80	**91**	**85**
%C # 9 Was the section on sensory and expressive deficits fully and accurately completed?	87	85	86	50	77	60	**65**	**75**
%C #10 Are appropriate strengths identified?	93	85	71	100	92	87	**91**	**88**
%C # 11 Are additional needs appropriately identified and described in sufficient detail to inform treatment planning and nursing interventions?	80	85	100	67	85	67	**87**	**80**
%C #15 Does the nursing update include an evaluation of interventions and individual's progress in meeting objectives relating to focus area #1 and indicate a recommendation concerning continuation of the interventions?	n/a	n/a	n/a	n/a	n/a	80	**n/a**	**80**
%C #20 Does the nursing update include an evaluation of interventions and individual's progress in meeting objectives relating to focus area #2 and indicate a recommendation concerning continuation of the interventions?	n/a	n/a	n/a	n/a	n/a	67	**n/a**	**67**
%C #25 Does the nursing update include an evaluation of interventions and individual's progress in meeting	n/a	n/a	n/a	n/a	n/a	78	**n/a**	**78**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

objectives relating to focus area #3 and indicate a recommendation concerning continuation of the interventions?								
%C #30 Does the nursing update include an evaluation of interventions and individual's progress in meeting objectives relating to focus area #4 and indicate a recommendation concerning continuation of the interventions?	n/a	n/a	n/a	n/a	n/a	57	**n/a**	**57**
%C #35 Does the nursing update include an evaluation of interventions and individual's progress in meeting objectives relating to focus area #5 and indicate a recommendation concerning continuation of the interventions?	n/a	n/a	n/a	n/a	n/a	50	**n/a**	**50**

N = All Nursing updates completed in the month
n = number audited (Target sample size is 4 per unit per month per audit sample plan)
n/a – these questions were not part of the earlier tool
Tab # 4 Nursing Update Audit Results

Analysis/Action Plan: Data shows generally improved attendance of the registered nurse at the IRP from the last reporting period. Data from the CINA shows performance around the quality of the initial nursing assessment was not at acceptable levels. Because of this, the Hospital, beginning in August, identified a nurse who will complete CINAs on the majority of admissions; when she is absent the nurse on the admissions unit completes the assessment. Early indications from one month's data (August) are that the change is improving the quality of the CINA, although the timeliness of CINAs appear to have decreased. Nursing believes this is due to the fact sections are not able to be completed for an appropriate reason (for example, individual is sleeping); in the past the nurse would have simply noted "unable to be completed" and finalized the CINA. Now the nurse is waiting to conduct the full assessment before finalizing it. Nursing is creating a two part CINA, part one which would be completed in the first 8 hours and the second part to be completed within 24 hours to address these issues. The draft may be completed by the site visit.

The nursing update audit tool was modified to reflect the nursing update form utilized during the review period and includes assessment of the quality of documentation and assessment. ***Tab # 28 Nursing Update form; Tab # 29 and # 4 Nursing Update Audit Tool/instructions/audit results.*** There is not full data yet from the new clinical chart tool to provide an assessment of progress around IRP interventions although there are data around the quality of the assessment. Performance is strong in indicators around documentation of acceptance of medication and the updates around co-morbid conditions and is improving in assessing and documenting sensory and expressive deficits. However, performance on indicators #7 (risk assessment) and #11 (needs identification) fell.

Several changes are underway around the nursing forms themselves. A new nursing assessment policy (***See Tab # 118 Nursing Assessment Procedure)*** was developed as were new forms for a monthly note and an annual assessment were developed; the monthly note format (called Nursing progress update) will be implemented effective October 18, 2010

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		as a paper form while it is being built into Avatar. ***Tab 28, Nursing Progress Update forms.*** The nursing annual assessment form will also be implemented as of October 18, 2010. The nursing update audit tool will need to be revised and may be available during the site visit. The competency nursing procedure was updated and a new Competency plan was finalized. ***See Tab # 116 Nursing Procedure- Competency Plan.***
VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	**Recommendations:** 1. Finalize the hospital policy that addresses medical services and then develop/refine/align a nursing policy/procedure accordingly. SEH Response: The Hospital policy on Medical Services was finalized in May, 2010 and includes related nursing procedures. The policy, with the Emergency Medical Response policy and Seizure Management policies were jointly developed by nursing and medicine. ***Tab #71, General Medical Services Policy; Tab # 70 Emergency Medical Services Policy and Tab # 62 Seizure Management Policy.*** 2. Consider revising the template to document nursing assessments for physical status change so that it is more clearly focused on assessments necessary for the particular physical status change. SEH Response: Completed. ***See Tab # 123 Nursing Procedure –Change in Condition.*** 3. Consider developing additional templates for nursing documentation for transfers to and return from EDs or acute care hospitalizations. If another template is not developed, eliminate administrative information on the current form (e.g. “did accompanying staff member require relief”), and assure that the current form includes all documentation requirements detailed in the hospital transfer policy. Consider developing a nursing transfer policy/procedure. SEH Response: The medical transfer form completed by the physician is in Avatar as of mid September. Nursing developed a nursing transfer policy, training will begin October 18th and implementation will be thereafter. ***See Tab # 104 Nursing Procedure – Transfers.*** 4. Develop/revise the monitoring instrument and include qualitative criteria; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. SEH Response: Audit tool is still being developed, with implementation targeted for late November or early December 2010. 5. Identify and take actions to resolve barriers to more complete documentation of non-routine nursing interventions for physical care. SEH Response: In addition to providing more clarity around documentation requirements in hospital policy, the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Hospital approved forms to assist with documentation around seizures. The Hospital also purchased and is awaiting delivery of the Lippincott Manual of Nursing Practice for each unit and managers. The manual will serve as the standard of practice for medical and surgical issues. Finally, documentation requirements relating to physical observation is included in the change in condition nursing procedure.
VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Recommendations:** 1. Identify and resolve barriers to documenting first dose response. SEH Response: The importance of documenting first dose response is part of the Medication Administration training, and there is a specific field in Avatar where this is to be documented. 2. Assure that the hospital and nursing policies/procedures relative to medication administration are aligned and clearly communicate expectations relative to first dose response. SEH Response: Completed. 3. Refine the medication administration environment. SEH Response: Several changes have been made to the medication rooms, including moving the locks to the top of the refrigerators and adding an additional paper towel dispenser. **Analysis/Action plan:** The Hospital has focused efforts on improving the rate of missed documentation for routinely scheduled medications. ***Tab # 102 Medication Administration documentation report.*** Each month, a report is generated that reviews the missed documentation of medication administration, a follow up to the Six Sigma study previously provided. The data shows significant improvement and reduced missing documentation; the rate of missing documentation fell from a high of 1.22% in May, 2010 (the month of the move) to 0.57% in August, 2010. (Target is 0.50% by December 2010). Further, data shows that in August, 2010, 48% of nurses have no missing documentation, up from 35% in March, 2010, that 37% have >1 but <= 10 missing; 13% have >10 but <=50; and only 3% (compared with 6% in March) have more than 50 missing. Information is also tracked by unit. This will continue. First dose documentation improvement will be a focus of the nursing leadership group beginning in November. Pharmacy will work with nursing on action steps to improve.
VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	**Recommendations:** 1. Assure that the hospital and nursing policies/procedures relative to medication administration are aligned. SEH Response: Completed. ***Tab # 125 Medication Ordering and Administration Policy, Tab # 114 Nursing Procedure on Medication Administration.*** 2. Resolve issues associated with "Certified Medication Giver".

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: Completed. No longer in the Hospital policy, and has been purged from the utilizing eMar nursing procedure and the blood glucose nursing procedure. It is being purged as it is discovered in other policies. **Analysis/Action plan:** See training data below. ***Tab # 120 Nursing Training Data***

SEH Nursing Staff - Total Compliance for Medication Training Data

as of March 5, 2010

Discipline	Total	Post-test Received	Did Not Receive	Total % Competency Rate	Total % Failed on 1st Attempt	Post-test Received	Total % Not Competent
LPN	33	33	0	100.00%	0.00%	100.00%	0.00%
RN	72	72	0	100.00%	0.00%	100.00%	0.00%
Office Sup. RN	5	5	0	100.00%	0.00%	100.00%	0.00%
Sup. RN	11	11	0	100.00%	0.00%	100.00%	0.00%
Grand Total	121	**121**	0	**100.00%**	0.00%	**100.00%**	0.00%

The Medication Administration training includes training on the “six rights”, drug allergies and incompatibilities, monitoring symptoms and response to medications, first dose protocols, reporting medication variances and other related topics. ***See Tab # 119 (Training course outlines) and # 120 (Nursing training data).***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors	**Recommendations:** 1. See VIII.D.4 and VIII.D.5 SEH Response: See VIII.D.4 and VIII.D.5
VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;	**Recommendation:** 1. Involve nursing staff who administer medications in identifying the barriers to documenting their queries and education about side effects. Based on their input, consider varied approaches to supporting staff to complete this documentation. SEH Response: Staff are aware of their obligation to educate about side effects and document education. The focus of the past six months has been to improve the overall documentation of medication administration, which has been effective. See VIII.D.4. Nursing leadership will focus on the development of a standard practice to insure nursing meets this requirement. In addition, this will be a focus on medication education groups nursing leads at the TLCS.
VIII.D.8	Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment	**Recommendations:** 1. See VIII.D.1, VIII.D.2, VIII.D.3, and VIII.D.9.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	teams to assess individuals' status and to modify, as appropriate, the treatment plan;	SEH Response: See VIII.D.1, VIII.D.2, VIII.D.3, and VIII.D.9 2. Consider accessing assistance to quickly develop/write necessary policies so that refinements can be quickly accomplished and implementation proceed at an increased pace. SEH Response: Over five days of technical assistance have been obtained. The Hospital is identifying resources to fund this for the upcoming fiscal year. **FACILITY FINDINGS:** See data in VIII.D.2
9	Ensure that each individual's treatment plan identifies:	
VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Recommendation:** 1. Develop and/or refine policies, procedures, forms, training curriculum, and competencies that are aligned with one another and that contain content designed to identify individuals at risk for choking/aspiration/swallowing difficulty and to assure necessary IRP interventions to ameliorate risk. SEH Response: The overall nursing competency plan was modified and includes clear direction around training requirements. In addition, the dysphagia nursing procedure was updated to provide for a screen, and new forms were developed. Implementation is targeted for October 18, 2010. ***See Tab# 111, Nursing Procedure on Dysphagia; Tab # 116 Nursing Competency Plan.*** In addition, nursing worked with the Infection Control Officer to develop nursing interventions for individuals with certain infectious diseases. ***Tab # 132 Infection Control- suggested nursing interventions for specified infectious diseases.*** Finally, the Hospital developed a new template for the Nursing Update (to be called the Nursing Progress Update) that is to be in Avatar and is considering whether to implement a paper form pending inclusion in Avatar. That decision will be made by October, 2010. ***See Tab # 28 Nursing Update forms.*** **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS

	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #18. The IRP includes the diagnosis, treatments, and interventions that nursing and other staff are to implement					90	92	**91**

N = All IRPs due in the review month
n = number audited
* Clinical chart audits were not conducted during this period.
Tab # 3 Clinical Chart Audit results
See also VIII.D.2 for additional data.

