			in both services. 3. Ensure at least one RN on duty on every unit 24/7. 4. Clarify the nursing organizational structure at the most senior levels, especially the roles of the "DON" and "ADON".

	IX. Documentation		
MES		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.	**Summary of Progress:** Please refer to Sections V, VI, VII, VIII and X for findings and judgments regarding SEH's documentation practices in each discipline and how those practices align with the requirements of the Settlement Agreement.

	X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications		
LDL		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.	**Summary of Progress:** 1. The Medical Executive Staff Committee has accepted a draft Seclusion and Restraint policy revision. Comments on this policy are outlined below. 2. Monitoring of S/R use has begun, however some of the numbers provided in one document do not match those provided in another document. 3. A new policy was developed for Emergency Involuntary Medication. There is a power point overview of requirements and sign in sheets indicating that the policy was reviewed with medical staff. Comments on this policy are outlined below. 4. The hospital reports that use of these measures has decreased.
LDL			**Methodology:** <u>Interviewed</u>: 1. DiAnne Jones, Assistant DON, Forensic Services 2. Deborah Krahling, Assistant DON – Civil Services 3. Laverne Plater , Nurse Consultant, Civil Services 4. General discussion with various unit RNs and Psych Techs <u>Reviewed</u>: 1. Mandatory Guidelines for Restraints and Seclusion (101-04) current and draft policies; 2. Education and Staff Development Restraint Application PowerPoint slides; 3. CPI program content; 4. Medical records of 11 individuals: BW, NB, DG, KJ, MM, CB, RM, JP, GD, ML, JB <u>Observed</u>: 1. Administration of Emergency IM meds (ML) 2. Change of Shift Report – RMB 6; JHP Ward 12

			Toured: 1. RMB 5 2. RMB 6 3. JHP 9 4. JHP 12
	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:	Please see sub-cells for findings and compliance.
LDL	X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Findings:** The draft policy specifically prohibits restraint, containment, or transportation in the prone position. However, it allows the application of a mechanical restraint to an individual who is on the floor in a prone position, and directs that the person be turned as quickly as possible. Restraint application usually takes more than a minute or two, resulting in the person being at risk during application. While it is understood that in the process of containing someone the initial position could be prone, the person should be quickly turned to a supine position. If mechanical restraints are needed, the restraints should be applied while the person is in supine position. The policy should be changed to state that if, in the process of containment, the individual is inadvertently in the prone position, s/he must be immediately turned to the supine position for respiratory assessment and additional measures. Definitions of restrictive alternatives are clear, with the exception of Medical Restraint. The Medical Restraint definition appears to focus on the medical/surgical procedure, rather than the behavior. Accepted professional standards are based on the purpose of the restraint, not

			the location or the nature of the treatment being provided at the particular time. If the purpose is to address behavioral issues e.g. combative/violent, the standards for behavioral restraint must be followed. If the person is "uncooperative" (as referenced in the policy), it is the behavior that requires the restraint, and all aspects of a behavioral restraint need to be followed. It may be useful to remove medical and protective measures from the seclusion and behavioral restraint policy because the standards for each are different. The current structure of the policy may invite blurring of distinctions among behavioral, medical, and protective restraints. Overall, the policy is neither organized nor sufficiently detailed to assure: the minimal use of seclusion or restraint; consistent application of standards; clear direction to assure individuals' safety when these measures are used. **Compliance:** Partial **Current recommendations:** 1. Consider developing a separate policy for medical and protective restraints that would also include voluntary mechanical supports and/or positioning devices since these are governed by different standards (see CMS interpretive guidelines). 2. Provide step-by-step operational direction in this policy, or charge the Nursing Department to develop the operational direction to assure consistent implementation of the umbrella policy.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Findings:** The CPI program includes content on the crisis cycle. However, it does not sufficiently emphasize working with the individual to identify triggers, as well as calming/soothing/de-escalation alternatives. The PowerPoint restraint training program offered through the Education

			and Staff Development Department spends too much time on JCAHO statistics and needs to be more focused on content that will support minimal and safe use of seclusion or restraint at St. Es. It also needs to be presented in a format and at a level that nursing staff will understand. **Compliance:** Partial **Current recommendations:** Augment CPI with a module that incorporates some of the content from the training on Trauma Informed Services.
LDL	X.A.3	the use of side rails on beds, including a plan:	**Findings:** Although it was verbally reported that side rails are not used, the restraint data for July – December 07 reflect use for at least one individual. The draft policy addresses the use of side rails as a protective measure. However, it does not sufficiently focus on the considerations/assessments/monitoring that must inform the safe use of side rails, such as how risks for falls, entanglement, and/or entrapment will be mitigated. Further, CMS standards for side rails as restraint differ from standards for restraints used for behavioral purposes. The policy does not clearly differentiate these. **Compliance:** Noncompliance **Current recommendations:** 1. See XA.1 above 2. Develop a tool and process to monitor side rail use.

LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Findings:** Standards relative to MD orders are not addressed e.g. ordered for specifically designated time period. Although the IRP should include strategies to minimize side rail use, it is not clear from the data what systemic actions have been taken to support this. No findings from monitoring use of side rails were presented. **Compliance:** Noncompliance **Current recommendations:** See XA.1 and 2 above
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	**Findings:** The draft policy addresses this requirement. **Compliance:** Partial **Current recommendations:** See XA.1 and 2 above
LDL	X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	Please see sub-cells for findings and compliance.
LDL	X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Findings:** The draft policy identifies levels of restrictive interventions, however, more examples are needed for the first and second levels. Record review reflected that individualized alternatives prior to the application of restraints were few to none. Of the records reviewed,

			incidents occurred at the nursing station, generally associated with the individual requesting information/action that was not provided. There was no evidence that the alternatives identified in the RN Nursing Assessment (admission) or Advanced Instruction for Treatment Preferences were utilized. However, these alternatives were also not in the IRP. Verbal discussions with staff, as well as record review, reflected that restraint might automatically follow staff assault, regardless of the individual's behavioral status after the assault. For example, a charge nurse described the most recent situation involving restraint use by saying that the individual had torn his shirt, therefore "of course" he was restrained. **Compliance:** Noncompliance **Current recommendations:** 1. Augment CPI with a module that emphasizes alternatives to restrictive measures. Consider incorporating some of the content from the training on Trauma Informed Services. 2. Determine whether or not individuals are routinely restrained following staff assault.
LDL	X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Findings:** In general, unit observations revealed an environment that was lacking in active treatment, and in many ways characterized by interactions that were more likely to give rise to aggressive behavior that could result in seclusion/restraint use. As noted above, of the charts reviewed, aggressive incidents occurred at the nursing station, generally associated with the individual requesting information/action that was not provided. This raises questions about whether or not the nursing staff were responsive to the individual's concerns, and the degree to which the interaction with the individual was consistent with the person's active treatment needs. Further, there was little evidence

			of active treatment in the clinical units. Large numbers of individuals were observed to be in the day rooms moving about, or sitting alone, without staff present. Although one group was observed being conducted by evening shift nursing staff in the day room, the group was not effectively conducted. For example, the group leader was totally quiet while one individual monopolized the group. When a second staff member joined the group, she sat outside the group making loud statements related to the topic (current events/presidential primaries) that did not encourage individuals' participation. Overall, nursing interactions with individuals appear to consist of answering questions/requests, or social small talk. There were some notable exceptions and indications that several nursing staff knew the individuals well. These staff members interacted in a warm, respectful manner that was directed toward improving the individual's ability to handle a specific situation. For example, in one situation involving an agitated individual who waited an unusual amount of time to receive IM meds, the psychiatric technician actively reinforced the person's coping skills, reminding him of what he had effectively done in past difficult situations. In another situation, a psychiatric technician made suggestions to an individual about how to avoid fights on the unit. In both of these instances, the verbal interactions provided the type of active treatment that minimizes the potential for behavioral emergencies. **Compliance:** Noncompliance **Current recommendations:** 1. Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning. 2. Train all nursing staff on how to initiate conversations and activities to improve the individuals' quality of life.

			3. Provide games, reading material, and other supplies to each unit that staff can use to involve individuals in leisure activities. 4. Consider ways to identify and utilize nursing staff, especially PTs, to act as unit level leaders for culture change.
LDL	X.B.3	are not used as part of a behavioral intervention; and	**Findings:** Reports reflected that three individuals had seclusion or restraint as part of a behavioral intervention. **Compliance:** Noncompliance **Current recommendations:** 1. Use positive behavior support team/psychologist to assist treatment team to develop alternative interventions. 2. Establish date by which the use of seclusion or restraint as part of a behavioral intervention will be prohibited.
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Findings:** The time that individuals were in restraint or seclusion coincided with the time limit of the physician order, despite periods of calm/quiet prior to the release time. Of equal concern is that fact that when individuals were released from restraint, there was a physician order for Day Room Restriction with Escort. This reflected that there is not an individualized approach to supporting an individual to successfully re-enter the treatment milieu. **Compliance:** Noncompliance **Current recommendations:** 1. Develop a tool and implement a monitoring process to identify and resolve incidences where the individual remains in seclusion or

			restraint when no longer an imminent danger to self or others. This tool/process should also identify any indicators of "routine" restrictions following seclusion or restraint. 2. Revise documentation forms to prompt a discussion with the individual and document the individual's ideas about what would most help him/her to successfully re-integrate into the treatment milieu.
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.
LDL	X.C.1	the specific behaviors requiring the procedure;	**Findings:** The documentation typically described the individual as "assaultive" without descriptions of specific behaviors and potential triggers to the behavior. **Compliance:** Noncompliance **Current recommendations:** Develop a tool and implement a monitoring process to identify and evaluate trends in standards adherence.
LDL	X.C.2	the maximum duration of the order;	**Findings:** In the charts reviewed, this was consistently present. Before determining full compliance, a larger sample is needed to confirm sustained compliance. **Compliance:** Partial **Current recommendations:**

			Continue current practice.
LDL	X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	**Findings:** Criteria for release were generally not behavioral. There were occasions when the person evidenced other behavior that would indicate readiness for release, however the person was not released until the order expired. Individuals remained in seclusion or restraint for the maximum duration of the order. **Compliance:** Noncompliance **Current recommendations:** 1. In order "jump start" a change in their thinking about criteria for release, provide RNs and MDs with a 'cheat sheet" of examples of how to write behavioral criteria for release. 2. Make an addition to the policy that directs the RN to contact the physician to review individual behaviors that may be different from the release criteria but that do, in fact, indicate readiness for release.
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Findings:** There was evidence that this was done. Before determining full compliance, a larger sample is needed to confirm sustained compliance. **Compliance:** Partial **Current recommendations:** Continue current practice.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-	**Findings:** When this requirement was met, which was inconsistent, there was not

		informed of the behavioral criteria for their release from the restrictive intervention;	evidence of a meaningful discussion about release criteria e.g. non-behavioral release criteria were not explained to the person in behavioral terms. **Compliance:** Noncompliance **Current recommendations:** Act on trends identified through monitoring to resolve discrepancies.
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Findings:** This was inconsistently met (e.g. was sometimes not conducted or conducted later than 1 business day) and not consistently thorough. The individual was not involved in a meaningful way and the IRP was not revised. The hospital's monitoring reports reflect that this occurs in less than half the incidents. **Compliance:** Noncompliance **Current recommendations:** Act on trends identified through monitoring to understand and resolve barriers.
LDL	X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Findings:** There was evidence that this was done. Before determining full compliance, a larger sample is needed to confirm sustained compliance. **Compliance:** Partial **Current recommendations:** Continue current practice.

LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	**Findings:** There is a nursing competency measure to address this that contains relevant criteria. However, aggregate data are not available to evaluate the degree to which staff achieve orientation and annual competencies. Furthermore, there is not a system to assure that those who do not achieve these competencies are not assigned to perform monitoring duties. Competency measures for other disciplines were not available. **Compliance:** Partial **Current recommendations:** 1. Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications. 2. Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. 3. Develop basic core competencies for all clinical disciplines consistent with their potential involvement in seclusion and restraint as well as less restrictive interventions.
LDL	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.	**Findings:** Seclusion and restraint use data provided in hospital reports showed lower use than data provided from nursing reports. Accuracy would improve if reporting/recording requirements were embedded into existing work processes and/or an effort was made to minimize the numbers of reports that must be generated. No data were provided relative to the use of emergency involuntary psychotropic medications.