Analysis/Action Plans: The Hospital only has two months of data on this requirement so it is unable to yet determine a

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		trend, but is aware that additional training is needed for staff around developing interventions. Using classroom, observation and coaching methods, the Hospital in August and September provided intensive training to treatment teams around clinical formulation and development of goals, objectives, and interventions. See V.A.3 and V.B.1 for training information. Nursing staff actively participated in this training. Thus, for most of the review period, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the monthly IRP observation and clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.
VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Recommendations:** 1. See VIII.D.1 and VIII.D. SEH Response: See VIII.D.1 and VIII.D.2 **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #19. The IRP identifies the related symptoms and target variables to be monitored by nursing and other staff					75	83	**80**

N = All IRPs due in the review month
n = number audited
Tab # 3 Clinical Chart Audit results

Analysis/Action Plans: The Hospital only has two months of data on this requirement so it is unable to yet determine a trend, but is aware that improvement is needed in developing the clinical formulation and identifying target variables to be monitored by nursing staff. Using classroom, observation and coaching methods, the Hospital in August and September provided intensive training to treatment teams around clinical formulation and development of goals, objectives, and interventions. See V.A.3 and V.B.1 for training information. Nursing staff were active participants in this training. For the most of the review period, however, staff did not have the benefit of this training, and thus the Hospital will allow staff an opportunity to implement practice changes reflective of what they learned in training before implementing significant additional new actions. The Hospital will continue the monthly IRP observation and clinical chart audits to identify areas and or units in which additional training or coaching may be needed and may identify additional actions during the upcoming review period if indicated.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.D.9.c	the frequency by which staff need to monitor such symptoms:	**Recommendation:** 1. Consider clarifying the policy relative to the fact that the second nurse needs to be present and observe the nurse

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		drawing up the insulin. SEH Response: Completed, although this recommendation is beyond the scope of the requirement that IRP interventions must address frequency by which staff need to monitor symptoms. **Facility's Findings:**

CLINICAL CHART AUDIT RESULTS							
	Mar*	Apr*	May*	Jun*	Jul	Aug	**Mean**
N					167	184	**176**
n					20	24	**22**
%S					12	13	**13**
%C. #20. The IRP identifies the frequency by which staff need to monitor such symptoms					80	75	**77**

N = All IRPs due in the review month
n = number audited
Tab # 3 Clinical Chart Audit results

Analysis/Action Plans: See VIII.D.9.b.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	
VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Recommendations:** 1. Aggregate and report to the IC Committee findings relative to clinical follow up when individuals have tested positive for blood borne pathogens. SEH Response: The Hospital does not agree with this recommendation and will not implement it. There may be occasions when the infection Control Committee will request information about clinical follow up, and those will be tracked, but it will not be done a routine basis. 2. Aggregate and report to the IC Committee findings relative to positive PPDs, including follow up. SEH Response: The Infection Control Officer, working with nursing, created a database on the shared drive for tracking PPD information on individuals in care, including date PPD is administered or attempted, the date it is read and the results. Under the protocol, nurse managers are to enter the information into the database for date of prior PPD (administered and read), date of current PPD (administered and read) and date of conversion for example, tracking by the Infection Control Officer and reporting to the Infection Control Committee. Unfortunately, the system is not yet working as designed, as nursing is not routinely yet entering the data. The Infection Control Officer and nursing leadership continue to work on strategies to improve tracking of this data. For example, a procedure is being

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		developed to require simultaneous notification of the GMO and the Infection Control Officer when a positive PPD is identified. Target date for implementation is November 1, 2010.

3. Implement the form for reporting employee infections; aggregate and report findings to the IC Committee.

SEH Response: Completed.

Facility's Findings:

Employee Health Indicators									Progress	
	Indicator		Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N1~4	***Total SEH employees****	***#***	***783***	***783***	***783***	***783***	***783***	***783***		***783***
1	Employees who had work restriction due to a communicable disease	%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%		**0.0%**
2	Employees who had a blood pathogen exposure	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%		**0.0%**
3	Employees who received influenza vaccine	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		**0.0%**
4	Employees who had a PPD conversion	%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%		**0.0%**

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

Patient Care Indicators									Progress	
	Indicator		Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N1/2	***Total Patient Days***	***#***	***9958***	***9408***	***9406***	***9105***	***9553***	***9532***		***9494***
N3	***Total Admissions***	***#***	***34***	***41***	***34***	***32***	***47***	***39***		***38***
1	Healthcare Associated Infections	Rate*	0.00	1.00	1.10	0.90	0.70	1.20		**0.00**
2	Multi-drug Resistant Organisms	Rate*	0.10	0.00	0.11	0.10	0.20	0.10		**0.00**
3	Patients who are cultured for MRSA on admission	%	0.0%	2.4%	0.0%	18.8%	12.8%	23.1%		**2.6%**

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

Hospital Hygiene Indicators									Progress	
	Indicator		Mar	Apr	May	Jun	Jul	Aug	Mean-P	Mean-C
N	***Total number observed***	***#***	***30***	***30***	***30***	***30***	***30***	***30***		***30***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		1 Hand Hygiene Compliance | # | 0.00 | 0.60 | 0.50 | 0.53 | 0.67 | 0.67 | | **0.11** ***See Tab # 131, Infection Control Data and Trends for additional information.*** **Analysis/Action Plan:** The Hospital will continue to monitor infection related trends. In addition, during this review period, the Hospital conducted a Hepatitis C Assessment and Treatment Review. ***See Tab 121 Hepatitis C Assessment and Treatment review***. The assessment reviewed the status of Hepatitis C screening and treatment among individuals in care, and developed guidelines for the assessment and treatment of Hepatitis C at the Hospital. Periodic checks will be conducted to assess fidelity to the guidelines.
VIII.D.10.b	assess these data for trends;	**Recommendations:** 1. Determine a format for minutes and follow through with planned actions designed to assure that IC Committee functions, from data analysis through follow-up on identified issues, are accurately represented in the minutes. SEH Response: Completed. Please note that Infection Control Committee did not meet in May or July, and the June minutes are not available due to the unexpected departure of the individual taking the minutes. Consider allocating administrative and IT support for program functions (e.g. report and minute preparation), so that the IC Coordinator can focus on program development and implementation. SEH Response: Completed. An administrative staff person has been identified to support the Infection Control Officer as needed, and an individual is identified to prepare committee minutes. The Director of Patient Statistics and Reporting is also available to the Infection Control Officer to assist with data analysis and presentation. See VIII.D.10.a for data. ***See Tab # 131, Infection Control Data and Trends. See also Tab # 130 for Infection Control Committee Minutes.***
VIII.D.10.c	initiate inquiries regarding problematic trends;	**Recommendations:** 1. See VIII.D.10.a, b, e SEH Response: See VIII.D.10.a, b, e.
VIII.D.10.d	identify necessary corrective action;	**Recommendations:** 1. See VIII.10.a,b,e SEH Response: See VIII.D.10.a, b, e.
VIII.D.10.e	monitor to ensure that appropriate	**Recommendations:**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	remedies are achieved;	1. See VIII.10.a and b. SEH Response: See VIII.10.a and b. 2. Identify and resolve barriers to timely response to ICC recommendations. SEH Response: The Infection Control Officer is a member of the Performance Improvement Committee and advises that Committee when Infection Control Committee recommendations are not responded to in a timely or appropriate manner. 3. Evaluate the clarity with which the IC policies/program description communicate role functions and responsibilities relative to infection control matters, especially those that require actions involving multiple departments. SEH Response: Completed. The Hospital does not believe that there is a lack of clarity in the infection control policies as to role functions.
VIII.D.10.f	integrate this information into SEH's quality assurance review; and	**Recommendation:** 1. Specify and document the linkages between the IC Committee and hospital-wide Quality Assurance/Performance Improvement. SEH Response: The Infection Control Officer represents the Infection Control Committee (ICC) at the Hospital's Performance Improvement Committee (PIC). He reports on Infection Control Committee activities and concerns and will report to the ICC the responses of the Performance Improvement Committee or requests by PIC for ICC action. He is regularly on the agenda for the PIC meetings.
VIII.D.10.g	ensure that nursing staff implement the infection control program.	**Recommendations:** 1. Identify and resolve barriers to documenting implementation of precautions. SEH Response: In September, 2010, orders for medical precautions went "live" in Avatar, and nursing staff will now use eMAR to respond to such orders. While a management report is not yet available, one will be in the future to facilitate tracking of implementation. Nursing has identified two representatives to act as liaisons with Infection Control and are nursing representatives to the Infection Control Committee. 2. Continue to develop a menu of IRP goals/interventions to support staff to include IC matters in the IRP as relevant. SEH Response: Completed. ***Tab # 132 Infection Control Suggested Interventions for Specific Infectious Diseases.***
11	Ensure sufficient nursing staff to provide nursing care and services	**Recommendations:** 1. Evaluate whether or not there are sufficient positions to implement the target NCHPPD and an RN mix that is consistent with the needs of the individuals served (see Recommendation 5, September, 2009 and other reports).

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Develop a short and long term plan to resolve variances. SEH Response: The Hospital has completed the analysis and has determined that additional positions are needed. The Hospital is working with the Department and the CFO's Office to identify positions and funding. 2. Evaluate staffing on a monthly basis to include: average NCHPPD provided by unit, and specified variance; average on-duty RN mix by unit, and specified variance; the number of occasions when nursing staff are pulled from one unit to another by role classification; the number, type, and percent of nursing position vacancies; turnover; overtime use; unscheduled leave use; 1:1 observations. Consider displaying these figures on one or two reports in order to support analysis and identify how these factors influence one another. Document the evaluation, actions taken, and effectiveness of these actions. SEH Response: Ongoing. Beginning in September, 2010, nursing included tracking 1:1 orders, overtime, SAR usage and unscheduled leave in the nursing hours of care per patient day report and is analyzing the staffing variances and the mix of staffing. ***See Tab # 108 Nursing Care Hours of Patient Care report.*** The average nursing care hours in May 2010 was 5.54, June 2010 was 5.26, July 2010 was 5.46 and August 2010 was 5.21. Beginning in September, the Hospital will also track 1:1 usage, call-ins, overtime and use of SAR nurses. 3. Add RN positions to provide a skill mix consistent with service needs. Develop a plan to adjust RN workload on an interim basis pending an adequate mix. SEH Response: While working to fill vacancies, the Hospital continues to address the RN work load. For example, it is identifying mechanisms to decrease paper work demands (EX: designating transfer form as UI data), appointed a dedicated admissions nurse to complete CINA for a majority of admissions – relieving RN on admission units of this demand, and redesigned the nursing update – greatly reduced numbers of categories – and with a focus on progress and strengths – which will require much less time to complete. In addition, it is working with the DMH and the District's CFO to identify funding for additional RN positions.

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.	**RESTRAINTS, SECLUSION, AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS**	
	By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	
X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	
X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Recommendations:** 1. Methodically review all policies (hospital and nursing) addressing restraint/seclusion as well as associated content in policies that address emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards. SEH Response: Completed. ***See Tab #51 Restraint or Seclusion for Behavioral Reasons Policy; Tab # 77 Involuntary Medication Administration Policy, Tab # 154 Medical or Protective Measures, Devices and Techniques Policy; Tab # 113 Nursing Procedure on Restraint and Seclusion.*** The revised Restraint or Seclusion for Behavioral Reasons Policy clarifies the responsibility of the RN and that of the recovery assistants. 2. Ensure that the content on all forms is consistent with policies/procedures and supports staff to complete required documentation. SEH Response: Ongoing. Changes are required in the Doctor's Order form for Seclusion and Restraint as well as the Level of Observation Flow Sheet both of which are currently in Avatar and require enhancements. Changes are pending Avatar redesign. ***Tab # 156, Avatar Issues List*** 3. Modify the audit tool in response to 1 and 2 above and continue monitoring. SEH Response: Completed. Audits are occurring. Additional adjustments to the revised audit form are likely based upon reviewers' input. 4. Establish or define the feedback loop to leadership when unit staff who review data have ideas about how to meet requirements. SEH Response: PID staff will be meeting with each unit that has an episode of restraint or seclusion to review the audit

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

results and prepare recommendations based upon input from unit staff.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C. #2.1a There is physician documentation in the medical record that low level of interventions were attempted.	100	n/a	40	100	75	100	**76**
%C. #2.1a There is nursing documentation in the medical record that low level of interventions were attempted.	50	n/a	60	100	75	100	**71**
%C #2.2a There is physician documentation in the medical record that moderate level of interventions were attempted.	100	n/a	60	100	75	100	**82**
%C #2.2a There is nursing documentation in the medical record that moderate level of interventions were attempted	75	n/a	80	100	75	100	**82**
%C #2.2c If no low or moderate level interventions were attempted, does the documentation include and justify a decision not to use them?	n/a	n/a	n/a	n/a	n/a	n/a	n/a

N = All restraint or seclusion episodes in the month
n = number audited
* Not in tool used during the month
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: During this review period, there was one incident of prone restraint, ordered by a covering psychiatrist. The matter was investigated by the Risk Manager, and both the physician and the nursing staff were counseled that using prone restraint is in clear violation of the policy.