			Compliance: Noncompliance **Current recommendations:** 1. Explore and resolve barriers to accurate reporting. 2. Evaluate potential ways to embed reporting requirements within other documentation requirements.
LDL	X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Findings:** The draft policy addresses this requirement, however the process for notifying teams is not clear. The hospital's monitoring report reflects that this occurs in 66% of the incidents. **Compliance:** Noncompliance **Current recommendations:** Explore and resolve barriers to adhering to this standard.
	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:	Please see sub-cells for findings and compliance.
LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Findings:** The policy for Involuntary Medication Administration provides step-by-step instruction for circumstances involving both emergent and non-emergent involuntary medication administration. It states: "The emergent administration of involuntary medications shall be considered to be an incident of drugs used as restraint…." and refers to the Restraint and Seclusion policy, indicating that the requirements of that policy shall apply. Neither policy gives sufficient direction for

			pharmacologic restraint. Further, the definitions do not comport with CMS standards, despite the fact that the PowerPoint training indicates that the definitional source is the CMS standard. Further, neither policy explicitly differentiates the use of emergency involuntary medication and/or pharmacologic restraint, from the use of PRN or STAT medication. PRN and STAT medications are not automatically considered pharmacologic restraint according to the CMS definitional criteria for restraint. In fact, PRN and STAT medication can support an individual's ability to utilize alternative interventions/coping skills, thereby limiting the potential for restraint use. In the charts reviewed, orders for involuntary psychotropic medication for psychiatric purposes were time limited consistent with the policy (72 hours). However, the 72 hour limit is inconsistent with the requirements for pharmacologic restraint that would follow the restraint and seclusion policy. PRN use appeared to be frequent. There was minimal evidence that underlying issues were explored, alternatives attempted, and the IRP did not address medication use beyond compliance. The hospital provided no monitoring data relative to emergency involuntary medication, prn use, use of stat meds. The proposal that nursing generate a report on this matter has potential to distract minimal nursing resources from direct services to individuals and is of grave concern. Alternatives, including enhanced paper or electronic technologies, should be explored. **Compliance:** Noncompliance **Current recommendations:** 1. Develop policies that define pharmacologic restraint consistent with CMS definitions, that establish clear standards for use, and

			that also describe the use of prn and stat medication. Clearly differentiate the requirements and indications for each of these three categories. 2. Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide. 3. Explore alternatives to gathering data that do not involve nursing staff filling out reports, in addition to regular documentation. Paper technologies, such as NCR copies of orders, pharmacy records, as well as electronic technologies should be explored.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Findings:** Documentation in the charts reviewed could not be consistently located and/or the individual was not consistently assessed by a physician within one hour. The fact that prn or stat medications were often ordered, and that there was no MD assessment within an hour of the administration, is likely to reflect the confusion that surrounds emergency involuntary medication, prns and stat meds. See above findings and recommendations. The hospital provided no monitoring data relative to this matter. **Compliance:** Noncompliance **Current recommendations:** See X.F.1
LDL	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	**Findings:** There was not evidence that this was consistently accomplished and the process for notifying teams is not clear. It is likely that this is influenced by the findings in X.F.1 above. The hospital provided no monitoring data relative to this matter.

		revised plan, as appropriate.	**Compliance:** Noncompliance **Current recommendations:** See X.F.1. Develop tools and implement processes to monitor adherence to this standard. Assure that data findings support action that is both practitioner-specific and system-wide.
LDL	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.	**Findings:** There is a nursing competency measure for this. However, aggregate data are not available to evaluate the degree to which nursing staff achieve orientation and annual competencies. Further, there is not a system to assure that those who do not achieve these competencies do not implement associated duties. Sign-in sheets for physician orientation to the new policy for emergency involuntary psychotropic medications, along with the PowerPoint used for teaching, were provided. However, as with nursing, there are no aggregate data to evaluate the percentage of medical staff who attended these sessions. Further, there is no other evidence that physician competencies for individual assessment and implementation of these policies are measured. **Compliance:** Partial **Current recommendations:** 1. Develop and implement a competency-based training curriculum to jointly train MDs and RNs on these policy requirements since most involve both disciplines and a collaborative effort will support success.

			2. Develop aggregate reports on the percent of staff that satisfactorily complete this training. 3. Develop a clear procedure regarding actions taken to limit practice when competence is not achieved.

	XI. Protection from Harm		
BJC		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.	**Summary of Progress:** 1. The Department policy "Protecting Consumers from Abuse" clearly states that abuse of consumers will not be tolerated and requires employees to maintain a respectful and professional relationship with consumers. This policy, effective March 2000, needs revision as detailed in cell XII.A and its sub-cells to match current practice. 2. The Department has a method for assigning a "type" for incidents, essential for tracking and trending. Collapsing the number of types is recommended in XII.A.1. 3. The small number of allegations of abuse and neglect in 2007—18 in the 12-month period—indicates substantial under-reporting and will require a concerted effort to raise consciousness of abuse and neglect on the campus, including upgrading employee training on the subject. 4. Some poor environmental conditions, particularly care for the personal hygiene and clothing needs of individuals, severely negatively impact the quality of life of persons in the hospital. 5. The requirement to investigate the criminal history of staff persons was not reviewed and we are unable to make findings at this time. **Compliance:** Noncompliance **Recommendations:** For discrete recommendations to fulfill the obligations of this Section, please refer to: 1. The recommendations listed below in Section XII regarding incident management. 2. The recommendations listed in Section XIV regarding environmental

			conditions. 3. The recommendations listed in Section VIII.D regarding nursing services. 4. Develop and implement a mortality review system that ensures that death reviews are timely, thorough and complete, contain specific recommendations for corrective action, and that such actions are implemented. (See Section VIII.A.2.b.iv. of SA and Report p. 110).