Data show that the Hospital is continuing to struggle with using and/or documenting low or moderate level interventions early on so as to maximize the opportunity to avoid a seclusion or restraint episode. The data is consistent with a special study of psychiatric emergencies conducted by the Performance Improvement Department from May through August, 2010. The review based upon data from the UI database of psychiatric emergencies, looked at location of the incident, individuals involved, whether the comfort plans were used, whether restraints or seclusion was used, whether involuntary medication was administered, and common stressors or precipitating factors. The review showed that psychiatric emergencies resulted in use of restraint 4% of the time and use of seclusion 15% of the time. The review also showed that there was often little evidence documented in the record that meaningful less restrictive interventions were attempted (i.e. comfort plans, or EARN) prior to restraint, seclusion or emergency involuntary medication (See section X.F). The report , which was completed in September 2010, was presented to Executive staff and PIC and final recommendations should be available by the time of the site visits. ***See Tab #157 Analysis of Psychiatric Emergencies.*** Based upon the report, one immediate change was to ensure comfort plans are

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		kept in binders on the units to ensure they are more readily accessible to staff.
X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Recommendation:** 1. See VIII.D.1 SEH Response: Training of direct care clinical staff on use of restraint and seclusion continues. Data Source: Training DB, 9/20/2010

Restraint or Seclusion for Behavioral Reasons

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	6	6	6	100%	100%/100%
Clinical Administrator	12	10	10	83%	83%/100%
Dentistry	13	12	12	92%	92%/100%
Dietary	4	1	1	25%	25%/100%
Medical	11	10	10	91%	91%/100%
Nursing - Nurse Manager	18	13	13	72%	72%/100%
Nursing - RN	87	58	58	67%	67%/100%
Nursing - LPN	31	23	23	74%	74%/100%
Nursing - RA	203	133	133	66%	66%/100%
Psychiatry	67	61	61	91%	91%/100%
Psychology	29	26	26	90%	90%/100%
Rehabilitation	20	14	14	70%	70%/100%
Social Work	16	15	15	94%	94%/100%
Treatment Mall	4	3	3	75%	75%/100%
Clinical (Other)	10	5	5	50%	50%/100%
Security Staff	11	0	0	0%	0%/100%
Total	**542**	**390**	**390**	**72%**	**72%/100%**

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

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

Data Source: Training DB, 9/20/2010

Restraint or Seclusion for Behavioral Reasons – New Employees Only

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Discipline	# Required	# Attended	# Competent	% Attended	% Competent*/ % of Attendees Competent**
Chaplain	4	4	4	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	8	8	8	100%	100%/100%
Nursing - RA	3	3	3	100%	100%/100%
Psychiatry	10	10	10	100%	100%/100%
Psychology	11	11	11	100%	100%/100%
Rehabilitation	3	3	3	100%	100%/100%
Social Work	4	4	4	100%	100%/100%
Clinical (Other)	2	2	2	100%	100%/100%
Total	**51**	**51**	**51**	**100%**	**100%/100%**

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

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

Data Source: Training DB, 3/1/2010~ 9/20/2010

NON-VIOLENT CRISIS INTERVENTION TRAINING DATA					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	6	3	3	50%	50%/100%
Clinical Administrator	12	3	3	25%	25%/100%
Dentistry	13	7	7	54%	54%/100%
Dietary	4	4	4	100%	100%/100%
Medical	11	5	5	45%	45%/100%
Nursing - Nurse Manager	18	8	8	44%	44%/100%
Nursing - RN	87	42	42	48%	48%/100%
Nursing - LPN	31	21	21	68%	68%/100%
Nursing - RA	203	120	120	59%	59%/100%
Psychiatry	67	51	51	76%	76%/100%
Psychology	29	21	21	72%	72%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(table continued below)

Rehabilitation	20	14	14	70%	70%/100%
Social Work	16	7	7	44%	44%/100%
Treatment Mall	4	2	2	50%	50%/100%
Clinical (Other)	10	3	3	30%	30%/100%
Total	**531**	**311**	**311**	**59%**	**59%/100%**

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

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

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

Analysis/Action Steps: Data shows that compliance with restraint and seclusion and NVCI training mandates continues to be problematic. Because of low levels of compliance, the Hospital is implementing several strategies. First, each month, Executive staff members are being provided with data from Office of Training that reflect the status of employee completion of training. This will allow them to respond more quickly as individuals become non-compliant with their required training. Second, the restraint and seclusion training and the Non-Violent Crisis Intervention trainings are held at least twice monthly as part of new employee orientation. These sessions are now open to existing employees and will be announced on the intranet so employees have additional opportunities for training.

The Analysis of Psychiatric Emergencies review completed by PID is providing good data around management of psychiatric emergencies and is being used to identify training needs. The Hospital is using the study to identify one or two units with the highest usage of restraint or seclusion and will provide additional training on the unit.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.A.3	the use of side rails on beds, including a plan:	**Recommendation:** 1. Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken. SEH Response: Use of side rails is monitored through the 24 hour nursing report. There is no reported use of side rails during the March to August review period. The Nurse Managers on the two units where side rails are available are monitoring usage closely. If incidents occur, they will be reviewed by PID to ensure compliance with policy.
X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Recommendation:** 1. See X.A.3. SEH Response: See X.A.3.
X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including	**Recommendation:** 1. See X.A.3.

<table>
<tr><th>SECTIONS</th><th>SETTLEMENT AGREEMENT TASKS</th><th>PROGRESS REPORT</th></tr>
<tr><td></td><td>identification .of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.</td><td>SEH Response: See X.A.3.</td></tr>
<tr><td>X.B</td><td>By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:</td><td></td></tr>
<tr><td>X.B.1</td><td>are used after a hierarchy of less restrictive measures has been considered and documented;</td><td>Recommendations:
1. Examine audit questions and scoring guidelines to assure that all least restrictive interventions are considered, even if the interventions do not appear as examples in the R/S policy.

SEH Response: The audit tool was modified to track interventions other than those specified in the Restraint or Seclusion policy.

2. See VIII.D.1.

SEH Response: See VIII.D.1.

Facility's Findings:
<table>
<tr><th colspan="8">SECLUSION AND RESTRAINT AUDIT RESULTS</th></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>Mar</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Mean</td></tr>
<tr><td>N</td><td>6</td><td>0</td><td>5</td><td>4</td><td>12</td><td>7</td><td>6</td></tr>
<tr><td>n</td><td>4</td><td>0</td><td>5</td><td>1</td><td>4</td><td>3</td><td>3</td></tr>
<tr><td>%S</td><td>67</td><td>n/a</td><td>100</td><td>25</td><td>33</td><td>43</td><td>50</td></tr>
<tr><td>%C # 3.1.a Documentation reflects that individual posed an imminent danger to self or others if not restrained or secluded</td><td>100</td><td>n/a</td><td>80</td><td>100</td><td>100</td><td>100</td><td>94</td></tr>
<tr><td>%C #3.1.b. Documentation reflects r/s used to ensure safety of individuals or others, after less restrictive interventions were tried after less restrictive interventions were determined to be ineffective in protecting the individual or others from harm*</td><td>n/a</td><td>n/a</td><td>100</td><td>75</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = All restraint or seclusion episodes in the month
n = number audited
* Question was not in the tool used during March and April
Tab # 55 Restraint and Seclusion Audit Results

Restraint and seclusion usage continues to fall well below the national public rates of percent of individuals restrained or secluded of 3.6% for restraint and 2.6% for seclusion.</td></tr>
</table>

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(tables and text below)

PERCENT OF INDIVIDUALS RESTRAINED OR SECLUDED

	Mar-10	Apr-10	May-10	June-10	July-10	Aug-10
Restraint	1.4%	0.0%	0.3%	0.0%	0.6%	0.6%
Seclusion	0.0%	0.0%	0.9%	0.9%	1.1%	1.1%

The Hospital's usage of *hours* of restraint and seclusion likewise is lower than the national public rate for hours of restraint (0.42) or seclusion (0.55).

RATE OF INDIVIDUALS RESTRAINED OR SECLUDED HOURS

	Mar-10	Apr-10	May-10	June-10	July-10	Aug-10
Restraint	0.03	0.00	0.00	0.00	0.02	0.01
Seclusion	0.00	0.00	0.01	0.1	0.03	0.01

See Tab # 53 PRISM report.

Analysis/Action Plans: Despite usage of restraint or seclusion far below the national public rate, the Hospital is not making significant progress in using alternative, less restrictive alternatives before implementing restraint or seclusion. See. X.A.1. The Hospital therefore conducted a review of psychiatric emergencies over a 4 month period; the study showed that 4% of psychiatric emergencies led to a restraint episode, and 15% led to a seclusion episode. The study also concluded that "[i]n general, QI found it difficult or impossible to discern the details of the interventions that were attempted before situations escalated into crises and staff turned to restrictive measures such as involuntary medication." ***See Tab # 100 Analysis of Psychiatric Emergencies.*** See X.A.1 for additional analysis completed by the Hospital around psychiatric emergencies. Specific recommendations emanating from the report should be available by the site visit.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	(see below)

Recommendations:

1. Develop unit/house based daily schedules that include TLC as well as evening and weekend programming at the earliest opportunity.

SEH Response: Completed. Ward based programming is available on Wards 1A and 1B and 1E for those individuals who are not yet ready to attend the TLCs (note, some individuals attend the TLCs only for half a day. ***See Tab # 69 TLC Catalogue.*** In addition, there is a full schedule of evening and weekend activities. See ***Tab # 85 Evening and Weekend Activity Schedules.***

2. Monitor EARN implementation.

SEH Response: Implementation ongoing. ***Tab # 117, EARN Implementation Report.*** A key implementation that

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

remains is around documentation but strategies are being piloted to determine how best to accomplish this.

3. Re-evaluate nursing staff deployment to TLCs and policies relative to newly admitted individuals' attendance at TLCs to ensure sufficient nursing staff in all areas providing active treatment.

SEH Response: Many individuals from 1F and 1G begin attending the TLC at least part of the day within ten days to two weeks of admission, and more programming is available on 1E, an admissions unit, than was available in the past. ***See Tab # 69 TLC Catalogue*** Groups on 1E include music therapy, art therapy, exercise, ADL/Self esteem, living well/eating well, Understanding your illness, Understanding your treatment, Substance abuse education, Sensory enhancement, Discharge planning, Medication Education, Spiritual awaking and A/V escape.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C. #3.1a Documentation reflects that individual posed imminent danger to self or others if not restrained/secluded.	100	n/a	80	100	100	100	**94**
%C #3.1.b. Documentation reflects r/s used to ensure safety of individuals or others, after less restrictive interventions were tried after less restrictive interventions were determined to be ineffective in protecting the individual or others from harm	n/a	n/a	100	100	100	100	**100**
%C # 4.1b The reviewer suspects that the individual was restrained or secluded for punishment, convenience or as alternative to active treatment.	0	n/a	20	0	0	0	**6**

N = All restraint or seclusion episodes in the month
n = number audited
* Questions were not in tool used during the month
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: Data from the restraint and seclusion audits show that in general, restraint or seclusion is utilized only to ensure the individual's safety or that of another. There was one case in July that the reviewer/auditor found that evidence suggested that the individual was abused or neglected during the restraint/seclusion event. That case was already known to the Risk Manager and had been investigated and substantiated. Further, as previously noted, data also suggest that there is inadequate documentation of utilization of less restrictive interventions before using restraint or seclusion. It should be noted that because the audits only look at instances where restraint or seclusion were utilized, the data will not capture those cases in which less restrictive interventions were tried and are successful. However, given the results of the Psychiatric Emergencies study, it appears that the Hospital is not

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		routinely using less restrictive interventions to the extent appropriate. SeeX.B.1.
X.B.3	are not used as part of a behavioral intervention; and	**Recommendation:** 1. Maintain compliance with this provision. SEH Response: See VIII.B.1.c
X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Recommendation:** 1. Proceed with planned form revision. SEH Response: Form has not yet been revised, but is in the queue for revision in Avatar. **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C #3.1c Documentation reflects that R/S event was terminated as soon as the individual met behavioral criteria for release or physician order expired or individual behavior indicated readiness for release, whichever occurred first.*	n/a	n/a	100	100	100	100	**100**

N = All restraint or seclusion episodes in the month
n = number audited
* Questions were not in tool used during March
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: Data suggest good performance on this measure. No further action is required.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	
X.C.1	the specific behaviors requiring the procedure;	**Recommendation:** 1. Proceed with form revision and continue monitoring. SEH Response: Form has not yet been revised, but is in the queue for revision in Avatar enhancement. **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

	Mar	Apr	Mar	Jun	Jul	Aug	Total
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C #3.2 c The record contains a physician's order for r/s	100	n/a	20	100	75	100	**71**
%C # 3.2e The order includes the specific behavior that required r/s	75	n/a	100	100	100	100	**94**

N = All restraint or seclusion episodes in the month
n = number audited
* Questions were not in tool used during the month
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: Data from the audits show generally a high level of compliance with this requirement, with a mean of 71 and 94 on the two related indicators. The absence of doctor's orders in May seem to be more on an aberration than a trend. Further the physicians that failed to write seclusion orders have been terminated. This will continue to be monitored through the restraint and seclusion audits.

The Risk Manager discovered two cases in which seclusion was effectively used without a doctor's order. In both of these cases, the individual was placed in what purportedly was the "quiet room" but in fact was placed in the seclusion room and was not permitted to leave. Investigation of abuse or neglect were conducted and substantiated.

X.C.2 — the maximum duration of the order;

Recommendation:
1. Revise the audit tool and continue monitoring.

SEH Response: Audit tool revised; duration of the order is now monitored through the restraint and seclusion audits.

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C # 3.2d The order includes duration that is consistent with hospital policy (not to exceed one hour)	100	n/a	100	100	100	100	**100**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 Restraint and Seclusion Audit Results

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		Analysis/Action Plans: The Hospital will continue to monitor this through the restraint and seclusion audits.
X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	**Recommendations:** 1. Involve physicians in identifying support necessary to write behavioral release criteria. SEH Response: PID is coordinating the efforts to strengthen the writing of behavioral criteria for release. By the time of the site visit sample criteria will be developed and available to physicians. 2. Proceed with planned form revision and continue monitoring. SEH Response: Form has not yet been revised, but is in the queue for revision in Avatar. **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C #3. 2f The order includes individualized behavioral conditions for release	75	n/a	100	100	66	100	**88**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: Seclusion and restraint audits will continue to monitor this requirement. See response to recommendation # 1 for additional information.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Recommendation:** 1. Proceed with plans to revise audit tool. SEH Response: Completed. Audit tool now tracks if the ordering physician was the individual's attending psychiatrist, and if not, whether the attending psychiatrist was notified. ***See Tab # 54 Restraint and Seclusion Audit tool/instructions.*** **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	**Total**
N	6	0	5	4	12	7	**6**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C #3.2 g was the treating psychiatrist the physician who ordered r/s	100	n/a	100	100	33	100	**88**
%C # 3.2h Did the ordering physician promptly consult with the individual's treating psychiatrist (if latter was not the ordering physician?	n/a	n/a	n/a	n/a	100	n/a	**100**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: The Hospital is meeting this requirement. No further action is required.

X.C.5 — ensure that at least every 30 minutes, individuals in seclusion or restraint must be reinformed of the behavioral criteria for their release from the restrictive intervention;

Recommendations:
1. See X.A.1.

SEH Response: See X.A.1

2. Proceed with planned form revision and continue monitoring.

SEH Response: See X.A.1

Facility's Findings:

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C # 3.4.e Nursing documentation indicates that individual was informed of behavioral criteria for release every 15 minutes	75	n/a	60	100	75	66	**71**

N = All restraint or seclusion episodes in the month
n = number audited
Tab # 55 Restraint and Seclusion Audit Results

Analysis/Action Plans: In this case, the audit tool does not align with the Agreement's requirement, as the audit tool is looking for documentation that the individual is informed of behavioral criteria for release every 15 minutes while the Agreement requires this be done only every 30 minutes. The audit tool will be modified to capture the requirements of the Agreement.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Recommendation:** 1. Involve treatment teams to explore and resolve barriers to compliance. SEH Response: The Director of Clinical Operations has implemented a new process to ensure debriefing is occurring. Effective September 15, 2010, clinical administrators will provide a copy of the debrief form to the Deputy Directors of Clinical Operations. In addition, the Deputy Directors will review the 24 hour nursing report to identify those cases of seclusion or restraint to ensure all debriefing forms are provided. **Facility's Findings:** (see table below) N = All restraint or seclusion episodes in the month n = number audited ***Tab # 55 Restraint and Seclusion Audit Results*** **Analysis/Action Plans:** The Director of Clinical Operations has identified the clinical administrator as the individual who is responsible for convening the treatment team debriefing and documenting the same in the record. This will become part of supervision. In addition, the deputy directors for clinical operations will review the 24 hour nursing report each day to determine if restraint or seclusion was used. The clinical administrator is responsible for providing the deputy directors with a copy of the form that summarizes the debriefing and ensuring that the form is in the medical record as well.
X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Recommendations:** 1. Explore and resolve barriers to documenting the assessment. Consider asking physicians if it would be helpful to include an assessment component on one of the existing forms. SEH Response: The Hospital will continue with its current protocol for assessment. 2. Assure that the audit question distinguishes the presence of an MD note from evidence of a face-to-face assessment. SEH Response: Completed. ***See Tab # 54 Restraint and Seclusion Audit tool/instructions.*** **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C # 5.1a Treatment team debriefing held within 24 hours or next business day of termination of r/s event	75	n/a	0	0	0	0	**18**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SECLUSION AND RESTRAINT AUDIT RESULTS (see table below) N = All restraint or seclusion episodes in the month n = number audited ***Tab # 55 Restraint and Seclusion Audit Results*** **Analysis/Action Plans:** The data shows improvement is needed on this requirement. The Medical Director and the Director of Psychiatry training have reminded physicians to ensure the progress note makes it clear if a face-to-face assessment was completed.
X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	**Recommendation:** 1. See VIII.D.1 SEH Response: See VIII.D.1.
X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	**Recommendation:** 1. Review all documentation and reporting requirements. Identify and pursue opportunities to extract data directly from AVATAR whenever possible. SEH Response: In mid-September, 2010 the Hospital received permission from the Department of Mental Health to eliminate the requirement for a UI to be completed for restraint and seclusion incidents; instead, the doctor's order will serve the function of the UI. Information about the incident from the doctor's order will be entered into the UI database for tracking purposes, and this will be crosschecked with the daily nursing report to ensure all incidents are recorded. In addition, the eMar was modified and nursing, at the time of administration, will note when medication was administered on an involuntary basis.
X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion	**Recommendation:** 1. Continue implementation of the system and associated monitoring. SEH Response: Ongoing. See ***Tab # 56 Risk Indicator Event System, Tracking reports for High Risk indicators.*** **Facility's Findings:**

SECLUSION AND RESTRAINT AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	Mean
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C 3.3g Physician conducted face-to- face assessment within one hour of initiation of r/s event	100	n/a	60	0	33	66	**63**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**SECLUSION AND RESTRAINT AUDIT RESULTS** (see table below) N = All restraint or seclusion episodes in the month n = number audited ***Tab # 55 Restraint and Seclusion Audit Results*** **Analysis/Action Plans:** The Hospital shows high performance in meeting this requirement.
X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Recommendations:** 1. Develop reports to monitor the use of emergency involuntary psychotropic medication administration. SEH Response: The Hospital took several steps to enhance the ability to track this information. First, Medical Staff Executive Committee approved the definition around use of "NOW" and "STAT" medications. Only medications with a STAT order may be given involuntarily. Next a drop down menu was added to EMAR to allow the tracking of whether, when administered, the medication was accepted voluntarily or involuntarily. This latter enhancement began being tested in mid-September, so reports are not yet available. It is expected the reports will be available by the next site visit. 2. Develop an audit tool to monitor adherence to policy requirements. SEH Response: Tool was developed but audits have not yet begun. ***Tab # 162 Emergency Involuntary Medication audit tool.*** Audits will be done by the PID and will begin in October for the September instances. The Hospital will attempt to identify relevant cases based upon the currently available reports. 3. Determine which position/body will review and analyze findings, take actions to address trends, evaluate the

SECLUSION AND RESTRAINT AUDIT RESULTS

	Mar	Apr	Mar	Jun	Jul	Aug	Mean
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C # 5.2a IRP was updated within 24 hours if 2 or more r/s episodes within 24 hour period or r/s episode occurred on 2 or more consecutive days or individual placed in r/s in excess of 12 consecutive hours or 3 or more episodes in a four week period	n/a	n/a	n/a	100	n/a	n/a	**100**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		effectiveness of actions taken, and document the process. SEH Response: Until September 2010, the Hospital was only able to track STAT medications that were administered by injection, which it was aware could both underreport and overreport emergency involuntary medication. Therefore in May, 2010, the Medical Staff Executive Staff Committee clarified the use of "NOW" orders and the use of "STAT" medication. Under the protocol, "NOW" is to be used for urgent situations, but if refused by the individual in care, medication would not be administered. "STAT" medication is to be used for emergencies, and can be given over the individual's objection. A drop down menu was modified in the eMAR screens, and nursing will record if the medication was administered involuntarily. While a management report is not yet available, once it is developed, the Hospital will be able to track emergency involuntary medications. Currently, the Pharmacy and Therapeutics Committee is reviewing the STAT IM data, and will review the data from the new report once it is available. Audits using the new tool will be completed by PID, and will begin in October. That data will also be shared with Pharmacy and Therapeutics Committee. **Facility's Findings:** The audits have not begun, but the audit form is completed. Below is the indicator that is in the new audit tool that will be implemented to assess performance in meeting this requirement. ***Tab # 162 Emergency Involuntary Medication Audit form***

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N								
n								
%S								
%C #1 EIMs are used on a time-limited, short term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress.								