	XII. Incident Management		
BJC		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.	**Summary of Progress:** 1. The incident investigations reviewed met professional standards, for the most part. 2. The hospital does not yet have an integrated incident management system that will support the production of trend and pattern reports. Changes in the incident database are necessary. The hospital and DMH need to revise incident policies, including definitions and codes, and revise the incident reporting form accordingly. The new policies should require the reporting of suspicious injuries and reports of abuse. 3. Although the Office of Quality Improvement is tracking recommendations from death reviews, the hospital is not responding with an effective system for the approval or revision of recommendations made at the close of investigations and death reviews and for ensuring their effective implementation. 4. Revisions in the operating procedures of the Mortality Review Committee will be necessary to conform to current practice standards. 5. The low number of abuse/neglect allegations made during 2007 indicates underreporting and call for increased, focused training on the identification and reporting of abuse and neglect.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Taylor, Director, Office of Policy and Procedures 2. R. Winfrey, Risk Manager 3. Z. Page, Director, Office of Quality Improvement 4. L. Mayo, Acting Director of Training 5. J. Mahar, Chief Compliance Officer 6. J. Gallo, Human Resource Director 7. L. Barrett, Human Resource Specialist

			8. F. Wade, Consumer Affairs Liaison (Advocate) <u>Reviewed</u>: 1. Policy 305-03: Unusual Incident Reporting and Documentation 2. Policy 301: Investigation of Patient Abuse and Neglect 3. CMHA Policy 50000.482.1: Protecting Consumers from Abuse 4. Death reports of five individuals 5. 10 investigations of serious incidents, including five deaths 6. Mortality Review Committee Minutes for 2007
BJC	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:	**Findings:** DMH policy "Protecting Consumers from Abuse" provides incident definitions of abuse, neglect, financial exploitation and unprofessional conduct. It further assigns responsibility to specific job titles to ensure the reporting and investigation of staff misconduct in these areas. SEH's policies, "Investigation of Patient Abuse and Neglect" and "Unusual Incident Reporting and Documentation", provide incident definitions and outline procedures for the identification and investigation of these incidents. Both the DMH and SEH policies will need to be revised to provide guidance for a comprehensive incident management system. Some suggestions for changes in these policies are presented in the cells below. A review of the log of the Patient Advocate for 2007 to the present revealed that some grievances were actually allegations of abuse—physical and verbal. No incident reports were completed on these incidents. (The Advocate coordinates the response to grievances.) The allegations that were not recognized as abuse allegations are described below. This mishandling of the allegations indicates a lack of appreciation of the serious investigation that an allegation of abuse/neglect should engender by supervisors and administrators.

<table>
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<tr><th>Individual involved</th><th>Allegation type</th><th>Date</th></tr>
<tr><td>KS</td><td>Verbal abuse</td><td>1/3/08</td></tr>
<tr><td>KS</td><td>Restraint injury</td><td>1/29/08</td></tr>
<tr><td>RE</td><td>Verbal abuse</td><td>10/10/07</td></tr>
<tr><td>B--</td><td>Physical abuse</td><td>5/25/07</td></tr>
</table>

Compliance:
Partial

Both the DMH and SEH policies will need to be revised to provide guidance for a comprehensive incident management system. There is substantial evidence that programmatic recommendations made at the close of abuse investigations and death reviews have not been forwarded to the appropriate parties for implementation.

Current recommendations:
1. Review and revise incident management policies.
2. Clarify the appropriate use of the grievance system and include the distinction between a grievance and an incident in incident training at orientation and during annual training.</td>
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<tr>
<td>BJC</td>
<td>XII.A.1</td>
<td>identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;</td>
<td>Findings:
The present DMH incident management system identifies two categories of incidents: major unusual incidents—high critical severity and unusual incidents –less critical severity. Within these two categories incidents are identified by 69 codes. Major unusual incidents constitute 49 of the 69 codes. These major unusual incidents include such events as allegations of abuse and neglect, deaths, suicide attempts, assaults resulting in injuries requiring more than first aid, and the introduction of contraband into the facility. The numerous codes increase the likelihood of coding errors, such as occurred in the</td>
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			11/10/07 incident involving MM and the 11/13/07 incident involving GH where the individuals fell, but the incidents were coded "elopements." Restraint and seclusion is included as a major unusual incident when it is not used in accordance with policy or in those instances where an injury is associated with the restraint or seclusion. **Compliance:** Partial **Current recommendations:** 1. Compress the number of incident types to reduce the likelihood of coding errors. 2. Revise the incident policies to require the reporting of all uses of restraint and seclusion.
BJC	XII.A.2	immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Findings:** SEH's policy 301 governing the investigation of abuse and neglect requires staff to report instances of patient abuse that they "see or hear" to the immediate supervisor of the offending employee. The supervisor is required to report the allegation to the Office of the Chief Executive Officer. This policy does not require employees to report allegations they are told about (by an individual, family member, etc.) or when an employee discovers a suspicious injury on an individual. Similarly, DMH policy Protecting Consumers from Abuse requires staff to report "any witnessed abuse" to their supervisor. DMH has a standard form for the reporting of incidents that will require revision to reflect changes in incident types and to facilitate tracking and trending of individuals who are repeat aggressors and repeat victims. These revisions should include, at a minimum, a

			numbering system for incidents that will provide each incident with a discrete number. Presently in incidents involving an altercation between individuals, two incident report forms should be completed. Interviews indicated this is often not done. Changing the proposed form to include a designation of the role of persons involved as "aggressor", "victim", "witness" or otherwise "involved" would eliminate the need for staff to complete two forms. Including on the form a code for the severity of injury would facilitate the reduction in the number of types of incidents, since incidents of the same type would not require a different code based on the severity of the injury. There would be no need for 10 different codes for assault/altercation if these two revisions were made. Review the 2006 draft revision of the Investigation of Patient Abuse and Neglect policy before implementing it to eliminate inconsistent definitions and errors in including individual-to-individual contact as abuse. Abuse is limited to actions or inaction of persons other than individuals in care. **Compliance:** Partial **Current recommendations:** 1. Revise both DMH and SEH policies to require employees to report witnessed, discovered (suspicious injuries) or reported incidents and allegations of abuse and neglect. 2. Revise the incident reporting form to include an incident number. 3. Consider revising the "role" designation on the draft incident reporting form and including a severity of injury code. 4. Review and correct the July 2006 revision of the Investigation of Patient Abuse and Neglect policy before implementing it.

BJC	XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Findings:** DMH policy, Protecting Consumers from Abuse, requires that in incidents of alleged abuse the named employee will be removed from the area and reassigned pending the results of the investigation (internal and/or criminal) or relocation of the consumer involved. SEH policy, Investigation of Patient Abuse and Neglect, requires the first-line supervisor to require the alleged offending employee to surrender his/her keys, identification and arrange for Security to escort the employee off the hospital grounds. **Compliance:** Partial **Current recommendations:** Revise the policies cited above so that they are consistent and clearly state that the named employee in allegations of abuse and neglect will be reassigned from direct support of individuals or will be placed on administrative leave, pending the conclusion of the investigation.
BJC	XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Findings:** Training for staff on the prevention and identification of abuse and neglect is presently inadequate. Annual training on abuse/neglect is folded into Consumer Rights and Unusual Incidents training. These are two of nine topics covered in a seven-hour training day. The PowerPoint presentation on Unusual Incidents does not include the definitions of or examples of abuse and neglect. The Consumer Rights presentation also does not cover these definitions or examples. It is unclear that employees who do not pass the competency test are required to repeat the training or denied employment. Review of the annual training for ten employees revealed that seven

had received training within the last 12 months.

Staff initials	Last training date
CH	No annual training
SLH	10/30/07
ED	11/27/07
AO	9/18/07
MB	12/11/07
EJ	9/15/07
BH	6/27/07
TT	11/29/06
MK	5/5/06
TA	1/18/07

The hospital recognized in its self-assessment that it lacks comprehensive and integrated training for employees.

Compliance:
Noncompliance

Current recommendations:
1. Revise and expand training on the prevention and identification of abuse and neglect at both annual and orientation training, making it a discrete training course. Include in the title of the training the terms "abuse" and "neglect".
2. Review and revise if necessary the practices in place when a prospective employee does not pass the competency test.
3. Implement plans to have employees complete annual training around the time of their birthday month, so that training is completed prior to the employee's annual performance review and is considered during the performance review.

BJC	XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	**Findings:** According to the Department of Human Resources there is no mandatory reporting obligation that requires written acknowledgment at SEH. The obligation to report is included in the policies discussed in XII.A.2. It is unclear whether employees who do not pass the competency test are required to repeat the training. **Compliance:** Noncompliance **Current recommendations:** 1. Revise policies as discussed above and expand and revise abuse and neglect prevention and identification training at annual and orientation training to ensure that employees understand their obligation to report. 2. Write guidelines to govern actions by instructors when employees fail the competency test at the conclusion of training.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Findings:** A poster was on the wall in each of the units toured. Also on the walls were posters demonstrating 20 languages. Individuals may point at the appropriate language sample to identify for staff members their language of preference. Staff would then arrange for translator services, if no staff members could speak the individual's language. Forms for filing a grievance were available on all the units reviewed. **Compliance:** Substantial **Current recommendations:** Continue current practice.

BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Findings:** DMH instructions require hospital staff to notify SEH's Security Office whenever a major unusual incident occurs, except for two situations: staff shortage and operational breakdown. The SEH Security Office is then required to notify the DC Metropolitan Police. While such notifications are important in certain circumstances, mandating that all major unusual incidents be reported to the police warrants further consideration. Examples where this is clearly not necessary include when an individual falls and when tobacco (contraband) is found in the hospital. **Compliance:** Partial **Current recommendations:** Revise the DMH policy to ensure that those incidents that require police notification are reported in a timely manner and those that do not require reporting are handled appropriately internally.
BJC	XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Findings:** In the SEH 2006 Inpatient Satisfactory Survey 57.4% of the 101 respondents said they agreed or strongly agreed with the statement: I felt free to complain without fear of retaliation. **Compliance:** Partial **Current recommendations:** Ensure that in the revisions to the relevant policies specific mention is made of the right for all persons to be free of retaliation or threats of retaliation for reporting an allegation of abuse or neglect in good faith. Include also the statement that staff members found to have engaged

			in threats or retaliation will be subject to disciplinary action.
BJC	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:	**Findings:** Hospital policy 305-03: Unusual Incident Reporting and Documentation requires the reporting of incidents by the staff member observing the incident and requires the Risk Manager to "independently conduct a thorough and comprehensive investigation of all Major Unusual Incidents to determine staff adherence to programmatic requirements." As reported in this cell and those that follow, implementation of the policy is variable. Investigations were generally well done, but the hospital failed to review and take actions on many of the programmatic recommendations. This failure to implement corrective measures requires immediate attention. Several of the five investigations concerned with matters other than death evidenced positive qualities. These included the following: • All interviews were summarized. • Relevant sections of the individual's treatment record were quoted (physical abuse allegation made by CW). • Some abuse investigations included appropriate recommendations based on the findings (suicide attempt of MT). • Conclusion (substantiated or unfounded) was supported by the findings (allegation of abuse of BB and suicide attempt of MT). • Investigation was begun within 24 hours of their having been reported (physical abuse allegation made by CW). The dates in the investigation report of CWs allegation of physical abuse are not accurate. The Administrative Actions section of the incident reporting form does not make sense. **Compliance:** Partial

			The investigations reviewed met practice standards in many respects, although some problems were evident. The inability of the hospital to review the recommendations for corrective actions, approve or revise them, and ensure implementation remains a significant issue. **Current recommendations:** Ensure the review of incident investigations with approval indicated by the signature of an appropriate staff member other than the staff completing the investigation.
BJC	XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Findings:** Recommendations for corrective measures were made in the death and other investigations reviewed. The hospital does not presently have a mechanism to obtain approval of the recommendations, revise them, or to monitor their implementation. **Compliance:** Noncompliance **Current recommendations:** Identify why recommendations are not being reviewed, approved or revised as needed and take measures to correct the problem. Identify persons/offices for monitoring implementation of the corrective measures and reporting back to the appropriate body.
BJC	XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	**Findings:** The Risk Manager completes some of the investigations of allegations of abuse and neglect and deaths. He has completed investigation training provided by Labor Relations Alternatives and DHS training. Other investigations are signed by members of the nursing staff and the Director of the Office of Policy and Procedures.

			Compliance: Partial **Current recommendations:** Ensure that all staff members who investigate serious incidents have investigation training.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	**Findings:** The investigations of five deaths completed by the Risk Manager revealed inconsistent procedures for approval of the death report. The death reports for HS and RB contain the statement "I have reviewed this investigation report for accuracy and completeness" below the printed name of the Associate Director of Medical Affairs, but the physician did not sign or initial the report. The death reports for MB and GF contain no such statement and no signature or initial of the physician. The death report for GK contained the approval statement but no name of who was supposed to have approved it and no signature or initial by that physician. **Compliance:** Noncompliance **Current recommendations:** Develop and implement procedures for the review of death reports completed by Risk Management by the appropriate member of the hospital's medical leadership.
BJC	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.	**Findings:** There is no reliable system in place to ensure the implementation of corrective actions made as a result of incident investigations. The recommendations made at the conclusion of four of five death investigations reviewed had not been approved by the Office of the Director of Medical Affairs. The absence of this approval meant that