N = All emergency involuntary medication episodes in the month
n = number audited
Tab # 162 Emergency Involuntary Medication Audit form

Analysis/Action Plans: The Hospital will develop the necessary management reports and implement the audits during the next review period.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Recommendations:** 1. See F.X.1 SEH Response: See X.F.1. Please note that the audit tool includes an indicator to measure this.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		2. Assure that the audit question distinguishes the presence of an MD note from evidence of a face-to-face assessment. SEH Response: Physician notes are to reflect specifically if a face to face assessment was conducted. The audits have not begun, but the audit form is completed. Below is the indicator that is in the new audit tool that will be implemented to assess performance in meeting this requirement. ***Tab # 162 Emergency Involuntary Medication Audit form*** **Facility's Findings:**

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS								
	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N								
n								
%S								
%C #2. A physician conducted a face-to-face assessment of the individual within one hour of the administration of the EIM								

N = All emergency involuntary medication episodes in the month
n = number audited

Analysis/Action Plans: The Hospital will develop the necessary management reports and implement the audits during the next review period.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
X.F.3	the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.	**Recommendation:** 1. Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes. SEH Response: This will be tracked through the emergency involuntary medication audits that are to begin in October, 2010. Further, PID is undertaking an analysis of STAT medication. This study will delineate whether a STAT medication was given voluntarily or involuntarily, as well as the frequency of STAT medication use. The audits have not begun, but the audit form is completed. Below is the indicator that is in the new audit tool that will be implemented to assess performance in meeting this requirement. ***Tab # 162 Emergency Involuntary Medication Audit form*** **Facility's Findings:**

EMERGENCY INVOLUNTARY MEDICATION AUDIT RESULTS

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		(see table below) N = All emergency involuntary medication episodes in the month n = number audited
X.G	By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Recommendations:** 1. See VIII.D.1 and X.C.8. SEH Response: VIII.D.1, X.A.2 and X.C.8. The training curricula for restraints and seclusion was modified in August to include a segment on emergency involuntary medication.

	Mar	Apr	May	Jun	Jul	Aug	**Mean-P**	**Mean-C**
N								
n								
%S								
%C #3. the individual's core treatment team conducts a review (within three business days) whenever three administrations of EI psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate								

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XI.	**PROTECTION FROM HARM**	
	By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect.· SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals' living at the facility.	The Hospital continues to operate in the new state of the art facility.

Training on reporting abuse and neglect continues to be included in the new employee orientation, and the annual renewal is offered multiple times during the year. Despite this, not all employees are current in their training. See data below. ***Tab # 135 Reporting Abuse and Neglect Training data and curriculum outline.*** The Hospital anticipates creating an online course for this training which will provide increased flexibility for staff to complete it. Finally, the Hospital continues to require criminal background checks for unlicensed staff prior to hiring. Such checks for licensed staff are not completed by SEH as they are done as part of the licensing process.

Data Source: Training DB, 9/29/2010

Reporting Suspected Individual Abuse, Neglect & Exploitation (03/01/10 ~ 09/20/10)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	2	2	2	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	9	9	9	100%	100%/100%
Dietary	4	4	4	100%	100%/100%
Medical	10	9	9	90%	90%/100%
Nursing - Nurse Manager	17	16	16	94%	94%/100%
Nursing - RN	78	54	54	69%	69%/100%
Nursing - LPN	31	26	26	84%	84%/100%
Nursing - RA	200	144	144	72%	72%/100%
Psychiatry	57	55	55	96%	96%/100%
Psychology	18	18	18	100%	100%/100%
Rehabilitation	17	17	17	100%	100%/100%
Social Work	12	12	12	100%	100%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	9	8	8	89%	89%/100%
Non-Clinical/Administrative	211	211	211	100%	100%/100%
Total	**691**	**601**	**601**	**87%**	**87%/100%**

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

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

Additional information: During this review period, the Hospital's PID conducted a review of psychiatric emergencies

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		between May 2010 and August 2010. The review looked at location of the incident, individuals involved, whether the comfort plans were used, whether restraints or seclusion was used, whether involuntary medication was administered, and common stressors or precipitating factors. The review showed that psychiatric emergencies resulted in use of restraint 4% of the time and use of seclusion 15% of the time. The review also showed that there was often little evidence documented in the record that meaningful less restrictive interventions were attempted (i.e. comfort plans, or EARN) prior to restraint, seclusion or emergency involuntary medication (See section X.F). The report which was completed in September 2010, was presented to Executive staff and PIC and final recommendations should be available by the time of the site visits. ***See Tab #157 Analysis of Psychiatric Emergencies.*** Also during this review period, the Hospital's Risk Manager identified two incidents that effectively constituted seclusion without a doctor's order. In both cases, he substantiated abuse after an investigation.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.	**INCIDENT MANAGEMENT**	
	By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	
XII.A	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Recommendation:** 1. Monitor the application of the Incident Management policies. SEH Response: Ongoing. The Hospital continues to monitor the application of the Incident Management policies in several ways. First, the Risk Manager reviews each UI in order, *inter alia*, to identify areas on noncompliance with the incident management policies. He also reviews collateral hospital reports such as the 24 Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents noted in the reports have corresponding UIs. Second, the Risk Manager investigation reports are reviewed by a supervisor to ensure the investigations and reports meet Hospital standards. Finally, all managers review monthly the Unusual Incident Monthly Report **(*See Tab # 142*)**; and the PRISM report **(*See Tab # 53*).** The Hospital reviewed all incident management policies to ensure consistency, and also to ensure the policy language reflects hospital practice, especially concerning actions taken with incidents involving potential criminal action. Minor changes also were made to update accurate department and position titles that are referenced in the policy, to clarify the timeframe for initiating an Unusual Incident investigation and other similar revisions. ***See Tab 134 Unusual Incident Reporting and Documentation Policy; See Tab 136 Unusual Incident Investigation Policy. See Tab 133 Reporting Suspected Abuse, Neglect, and Exploitation of Individuals in Care Policy.*** The Hospital also drafted a High Risk Indicator Review and Tracking Policy that is expected to be finalized by November 2010. The policy encompasses a two-tiered approach to high risk situations by monitoring systemic trends and by addressing the high-risk indicators for specific individuals in care. ***Tab 151 High Risk Indicator Review and Tracking policy.*** By posting a broadcast on the Hospital's intranet site, the Risk Manager has taken actions to ensure that hospital practice is consistent with the free of retaliation reporting component of the A/N/E policy. ***See Tab # 138 Internet Posting on Staff Duty to Report***.
XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Recommendation:** 1. Monitor the application of the Incident Management policies. SEH Response: See Section XII.A. The Hospital continues to monitor the improper use of seclusion and restraint as defined in the Reporting Suspected

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

A/N/E policy ***See Tab 133 Reporting Suspected Abuse, Neglect, and Exploitation of Individuals in Care Policy.*** There was one incident where an Individual in care was mechanically restrained in the prone position. That incident was discovered and investigated by the Risk Manager who substantiated a finding and cited also the failure to report the prone restraint. Training and personnel actions will be proposed as recommendations by the Risk Manager as corrective actions related to this incident. The Seclusion and Restraint training was immediately modified to reiterate that the hospital's policy forbids the restraining of an Individual while in a prone position. The Risk Manager also discovered three cases in which seclusion occurred without a doctor's order. While in all cases the doctor had verbally approved the use of seclusion, the failure to write an order violates policy. Two of the physicians have been terminated, and the third was counseled.

The Hospital continues to track the accuracy of seclusion and restraint reporting through the seclusion and restraint audits. The audits indicated that 94% of the seclusion and restraints episodes which were reviewed were documented with a UI report. ***See Tab # 55 Seclusion and Restraint Audit Results.***

SECLUSION AND RESTRAINT AUDIT RESULTS							
	Mar	Apr	Mar	Jun	Jul	Aug	**Mean**
N	6	0	5	4	12	7	**6**
n	4	0	5	1	4	3	**3**
%S	67	n/a	100	25	33	43	**50**
%C # 3.4p An Unusual Incident Report was completed about the R/S event.	100	n/a	100	100	75	100	**94**

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.A.2	immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Recommendation:**

1. Continue current practice of identifying failure to report allegations of A/N/E in the manner prescribed in policy.

SEH Response: Current practice continues.

Report Delay of Abuse and Neglect Incidents														
Report Gap (Days)	**Previous Review Period (Sep-09 ~ Feb-10)**						**Current Review Period (Mar-10 ~ Aug-10)**						**Previous Total**	**Current Total**
	2009-9	2009-10	2009-11	2009-12	2010-1	2010-2	2010-3	2010-4	2010-5	2010-6	2010-7	2010-8		
<=1 day (on time)	**3**	**2**	**3**	**1**	**3**	**3**	**2**	**1**	**1**	**1**	**2**	**4**	**15**	**11**
>1 & <=5 days	**3**	**3**	**0**	**3**	**3**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**12**	**2**
>5 & <=10 days	**1**	**0**	**0**	**2**	**0**	**1**	**1**	**0**	**2**	**1**	**0**	**1**	**4**	**5**
>10 days	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**1**	**2**	**1**	**2**	**0**	**4**	**6**
Total abuse/neglect	**8**	**7**	**4**	**6**	**6**	**4**	**3**	**3**	**5**	**3**	**5**	**5**	**35**	**24**

UIs														
Percent of timely reporting (<=1 day)	***38%***	***29%***	***75%***	***17%***	***50%***	***75%***	***67%***	***33%***	***20%***	***33%***	***40%***	***80%***	***43%***	***46%***
Reports Delayed (>1 day)	***5 63%***	***5 71%***	***1 25%***	***5 83%***	***3 50%***	***1 25%***	***1 33%***	***2 67%***	***4 80%***	***2 67%***	***3 60%***	***1 20%***	***20 57%***	***13 54%***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		See Tab # 142 UI Monthly Report. **Analysis/Action Steps:** Overall the number of abuse/neglect reports dropped in the current review period (24) compared with the previous review period (35). The percentage of delayed abuse/neglect reports (>1 day after incident occurred) slightly dropped (54%) from the previous period (57%). Timely abuse/neglect UI reporting notably improved for the past few months. During this reporting period there were 13 delayed reports of A/N/E allegations. However, 7 of the 13 cases, while delayed in reporting from the date of incident, ***were*** timely reported upon discovery of the incident. The Risk Manager posted a broadcast on the Hospital's intranet site that reiterates the hospital policy that staff shall be free of retaliation when reporting an allegation of A/N/E. ***See Tab # 138 Internet Posting on Staff Duty to Report***. The Risk Manager has taken actions to ensure that staff are compliant with their duty to report UIs of all types. The Risk Manager also reviews collateral hospital reports such as the 24 Hour Nursing Report and Code 13 reports as a means of checks and balance to ensure that incidents of any type noted in the reports have corresponding UIs if required by the policy. See also XII.A.1
XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Recommendation:** 1. When a staff member is named in an allegation of A/N/E, the investigation should document that the decision to not remove the staff member was made with the agreement of the Risk Manager and as prescribed by Policy 301-01. SEH Response: The Hospital disagrees with the recommendation. The Reporting A/N/E policy specifically provides that the decision to place an individual on administrative leave rests with the Executive staff member, and he or she must ensure the individuals in care are protected. Nor does it require the concurrence of the Risk Manager. ***See Tab 133 Reporting Suspected Abuse, Neglect, and Exploitation of Individuals in Care Policy.***
XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Recommendation:** 1. Continue efforts to ensure that all staff members receive annual A/N/E training and pass the competency test.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: The Hospital continued efforts to ensure that all staff member receive annual A/N/E training and pass the competency test. Compared to the last reporting period, there is substantial improvement in the number of staff who have competently completed A/N/E training as either annual refresher training or new employee training. During this review period, 100% of all new hires and 87% of continuing employees have been trained to competency. Training data is regularly monitored by the Training and Professional Development staff to determine employee compliance with A/N/E training. A non-compliance notification is sent to staff that have not completed training. ***See Tab # 135 Reporting Abuse and Neglect Training Data.***

Data Source: Training DB, 9/30/2010

Reporting Suspected Individual Abuse, Neglect & Exploitation (03/01/10 ~ 09/20/10)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	2	2	2	100%	100%/100%
Clinical Administrator	12	12	12	100%	100%/100%
Dentistry	9	9	9	100%	100%/100%
Dietary	4	4	4	100%	100%/100%
Medical	10	9	9	90%	90%/100%
Nursing - Nurse Manager	17	16	16	94%	94%/100%
Nursing - RN	78	54	54	69%	69%/100%
Nursing - LPN	31	26	26	84%	84%/100%
Nursing - RA	200	144	144	72%	72%/100%
Psychiatry	57	55	55	96%	96%/100%
Psychology	18	18	18	100%	100%/100%
Rehabilitation	17	17	17	100%	100%/100%
Social Work	12	12	12	100%	100%/100%
Treatment Mall	4	4	4	100%	100%/100%
Clinical (Other)	9	8	8	89%	89%/100%
Non-Clinical/Administrative	211	211	211	100%	100%/100%
Total	**691**	**601**	**601**	**87%**	**87%/100%**

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report	**Recommendation:** 1. Continue current practice.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	incidents to SEH and District officials;	SEH Response: Current practice continues. A/N/E training is part of the mandatory new employee training that each new employee must complete within the first two weeks after their employment start date.

Data Source: Training DB, 9/30/2010

Reporting Unusual Incidences (03/01/10 ~ 09/20/10)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	4	4	4	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	8	8	8	100%	100%/100%
Nursing - RA	3	3	3	100%	100%/100%
Psychiatry	10	10	10	100%	100%/100%
Psychology	11	11	11	100%	100%/100%
Rehabilitation	3	3	3	100%	100%/100%
Social Work	4	4	4	100%	100%/100%
Clinical (Other)	2	2	2	100%	100%/100%
Non-Clinical/Administrative	6	4	4	67%	67%/100%
Total	**57**	**55**	**55**	**96%**	**100%/100%**

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

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

Data Source: Training DB, 9/30/2010

Understanding the Rights of Individuals Receiving Care (03/01/10 ~ 09/20/10)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent****
Chaplain	4	4	4	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	8	8	8	100%	100%/100%

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Nursing - RA	3	3	3	100%	100%/100%
Psychiatry	10	10	10	100%	100%/100%
Psychology	11	11	11	100%	100%/100%
Rehabilitation	3	3	3	100%	100%/100%
Social Work	4	4	4	100%	100%/100%
Clinical (Other)	2	2	2	100%	100%/100%
Non-Clinical/Administrative	6	4	4	67%	67%/100%
Total	**57**	**55**	**55**	**96%**	**100%/100%**

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

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

Data Source: Training DB, 9/30/2010

Reporting Suspected Individual Abuse, Neglect & Exploitation (03/01/10 ~ 09/20/10)					
Discipline	**# Required**	**# Attended**	**# Competent**	**% Attended**	**% Competent*/ % of Attendees Competent***
Chaplain	4	4	4	100%	100%/100%
Dentistry	4	4	4	100%	100%/100%
Medical	1	1	1	100%	100%/100%
Nursing - Nurse Manager	1	1	1	100%	100%/100%
Nursing - RN	8	8	8	100%	100%/100%
Nursing - RA	3	3	3	100%	100%/100%
Psychiatry	10	10	10	100%	100%/100%
Psychology	11	11	11	100%	100%/100%
Rehabilitation	3	3	3	100%	100%/100%
Social Work	4	4	4	100%	100%/100%
Clinical (Other)	2	2	2	100%	100%/100%
Non-Clinical/Administrative	6	6	6	100%	100%/100%
Total	**57**	**57**	**57**	**100%**	**100%/100%**

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

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

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		training. ***See Tab # 129 New Employee Training Curricula and Data***
XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Recommendation:** 1. Continue current practice. SEH Response: The Hospital continues its current practice of posting on each house a brief statement of how to report incidents.
XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Recommendation:** 1. Continue to address the question of law enforcement referral in each investigation of A/N/E and whenever criminal activity is involved. SEH Response: Ongoing. In May 2010, there was one incident where there was an allegation of a sexual assault by an Individual in care against another Individual in care (AWB and TJ). MPD was contacted and its Sexual Assault Unit conducted a full investigation. The Sexual Assault Unit determined that the allegations were unsubstantiated due to lack of evidence.
XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline "harassment, threats, or licensure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Recommendation:** 1. Advise staff who report A/N/E and express fear of retaliation to contact the Risk Manager immediately should they experience retaliation or threats. SEH Response: The right to be free from retaliation for reporting an allegation of A/N/E continues to be covered in both the new employee and refresher modules of the Reporting Suspected A/N/E training. ***See Tab # 135 Reporting Abuse and Neglect Training data.*** The Risk Manager has reiterated the hospital policy in this regard to staff via a bulletin on the Hospital's intranet site. ***See Tab # 138 Internet Posting on Staff Duty to Report***. Subsequent to this posting, the Risk Manager was directly contacted by staff regarding a couple of incidents where they had concerns regarding retaliation in reporting. There have been no reports or evidence that any individual or staff experienced retaliation for reporting allegations of abuse, neglect or exploitation during this review period.
XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Recommendation:** 1. Take any measures possible to expedite the complete and timely investigation of incidents. 2. SEH Response: The Hospital still faces challenges in completing timely investigations of incidents as defined in the policy. ***See Tab # 136 Unusual Incident Investigation Policy***. During this period, the Risk Manager prioritized the investigation workload and focused on investigating those cases in which the allegations were substantiated. A new PI director was hired in the beginning of August 2010. An additional investigator who will assist the Risk Manager with conducting investigations and writing investigation reports was hired at the end of September 2010, and an additional position to assist the Risk Manager is identified. The Unusual Incident Investigation policy was updated with the

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		requirement that the Risk Manager shall initiate investigation within 5 days of notification. ***See Tab # 136 Unusual Incident Investigations Policy (revised).***
XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Recommendation:** 1. Provide close supervision of investigation to ensure their completeness. SEH Response: Ongoing
XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	**Recommendation:** 1. Continue current practice. SEH Response: The Risk Manager and the investigator have completed the required competency based training on investigations.
XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	**Recommendations:** 1. Link the determination rationale to the relevant section/phrase in the incident type definition as provided in hospital incident policies. SEH Response: All investigations are reviewed by the Director, PID. 2. Ensure that all persons who may have witnessed an incident are interviewed. SEH Response: Ongoing. 3. Identify violations of hospital policy in investigations and provide appropriate recommendations to remediate shortcomings in performance. SEH Response: Ongoing as of August 5, 2010, upon receipt of the DOJ report.
XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as s result of investigations.	**Recommendations:** 1. Implement the plan to assign Quality Improvement Coordinators to specific houses and disciplines to ensure recommendations made in incidents reach the responsible staff members and to facilitate implementation. SEH Response: This specific process has not started yet. PID is in the process of filling key positions that are essential for carrying out this function. However, the Risk Manager continues to update the UI database with recommendations made in incidents. The Performance Improvement Director is in the process of developing a tracking and follow-up system of recommendations which includes those recommendations made in incidents. This system is expected to be completed by November 2010. 2. Ensure SERC recommendations are tracked, approved and implemented effectively, as these relate to the most

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		serious incidents in the hospital. SEH Response: In September 2010, the Performance Improvement Director began the development of a tracking system for follow-ups for those recommendations made from the SERC, Risk Management and Safety Investigations, Performance Improvement Committee and the Mortality & Morbidity Committee. The uploading of all recommendations made from the aforementioned PID sources in 2010 is near completion. This system is expected to be fully implemented in November.
XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Recommendations:** 1. Develop and promulgate a hospital wide policy, accompanied by prescribed forms, for accounting for individuals. SEH Response: The High Risk Indicator Review and Tracking Policy is drafted and is expected to be finalized by November 2010. The policy encompasses a tiered approach to high risk situations by monitoring systemic trends and by addressing the high-risk indicators for specific individuals in care. The policy will require clinical responses in the form of active participation from Performance Improvement, Nursing and Medical Affairs for monthly high risk reviews to address systemic trends and from the Medical Director, Chief Nurse Executive, Director of Clinical Operations and the treating psychiatrist to address high risk indicators for specific individuals in care. ***See Tab # 151 High Risk Indicator Review and Tracking Policy (draft).*** 2. Implement as quickly as possible plans for PID staff to ensure that recommendations reach the relevant staff members and assist in implementing the recommendation and in monitoring their effectiveness. SEH Response: In September 2010, the Performance Improvement Director began the process of developing a tracking system for follow-ups for those recommendations made from the SERC, Risk Management and Safety Investigations, Performance Improvement Committee and the Mortality & Morbidity Committee. The uploading of all recommendations made from the aforementioned PID sources in 2010 is near completion. This system is expected to be fully implemented in November. Once PID has filled key positions essential for this function, the plan to assign Quality Improvement Coordinators to specific houses and disciplines will move forward. The Risk Manager continues to update the UI database with recommendations made in incidents.
XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	**Recommendation:** 1. Proceed with plans to expand the UI database to include the investigation disposition. SEH Response: Complete. ***See Tab 160 UI Database Follow-up/Investigation Findings Screenshots.***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.E	By 24 months from the Effective Date hereof~ SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:	**Recommendations:** 1. Identify a listing of specific actions to reduce violence, such as increased recreational activities, incentives to houses which reduce violence, formation of a Peacemaker's group among individuals in care, and implement the actions as resources become available. The specific actions are suggestions only; the hospital should adopt activities that fit its needs and resources. SEH Response: This exceeds the scope of the requirement and will not be addressed. 2. Consider a kick-off event for the Violence Reduction Initiative that garners enthusiasm from individuals and staff. SEH Response: This exceeds the scope of the requirement and will not be addressed. 3. Continue current practice of tracking and trending incidents. The Hospital continues its current practice of tracking and trending incidents in the Unusual Incident Monthly Report and through monthly PRISM reports. ***See Tab # 142 Unusual Incident Monthly Report (March August 2010) and # 53 PRISM report.*** The Risk Manager has begun an analysis of physical assault data which was presented to the combined Violence Reduction and Risk Management Committees. The intent is to provide a monthly analysis once the PID section is fully staffed. ***See Tab # 145 Risk Management & Safety/Violence Reduction Initiative Cross Over Meeting Minutes***.
XII.E.1.	Track trends by at least the following categories:	
XII.E.1.a	type of incident;	**Recommendations:** 1. Consider issuing a house-specific PRISM report on a regular periodic basis. 2. Since May 2010, the teams are provided with house-specific incident data in the Unusual Incident Monthly Report. ***See Tab # 142 Unusual Incident Monthly Report (March through August 2010)*** 3. Include a review of the concerns expressed to the Consumer Rights Advocate/Peer Advocate to ensure that all allegations of abuse and neglect are reported through the proper channels. SEH Response: Consumer Rights Advocates and Peer Advocates report to the Risk Manager any suspected allegations of abuse and neglect. There were eight allegations of abuse and neglect that were received through the consumer grievance process and then reported by a Consumer Rights Advocate/Peer Advocate to the Risk Manager (DC, VG, AWB, AWB, GD, KH, BR, HS). ***See Chura Tab # 10 List of All Investigations***. 4. Ensure that the UI database correctly identifies the incident type in those cases where this might have changed during the course of an investigation.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		SEH Response: The Risk Manager ensures that the UI database is updated to reflect any additional incident type/categories that are discovered during an investigation. The Risk Manager also writes in the investigation report if there are additional incident type/categories that are identified during the course of investigation. Data of type of incident is tracked and available.