			the recommendations were not forwarded to the appropriate parties for implementation. The four deaths where recommendations were not considered in a timely manner were RB (date of death 10/2007), GF (10/07), MB (12/07) and HS (12/07). The importance of attention to these recommendations is evident since they address such fundamental issues as taking vital signs on a regular basis and when an individual is ill, techniques for bed checks, procedures for the timely attendance by a physician for individuals who are ill, training for general medical officers on standards of care for hypotension, dehydration and malnutrition. (This is a partial, not complete list.) The Risk Management and Safety Committee would be an appropriate forum for the identification of corrective and preventive actions for many actions. This committee considers reports compiled by the Risk Manager. In the second half of 2007, the Committee met in June, September, November and December. Minutes did not include the attached reports from the Risk Manager, but referenced them. Recommendations were made in response to these reports, but were not referenced again in later minutes. Thus, there is no evidence that the recommendations were forwarded to the appropriate parties for implementation and no evidence that implementation was monitored. **Compliance:** Noncompliance **Current recommendations:** 1. Identify the source of the problem in failing to give timely consideration and approval to recommendations made at the close of a death investigation by the Risk Manager. 2. Ensure the Risk Management and Safety Committee reviews all serious incident investigations in addition to reports on incidents prepared by the Risk Manager. 3. Identify a method for reviewing the effective implementation of

			corrective and preventive actions identified by the incident review process.
BJC	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.	**Findings:** The hospital's review of deaths does not meet practice standards, including in its failure to implement corrective actions identified in the investigation and review of deaths as identified above. Problems also include: • The Mortality Review Committee minutes for 2007 provided by the hospital addressed the death of six of the 12 individuals who died during the year. Not addressed were individuals who died in June, September and October. • The minutes of the review of the death of MH in January 2007 state that recommendations were made, but do not identify what they were. • The death of MH was associated with an episode of restraint. The cause of death was undetermined at the time of the January Mortality Review Committee meeting, pending toxicology and pathology analysis. There was no follow-up on the cause of death and no further mention of this death in the subsequent minutes. • Despite findings that nursing and medical care seriously deviated from practice standards and hospital policy, there is no evidence in the minutes that the question of neglect was considered. Review of the report entitled, "Responses Needed for 2007 SEH Quality Improvement Reviews", indicates that a response was received from the responsible party in slightly more than one-third (36%) of the corrective measures that had been approved over the year. The vast majority of the 56 issues in the report were corrective actions identified during the review of deaths that occurred in April, July, August and September 2007.

			The hospital has identified corrective measures in response to deaths and other serious incidents. It does not presently have a process for the timely review, revision or approval of these recommendations, their promulgation to the responsible parties, and monitoring of implementation. See also XIIB.4. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the review of deaths and the operations of the Mortality Review Committee to meet current practice standards. 2. Review the role of the Office of Quality Improvement and expectations around response to its reports.
BJC	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.	**Findings:** The investigations of serious incidents are not retrievable by the name of the particular staff member involved. The incident management database contains the individual's hospital ID number, not his/her name. The development of a more expansive database will be necessary to meet this condition. **Compliance:** Partial **Current recommendations:** 1. Include the names of individuals in the incident management database. 2. Revise the incident management information system when appropriate to reflect the changes made in the incident definitions

<table>
<tr><td></td><td></td><td></td><td>and codes and on the incident reporting form.</td></tr>
<tr><td>BJC</td><td>XII.E</td><td>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:</td><td>Findings:
The hospital is tracking incidents and reporting on a limited number of variables, such as general location, time of incident and incident type. Recommendations made in the succeeding cells will facilitate the collection of usable data.

The listing of the individuals who died in 2007 with their date of death produced by the hospital in response to our document request is not consistent with the Office of Monitoring Systems Unusual Incident Monthly Trend Summary, calling into question the validity of some of the data. The specific death data that is not consistent is shown below.

<table>
<tr><th>#deaths on trend report</th><th>SEH listing of 2007 deaths</th></tr>
<tr><td>February ----- 1</td><td>No February deaths in 2007</td></tr>
<tr><td>April ----------0</td><td>EL died 4/22/07</td></tr>
<tr><td>August----------3</td><td>MS died 8/6/07; no other August deaths</td></tr>
<tr><td>October--------5</td><td>GH died 10/9/07
GF died 10/27/07
HS died 10/6/07
RB died 10/10/07</td></tr>
<tr><td>September----0</td><td>DH died 9/29/07</td></tr>
<tr><td>Total deaths on report=14</td><td>Total deaths listed=12</td></tr>
</table>

The hospital is presently tracking a number of variables related to incidents. It does not have the capacity to track actions taken or staff members involved.

Compliance:
Partial</td></tr>
</table>

			Current recommendations: 1. Redesign the incident information systems so that the hospital can produce periodic reports on the characteristics of incidents specified in the Settlement Agreement. 2. Identify and correct whatever made the death tracking inaccurate and be sure it did not infect other counts as well.
	XII.E.1	Track trends by at least the following categories:	Please see sub-cells for findings.
BJC	XII.E.1.a	type of incident;	**Findings:** The Office of Monitoring Systems' January 08 report of the 2007 incidents identifies the number of incidents per month by type. Of the 541 Major Unusual Incidents, medical emergencies (13%) and disappearance/unauthorized leave (16%) constituted the greatest percentage. Sixty-four percent of all incidents are categorized as Unusual Incidents (less critical severity). Assaults/altercations (requiring no more than first-aid treatment) represent slightly more than half of these. **Compliance:** Partial **Current recommendations:** Produce reports on incidents on a more frequent basis—initially on a quarterly basis.
BJC	XII.E.1.b	staff involved and staff present;	**Findings:** The hospital does not yet have the capacity to produce a report identifying the staff members involved in incidents.