Type of Incidents

UI Type		Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Mean-P	Mean-C
Abuse/Neglect/Exploitation		3	3	5	3	5	5	**6**	**4**
Physical Assault		31	36	25	30	44	44	**30**	**35**
Sexual Assault		1	0	2	1	0	1	**0**	**1**
Contraband		8	6	12	13	6	11	**6**	**9**
Crime		0	0	4	1	0	0	**0.7**	**0.8**
Death		0	0	0	0	1	1	**1.2**	**0.3**
Emergency Invol. Medication		0	0	4	9	6	3	**0**	**4**
Environment		1	0	6	4	0	5	**1.2**	**2.7**
Fall		12	14	18	15	31	25	**9**	**19**
Fire		2	1	0	2	1	0	**0.7**	**1.0**
Medical Emergency		16	15	29	14	31	19	**11**	**21**
Medication Refusal		3	8	33	20	22	32	**4**	**20**
Medication Variance		14	12	9	15	13	11	**19**	**12**
Physical Injury		20	35	26	28	38	41	**18**	**31**
Psychiatric Emergency		12	6	29	24	29	29	**10**	**22**
Reportable Disease		0	0	0	0	0	0	**0**	**0**
Restraint		4	0	1	1	2	3	**1**	**2**
Seclusion		2	0	4	3	3	4	**3**	**3**
Security Breach		2	1	1	3	4	5	**2**	**3**
Suicide Attempt/Gesture		1	0	1	3	1	0	**0.3**	**1.0**
Unauthorized Leave		3	2	7	5	2	3	**5**	**4**
Vehicle Accident		1	3	0	0	0	2	**1.0**	**1.0**
Vital Sign/Finger Stick Refusal		0	3	1	4	1	6	**3**	**3**
Other	Attempted UL*	1	5	4	5	7	7	**1**	**5**
	Self Injurious Behavior*	0	2	1	2	3	3		**2**
	Other (None of above)	9	9	22	25	36	29	**18**	**22**
Total**		***113***	***121***	***206***	***173***	***208***	***219***	***121***	***173***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		* *Attempted UL and Self Injurious Behavior were reported under the 'Other' category and classified following manual review.* ** *One incident may be categorized in multiple UIs and thus the sum of each column may exceed the total number of Uis.*
XII.E.1.b	staff involved and staff present;	**Recommendation:** 1. Review the incident history of named staff members to identify patterns of behavior. SEH Response: 'Prior Incident History' is now a category in the investigation report template. The incident history of named staff is reviewed and included in the Investigation Report.
XII.E.1.c	individuals involved and witnesses identified;	**Recommendations:** 1. Implement as planned the Risk Indicator performance improvement initiative described in the next section of the report. This will include, but not be limited to, identifying individuals who are repeat victims and aggressors. SEH Response: The Hospital continues to track and monitor Individuals who are involved in multiple incidents through it's Unusual Incident Monthly Report. ***See Tab # 142 Unusual Incident Monthly Report (March through August 2010)***

Patients Involved in Unusual Incidents and their Role Type of Incidents

Category	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Total	Mean	Percent
Unique Patients Involved by # of Total UIs involved	**98**	**102**	**117**	**94**	**110**	**115**		**99**	**100%**
1 Incident	*68*	*74*	*68*	*60*	*63*	*65*		***66***	***66%***
2 Incidents	*22*	*18*	*29*	*13*	*25*	*23*		***19***	***19%***
3 Incidents	*3*	*6*	*8*	*12*	*6*	*10*		***7***	***7%***
4~5 Incidents	*4*	*3*	*9*	*3*	*10*	*10*		***5***	***5%***
6~10 Incidents	*1*	*1*	*2*	*5*	*4*	*5*		***2***	***2%***
>=11 Incidents	*0*	*0*	*1*	*1*	*2*	*2*		***1***	***1%***
Pts involved >=4UIs (#)	*5*	*4*	*12*	*9*	*16*	*17*		***7***	***7%***
(%)	*5%*	*4%*	*10%*	*10%*	*15%*	*15%*		***7%***	
Unique Patients Involved as Alleged Aggressor for >=1 UI*	**22**	**31**	**33**	**32**	**30**	**34**		**30**	**100%**
1 Incident	*14*	*21*	*21*	*24*	*16*	*25*		***22***	***71%***
2 Incidents	*5*	*7*	*7*	*3*	*6*	*5*		***5***	***16%***
3 Incidents	*2*	*1*	*2*	*2*	*4*	*2*		***2***	***6%***
4~5 Incidents	*1*	*2*	*3*	*2*	*2*	*1*		***1***	***5%***
6~10 Incidents	*0*	*0*	*0*	*1*	*2*	*0*		***0***	***1%***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

>=11 Incidents	*0*	*0*	*0*	*0*	*0*	*0*		***0***	***0%***
Total Patient Records by Role**	**146**	**148**	**218**	**185**	**226**	**242**		**167**	**100%**
Alleged Aggressor	*35*	*46*	*53*	*53*	*63*	*75*		***49***	***29%***
Alleged Victim	*32*	*34*	*29*	*23*	*27*	*35*		***37***	***22%***
Involved	*61*	*51*	*121*	*93*	*120*	*118*		***68***	***41%***
Witness	*3*	*2*	*7*	*3*	*2*	*2*		***3***	***2%***
Other	*2*	*1*	*3*	*1*	*3*	*0*		***5***	***3%***
Not Identified	*13*	*14*	*5*	*12*	*11*	*12*		***6***	***3%***

The Risk Manager provides the Medical Director with specific details of individuals who are involved in multiple incidents in the Risk Indicator Report. ***See Tab # 56 Risk Indicator Event System and Risk Indicators February 17, 2010 through September 3, 2010.***

Upon review of the Risk Indicator Report, the Medical Director provides recommendations and documents them in AVATAR. PID staff extracts those recommendations and places them into a spreadsheet which is shared with the respective clinical Administrator for incorporation into the treatment planning process for that individual.

2. Ensure Risk Indicators consider not only the frequency of an occurrence but also the severity.

SEH Response: The severity of unusual incident occurrences are tracked and monitored in the Unusual Incident Monthly Report. ***See Tab # 142 Unusual Incident Monthly Report (March through August 2010)***

Severity															
Severity	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Total**	**Mean**	**Percent**
Catastrophic	0	0	0	0	1	0	0	0	0	0	0	0	**1**	**0**	**0.1%**
High	5	6	4	5	16	15	21	19	62	43	62	38	**296**	**25**	**16.8%**
Medium	48	34	21	47	52	73	43	43	81	77	78	115	**712**	**59**	**40.4%**
Low	42	77	66	62	87	63	49	59	63	53	68	66	**755**	**63**	**42.8%**
Total	***95***	***117***	***91***	***114***	***156***	***151***	***113***	***121***	***206***	***173***	***208***	***219***	**1764**	***147***	**100.0%**

XII.E.1.d location of incident;

Recommendations:

1. Implement plans to provide teams with house-specific incident data on a regular periodic basis.

SEH Response: Since May 2010, the teams are provided with house-specific incident data in the Unusual Incident Monthly Report. ***See Tab # 142 Unusual Incident Monthly Report (March through August 2010)***

Incident Location

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Unit	May-10	Jun-10	Jul-10	Aug-10	Total	Average	Percent
1A (Allison)	15	7	22	20	**64**	***16***	**8%**
1B (Barton)	11	6	8	9	**34**	***9***	**4%**
1C (O'Malley)	5	8	1	5	**19**	***5***	**2%**
1D (Dix)	25	21	14	21	**81**	***20***	**10%**
1E (Hayden)	9	15	31	31	**86**	***22***	**11%**
1F (Shields)	46	28	37	26	**137**	***34***	**17%**
1G (Howard)	10	8	7	6	**31**	***8***	**4%**
2A (Gorelick)	8	6	4	7	**25**	***6***	**3%**
2B (Nichols)	7	4	9	4	**24**	***6***	**3%**
2C (Blackburn)	6	4	11	4	**25**	***6***	**3%**
2D (Franz)	12	11	19	24	**66**	***17***	**8%**
Annex A	12	6	9	13	**40**	***10***	**5%**
Annex B	0	1	2	3	**6**	***2***	**1%**
TLC-Intensive	8	11	6	11	**36**	***9***	**8%**
TLC-Transitional	5	12	12	10	**39**	***10***	**5%**
SEH Other	23	20	10	16	**69**	***17***	**9%**
Non-SEH	**4**	**5**	**6**	**9**	**24**	***6***	**3%**
Grand Total	**206**	**173**	**208**	**219**	**806**	***202***	**100%**

2. Identify and track responses to the location data provided to teams.

SEH Response: The Hospital does not agree with this recommendation.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XII.E.1.e	date and time of incident;	**Recommendation:** 1. Identify and track responses to the time of day incident data provided to teams. SEH Response: Time of day incident data is made available to teams.
XII.E.1.f	cause(s) of incident; and	**Recommendations:** 1. Continue the review of individuals involved in multiple incidents by the Medical Director. SEH Response: The Hospital continues to track and monitor Individuals who are involved in multiple incidents through its Unusual Incident Monthly Report and high risk indicator system. ***See Tab # 142 Unusual Incident Monthly Report (March through August 2010)***

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT

Patients Involved in Unusual Incidents and their Role Type of Incidents

Category	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Total	Mean	Percent
Unique Patients Involved by # of Total UIs involved	**98**	**102**	**117**	**94**	**110**	**115**		**99**	**100%**
1 Incident	*68*	*74*	*68*	*60*	*63*	*65*		***66***	***66%***
2 Incidents	*22*	*18*	*29*	*13*	*25*	*23*		***19***	***19%***
3 Incidents	*3*	*6*	*8*	*12*	*6*	*10*		***7***	***7%***
4~5 Incidents	*4*	*3*	*9*	*3*	*10*	*10*		***5***	***5%***
6~10 Incidents	*1*	*1*	*2*	*5*	*4*	*5*		***2***	***2%***
>=11 Incidents	*0*	*0*	*1*	*1*	*2*	*2*		***1***	***1%***
Pts involved >=4UIs (#)	*5*	*4*	*12*	*9*	*16*	*17*		***7***	***7%***
(%)	*5%*	*4%*	*10%*	*10%*	*15%*	*15%*		***7%***	
Unique Patients Involved as Alleged Aggressor for >=1 UI*	**22**	**31**	**33**	**32**	**30**	**34**		**30**	**100%**
1 Incident	*14*	*21*	*21*	*24*	*16*	*25*		***22***	***71%***
2 Incidents	*5*	*7*	*7*	*3*	*6*	*5*		***5***	***16%***
3 Incidents	*2*	*1*	*2*	*2*	*4*	*2*		***2***	***6%***
4~5 Incidents	*1*	*2*	*3*	*2*	*2*	*1*		***1***	***5%***
6~10 Incidents	*0*	*0*	*0*	*1*	*2*	*0*		***0***	***1%***
>=11 Incidents	*0*	*0*	*0*	*0*	*0*	*0*		***0***	***0%***
Total Patient Records by Role**	**146**	**148**	**218**	**185**	**226**	**242**		**167**	**100%**
Alleged Aggressor	*35*	*46*	*53*	*53*	*63*	*75*		***49***	***29%***
Alleged Victim	*32*	*34*	*29*	*23*	*27*	*35*		***37***	***22%***
Involved	*61*	*51*	*121*	*93*	*120*	*118*		***68***	***41%***
Witness	*3*	*2*	*7*	*3*	*2*	*2*		***3***	***2%***
Other	*2*	*1*	*3*	*1*	*3*	*0*		***5***	***3%***
Not Identified	*13*	*14*	*5*	*12*	*11*	*12*		***6***	***3%***

The Risk Manager provides the Medical Director with specific details of individuals who are involved in multiple incidents in the Risk Indicator Report. **See Tab # 56 Risk Indicator Event System Sept 2010 and Risk Indicators February 17, 2010 through September 3, 2010.**

Upon review of the Risk Indicator Report, the Medical Director provides recommendations in AVATAR. PID staff extracts those recommendations and places them into a spreadsheet which is shared with the respective clinical administrator for incorporation into the treatment planning process for that individual.

2. Identify contributing factors in investigations when possible.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		3. SEH Response: Contributing factors in investigations are identified in investigations when possible.
XII.E.1.g	actions taken.	**Recommendation:** 1. Move beyond planning to review the implementation of actions taken in response to specific incidents and in response to incident patterns and trends to include actual audits. SEH Response: The High Risk Indicator Review and Tracking Policy is drafted and is expected to be finalized by November 2010. The policy encompasses a two-tiered approach to high risk situations by monitoring systemic trends and by addressing the high-risk indicators for specific individuals in care. The policy will require clinical responses in the form of active participation from Performance Improvement, Nursing and Medical Affairs for monthly high risk reviews to address systemic trends and from the Medical Director, Chief Nurse Executive, Director of Clinical Operations and the treating psychiatrist to address high risk indicators for specific individuals in care. ***See Tab # 151 High Risk Indicator Review and Tracking Policy (draft).*** In addition, a Risk Trigger Implementation Schedule was developed which defines the current implementation of systemic risk trigger and data sources and the schedule of phasing in additional systemic risk trigger at three months, six months and later intervals. ***See Tab # 149 High Risk Indicator Implementation Schedule.*** The Hospital continues to monitor risk indicators and clinical responses to behavioral and medical risks for specific individuals in care. ***See Tab # 56 Risk Indicator Event System Sept 2010 and Risk Indicators February 17, 2010 through September 3, 2010.***
XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing. the individual's current treatment regimen.	**Recommendation:** 1. Provide a guidance document that clearly indicates for IRP teams the hospital's expectations for referencing incidents in an individual's IRP and revising the IRP as necessary. SEH Response: See IRP materials, Tab # 1.
XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the	**Recommendation:** 1. Take steps to move the plan forward for identifying individuals in high risk situations and securing an appropriate clinical response. SEH Response: See XII.E.1.g

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	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.	

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIII.	**QUALITY IMPROVEMENT**	
	By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	
XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Recommendation:** 1. Implement the plan for monitoring high risk situations as outlined on the deployment schedule when approvals have been obtained, a guidance document has been developed and staff training has been provided. SEH Response: The Hospital's Performance Improvement Committee modified the high risk indicators and the deployment schedule since the site visit in May, adjusting it to reflect what was already occurring and to refocus in a number of areas. The new schedule is set forth in ***Tab # 149, High Risk Indicator Implementation Schedule.*** Currently implemented risk indicators are 1) self injurious behavior to include suicide, suicide attempt and other self injurious behavior (Tracked through UI reporting); 2) aggression to others (Tracked through PRISM); 3) allegation of abuse, neglect, exploitation (Tracked through UI reporting); 4) unauthorized leave (Tracked through PRISM); 5) mortality review (Tracked through Committee minutes); 6) restraint (Tracked through PRISM); 7) seclusion (Tracked through PRISM). The indicators for three month implementation include: 1) medication variance; 2) diabetes while taking atypical anti-psychotics; 3) communicable diseases; 4) MRSA; 5) Hepatitis C; 6) Tardive Dyskinesia; 7) falls; 8) polypharmacy; 9) individualized supervision. The six month indicators are 1) body mass index; 2) bowel dysfunction; 3) STAT medications; 4) NOW medications; 5) seizure disorder; 6) and medical hospitalization. Finally, set for later implementation are illicit substances, dysphagia and polydipsia. The Hospital continues to publish each month its PRISM report (***See Tab # 53 PRISM Report)*** and is also publishing each month a report on documentation relating to medication administration. ***See Tab # 102 Medication Administration Documentation Data.*** The PRISM Report continues to track admissions, discharges, transfers, 30 day readmission rate, UIs, elopements, patient injuries, staff injuries, ADRs, likely emergency involuntary medications, and restraint and seclusion. Use of seclusion and restraint remain far below the national public rate, the 30 day readmission rate shows an increase in June and July, the UI rate increased in both June and July (this may in part be due to better reporting) and elopements have declined significantly. Finally both the patient and staff injury rates dropped in August after peaking in July. The Medication Administration report shows a significant improvement, from a missing documentation rate of 1.15% in March to just 0.57% in August.
XIII.B	Analyze data regularly and, whenever appropriate, require the development and	**Recommendations:** 1. Obtain the approval of the Executive Committee for the Risk Indicator performance improvement initiative.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
	implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	SEH Response: Completed. 2. Begin work on a guidance document that expansively describes the Risk Indicator performance improvement initiative. SEH Response: The Hospital is developing a policy, titled "High Risk Indicator Review and Tracking policy", to serve as the guidance document. A copy of the draft available at the time of this report is attached at ***Tab # 151, High Risk Indicator Tracking and Review Policy.*** It is expected that the policy will be finalized by the site visit. The policy describes a multi-tiered system of tracking and review - - one at a systemic level and the other at an individual case review level. 3. Implement the Risk Indicator performance improvement initiative when staff training has been provided and other resources are available. SEH Response: The tracking system of individual cases and responses has been ongoing since January 2010 and continues. ***See Tab # 56 High Risk Event Tracking system and reports.*** With respect to the more systemic reviews, training of clinical staff will begin in October, 2010. However, as indicated above some of the indicators are being monitored at this time. **Analysis/Action Plan**: The Hospital continues to monitor key indicators each month and produces the PRISM report. ***See Tab # 53 PRISM report.*** In addition, the Medical Director or Director of Psychiatric Services continues to review the care of those individuals who reach the threshold of three UIs in a month, and the recommendations are entered into a progress note in Avatar and also captured in the UI database. With respect to the systemic indicators identified by PIC and approved by Executive Committee, both the Performance Improvement Department and PIC are monitoring trends for the initial phase indicators. PID will conduct more in depth reviews as trends are identified, or at the request of PIC. To date a study of psychiatric emergencies was undertaken and the recommendations from the study should be available during the site visit. ***See Tab # 100 Analysis of Psychiatric Emergencies.*** In addition the incidence of falls is being audited by PID to determine if there is a correlation between falls and staffing levels, shift, unit or day of the week. That study should be complete by the site visit. Finally the PID has planned a study of STAT medication usage. Senior Clinical leadership also began meeting to address the treatment of personality disorders at the Hospital. The focus of the effort was to identify treatment options (current and optimal) at the Hospital and in the community, to consider ways of reducing stressors at the Hospital, and thereby reduce the number of behavioral events, highlight staff training needs for early detection, prevention and appropriate response to behavioral events and the need for additional data. While not final, early recommendations include evaluating the cost and benefit of a DMH initiative to develop DBT capacity in the community as part of a continuum of services; evaluation of the rules that the Hospital or units have that may add to the stress on individuals in care; and expand NVCI training; develop a rapid response and

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		debrief team to intervene with individuals and debrief staff. PID and the Office of Patient Statistics and Reporting also support the various audits under the Agreement. PID staff conducts the transfer, discharge, restraint/seclusion audits, observe IRP conferences, do data related data analysis and special studies. The Office of Patient Statistics and Reporting and provides the analysis each month for PRISM as well as the discipline audits and pharmacy related data. PID has identified 7 projects either underway or set to begin this Fall. See ***Tab # 139 Performance Improvement Projects***
XIII.B.1	disseminating corrective action plans to all persons responsible for their implementation;	**Recommendations:** 1. Standardize the language used for this initiative, i.e., Risk Trigger Events v Risk Trigger Indicator v Risk Indicator in the guidance document. SEH Response: Completed. As of September 15, 2010 the Hospital will use Risk Indicator. 2. Ensure the Medical Director's review of the IRP and meeting with the team occurs in a timely manner. SEH Response: The Hospital objects in part to this recommendation insofar as it seems to require the Medical Director to meet with team in every case identified in the High Risk Indicator Event system. The Hospital's Medical Director is reviewing the record and consulting with the relevant members of the treatment team, but is not meeting with the entire team in all cases. He is completing a note in Avatar with his recommendations that is available to all team members. The Medical Director's notes are in Avatar and also are tracked by the Risk Manager for follow up. In most cases, this occurs within 30 days of being notified of that the risk indicator was met.
XIII.B.2	monitoring and documenting the outcomes achieved; and	See XIII. A and XIII. B
XIII.B.3	modifying corrective action plans, as necessary	See XIII. A and XIII. B
XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Recommendation:** 1. Continue to identify areas for improvement and ensure the effective implementation of remedial actions. SEH Response: This is continuing. In an effort to improve performance at Saint Elizabeths Hospital, recommendations which are generated from various sources will be localized and tracked within one central repository, the "Recommendations Tracking Form". The recommendations originate from several locations including investigations, audits, special studies, special event review committee (SERC), morbidity and mortality reviews (M&M), and performance improvement committee (PIC) and its sub workgroups. On the tracking form, recommendations will be organized by areas of concern, such as but not limited to, Abuse, Neglect, Exploitation, Operational Issues, and Medical Practice; with various subcategories such as Unprofessional Behavioral, Accountability of Patients, Elopement, Restraint, and Seclusion. The Performance Improvement Department will follow up on the delineated

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
		recommendation, and on the tracking form, the date of follow up and the progress toward full implementation of recommendation will be noted. This information will be reported to PIC each month.
XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation	See XIII.A.,B. and C.
XIII.C.2	monitoring and documenting the outcomes achieved; and	See XIII. A.,B. and C.
XIII.C.3	modifying corrective action plans, as necessary.	See XIII. A.,B. and C.
XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Recommendation:** 1. Continue making progress toward implementation of the various PI initiatives described in earlier cells. SEH Response: See XIII.A through XIII.C

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIV.	**ENVIRONMENTAL CONDITIONS**	
	By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	
XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Recommendation:** 1. Maintain vigilance in identifying suicide hazards. SEH Response: Ongoing.
XIV.B	By 36 months from the Effective Date hereof, SHE shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Recommendation:** 1. Maintain vigilance in removing contraband that poses a threat to the safety of staff and individuals. SEH Response: Ongoing. Since the move to the new building, all staff, visitors and individuals in care now pass through a metal detector and all bags are searched.
XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	**Recommendation:** 1. Continue current practice. SEH Response: Level of practice continues.
XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory .individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.	**Recommendation:** 1. Continue current practice. SEH Response: Level of practice continues.
XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	**Recommendation:** 1. Continue current practice. SEH Response: Level of practice continues.

SECTIONS	SETTLEMENT AGREEMENT TASKS	PROGRESS REPORT
XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	**Recommendations:** 1. Encourage individuals and staff to help maintain the new hospital environment. SEH Response: Ongoing 2. Ensure vigilant oversight of the environment on Annex A and Annex B. SEH Response: Ongoing. Executive staff continue to visit Annex A and B and regular intervals.