			Compliance: Noncompliance **Current recommendations:** Consider changing the incident reporting form to identify aggressor, victim, witness and otherwise involved making it possible to report on staff members involved.
BJC	XII.E.1.c	individuals involved and witnesses identified;	**Findings:** The hospital does not presently have the capacity to identify staff and individuals who are witnesses to incidents without reading each incident investigation. Under present reporting requirements in altercations between individuals, a second reporting form should be completed to identify by name the second individual involved. This is reportedly not done on a regular basis. **Compliance:** Noncompliance **Current recommendations:** 1. Consider revising the incident reporting form so that a single reporting form identifies aggressor, victim, witness and persons otherwise involved. 2. Once this information is available in an information system, provide reports on individuals and staff members frequently involved in incident so that further inquiry can begin and corrective measures taken as indicated.
BJC	XII.E.1.d	location of incident;	**Findings:** The Office of Monitoring Systems produced a report at the end of January 2008 identifying the location of the incident for each month in 2007. The report identified six possible locations, five on the campus

			and one titled "non-campus or unknown". This report indicates that 1506 incidents were reported, nearly half (49%) of which occurred on the civil units of the hospital. **Compliance:** Partial **Current recommendations:** 1. Identify the location of incidents more precisely down to the unit level. 2. See also the recommendation below.
BJC	XII.E.1.e	date and time of incident;	**Findings:** The January 2008 report of the 2007 incidents includes a chart of the number of incident by hour of the day. Both the day and evening shift had an equal number of incidents. Forty percent of the incidents occurred between 7 and 10 AM and 4 and 7 PM. Further analysis matching time and location may provide sufficient information for the identification of preventive measures. **Compliance:** Partial **Current recommendations:** Provide a report of the high-risk times of day and location to the Risk Management and Safety Committee for review and action.
BJC	XII.E.1.f	cause(s) of incident; and	**Findings:** The hospital has identified contributing factors to some serious incidents, particularly in death reviews, but the hospital is not able to track these and present them in usable form. **Compliance:**

			Partial **Current recommendations:** Invest in the Risk Management and Safety Committee the responsibility to identify and review factors that have been identified in serious incidents and make recommendations for corrective measures.
BJC	XII.E.1.g	actions taken.	**Findings:** The hospital does not presently have the capacity to track actions taken in response to incidents. See XII.C **Compliance:** Noncompliance **Current recommendations:** 1. Identify the source of the problem in the failure to approve or revise recommendations for corrective actions and take action to remedy the problem. 2. When the incident management database is expanded and improved, collect and report on corrective measures.
BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Findings:** The hospital has yet to implement this portion of the Settlement Agreement. **Compliance:** Noncompliance **Current recommendations:** Include both behavioral and medical issues when determining the hospital's quality indicators and triggers that will require a specific

			clinical response.
BJC	XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Findings:** Incident management procedures at the hospital are presently not able to readily identify individuals at risk. The hospital produced a listing of individuals involved in incidents in 2007. This included the individual's name, gender, age, commitment status and the date of the incident, but not the type of incident. A second report on incidents provided the date of the incident and a description of the incident (narrative not code) and the immediate response, but did not identify the individual(s) involved. One needed to cross-match incident numbers in the two reports. Thus, it would be very time-consuming and difficult to read each narrative (on 117 pages) and match it with the other report to identify individuals who were repeat aggressors, repeat victims, and those who evidenced suicidal gestures or attempts. **Compliance:** Noncompliance **Current recommendations:** Refine the incident management system so that it identifies the type of incidents in which individuals are involved and run reports that will identify repeat aggressors, repeat victims and those individuals demonstrating suicidal gestures or attempts.

	XIII. Quality Improvement		
BJC		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.	**Summary of Progress:** 1. The hospital produced a Performance Improvement Plan 2007 which provides a committee structure for identifying performance improvement initiatives. The Plan states that the hospital will use the "Plan, Do, Study, Act" model. 2. The hospital reported that it is in the process of developing a set of quality indicators. It is tracking some performance indicators related to restraint and seclusion, mall group cancellations, attendance of clinical staff at IRP conferences and the currency of IRPs.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Maher, Chief Compliance Officer 2. R. Winfrey, Risk Manager 3. Z. Page, Director, Office of Quality Improvement <u>Reviewed</u>: 1. Performance Improvement Plan 2007 2. Monthly Trend Analysis for November 2007 3. Performance Improvement Committee minutes
BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Findings:** The hospital has begun reporting on three performance indicators: restraint and seclusion use, Interdisciplinary Recovery Plans (IRP) and mall group cancellations. It will reportedly shortly be identifying other quality indicators. In the absence of other indicators, there is no information to report in many of the later cells in this section of the report. The hospital produced a document entitled, "Performance Improvement

			Plan 2007" that provides a committee structure for identifying and tracking performance improvement initiatives. No initiatives are identified in this document. The most striking findings reported in the self-assessment (November 2007) related to IRPs were: • The low percentage of IRPs that indicated the general medical officers on the forensic service attended--13%. • Of the 130 IRPs reviewed, 78% were current. • The wide disparity in the number of individuals participating in their IRP between the forensic and civil services---18% of 55 IRPs for civil and 63% of 46 IRPs for forensic services. Treatment mall cancellations showed a decreasing trend in October and November with 40 cancellations in each month down from an average of 65 cancellations for May through September. In the most recent quarter (September –November), psychiatry cancelled one-third of the mall groups cancelled, however this was only 11% of the 466 psychiatry groups scheduled. Afternoon mall groups were 1.5 times more likely to be cancelled than morning groups. The trend line for restraint use for the one-year period October 06—September 07 has remained steady. Restraint use overall is three times more frequent on the civil services than the forensic. All other trending and outcome reports will follow by several months at least the identification of other quality indicators. The hospital has begun to review a limited number of quality indicators and will be identifying additional indicators and triggers.

			Compliance: Partial **Current recommendations:** Continue with plans to identify other quality indicators and include both physical and behavioral triggers.
BJC	XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Findings:** The hospital produces a Monthly Trend Analysis. It reports census related data--numbers and demographics of individuals, admissions and discharges, median length of stay. As noted, quality performance-related statistics are provided on three issues: Interdisciplinary Recovery Plans (IRP), mall group cancellations and restraint and seclusion use, as discussed above. No information was provided to indicate that the hospital had implemented corrective actions to address the issues raised by the analysis of data related to IRPs, restraint and seclusion and mall group cancellations. The number of quality indicators measured is very limited and no information was provided to indicate that the hospital had implemented corrective actions to address the issues raised by the analysis of the quality indicator data described above. **Compliance:** Noncompliance **Current recommendations:** 1. Select additional quality indicators and begin collecting baseline data that includes the identification of individuals who reach an indicator or trigger. For example, identify individuals who have been the victim of an assault that required more than first aid. 2. Identify corrective measures for priority quality indicators and

			measure performance.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Findings:** The hospital will need to develop a policy to guide the review of quality indicator data, procedures for notifying IRTs when individuals have met a target, a method for receiving feed-back from IRTs on actions taken and procedures for monitoring implementation on at least a sample basis. **Compliance:** Noncompliance **Current recommendations:** 1. Select quality indicators and begin collecting baseline data. 2. Begin the conversation on the policies and procedures that will govern quality indicators and triggers (those events under each quality indicator which require a specific response by the IRT).
BJC	XIII.B.2	the anticipated outcome of each step; and	**Findings:** See above findings and recommendations for XIII.B.1. **Compliance:** Noncompliance
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	**Findings:** See above findings and recommendations for XIII.B.1. **Compliance:** Noncompliance

BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Findings:** The hospital will soon be developing quality indicators and following this the hospital will develop policies and procedure that should include monitoring the effective implementation of corrective action plans. Procedures for the review of implementation of corrective measures related to quality improvement will necessarily follow the identification of quality indicators and triggers. **Compliance:** Noncompliance **Current recommendations:** Begin the conversation on the policies and procedures that will govern quality indicators and triggers.
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	**Findings:** See findings and recommendations above for XIII.C. **Compliance:** Noncompliance

BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	**Findings:** See findings and recommendations above for XIII.C. **Compliance:** Noncompliance
BJC	XIII.C.3	modifying corrective action plans, as necessary.	**Findings:** See findings and recommendations above for XIII.C. **Compliance:** Noncompliance
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Findings:** The hospital will be setting goals for 2008 and identifying quality indicators and triggers. The hospital has not yet identified performance goals for 2008. **Compliance:** Noncompliance **Current recommendations:** Select a limited number of performance goals and take steps to ensure that the entire hospital is aware of these goals and that the administration is counting on each staff member and individual to move the hospital toward achieving them.

	XIV. Environmental Conditions		
BJC		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:	**Summary of Progress:** 1. The hospital completes monthly environmental status reviews, but they lack a focus on suicide hazards. 2. The quality of life of some individuals is seriously diminished by inattention to their personal hygiene, lack of personal hygiene supplies, lack of clothing, and lack of bedding. The lack of unit supervisors is contributing to the inability to monitor these conditions and address the failure of the direct support staff to provide appropriately for the individuals assigned to them. 3. Facilities for laundering clothes are inadequate. 4. Investigations by Risk Management should be expanded to include all incidents that result in serious injury or imminent risk of serious injury and should identify contributing factors, including those related to staff levels and staff assignments.
BJC			**Methodology:** Interviewed: 1. D. Kharhling, Assistant Nursing Director--Civil 2. R. Winfrey, Risk Manager 3. J. Henneberry, Director of Forensic Services Reviewed: 1. Engineering and Maintenance Monthly Status reports for June—August and December 2007. 2. Engineering and Maintenance Checksheet 3. Environmental and Water Temperature Readings for the John Howard Pavilion for February 1—8, 2008. 4. Executive Summary of the Environmental Self-Assessment Survey 5. Incident reports reported to DMH in November and December 2007. 6. Draft of Policy 107-02: Patient Searches

			Toured: Seven units—Unit 1, Unit 4, and two civil admission units; Units 6, 7 and 9 on the forensic service.
BJC	XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Findings:** The Engineering and Maintenance check sheet completed each month has a very limited focus on the identification of suicide hazards. Of the approximately 90 items on the check sheet, fewer than five relate to suicide hazards. These include identifying whether shower curtains and window and privacy curtains are break-away and that extension cords are not in use. **Compliance:** Noncompliance **Current recommendations:** 1. Identify a list of possible suicide hazards, paying particular attention to bathrooms and bedrooms where most suicides in institutions occur. Prioritize the correction of these hazards, determining timelines and cost. 2. Include this list of suicide hazards on the environmental checklist or identify another method for the periodic and systematic review of each of the areas to which individuals have access. 3. Alert staff to the presence of suicide hazards on their units.
BJC	XIV.B	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Findings:** A review of the contraband incident reports forwarded to DMH in November and December 2007 indicated that in 17 of the 18 incidents the contraband was cigarettes and/or matches/lighters. In the remaining instance the contraband was both cigarettes and street drugs (not named). The Building and Inspection Checklist does not include an item to

			identify the presence or absence of contraband. The hospital's draft policy, "Patient Searches" needs to be reviewed and revised as it lacks essential definitions and several portions are unclear. For example, the policy fails to define a strip search and a body cavity search. Who can perform each and under which conditions is unclear, e.g., the statement "A nurse and a doctor must be present to conduct a body cavity search" is unclear as to whether the nurse and the doctor are conducting the search or witnessing the search. The "Patient Search" policy needs reorganization and revision. **Compliance:** Partial **Current recommendations:** 1. Enter into conversations with DMH regarding its expectation that the hospital report incidents that involve finding only cigarettes. 2. Revise the building inspection checklist to include evidence of contraband or find an alternate method that would meet the same objective. 3. Reorganize and revise the draft "Patient Search" policy.
BJC	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.	**Findings:** Review of incident data produced by the Office of Monitoring Systems indicates that in 2007, there were 238 incidents of unauthorized leave or disappearance. This is an average of 20 per month and constitutes 16% of the 2007 incidents. Review of the incidents reported to DMH in November and December indicated that 50 incidents related to unauthorized leave, disappearance or elopement. Some of these incidents involved voluntary individuals who did not return to the hospital from a pass.

			It is impossible to tell from reading these incident reports where inadequate staffing or inattentive staff were contributing factors in the relevant incidents. The summary incident data for 2007 indicates there were 505 altercations/assaults that did not result in injuries that required more than first aid and six incidents of altercations/assaults that resulted in serious injury. These incidents constituted one-third of all incidents. The number of assaults/altercations ranged from 32 in April 07 to 59 in November 07. Incident and death investigations reviewed did not regularly address the issue of staffing levels, staff assignments or staff response. **Compliance:** Partial **Current recommendations:** 1. Conduct an investigation into all incidents that result in serious injury, looking to make findings on the adequacy of staffing levels, staffing assignments, and neglect in the form of failure to provide adequate supervision. 2. Conduct investigations into the unauthorized leaves of potentially dangerous individuals and those who are at risk because of their disability to determine the contributing factors, including those related to staffing levels and assignment.
BJC	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	**Findings:** Review of the Engineering and Maintenance Department monthly status reports for June—August, November and December 2007 reveals that in those five months, there were 29-calls for elevator problems. Repeat calls were reported for the John Howard Pavilion and Units CT

		local authorities.	2, 7, and 9. All elevator problems were reported fixed within the month they occurred (specific dates were not provided). The hospital responded and fixed all elevator problems. It is not possible to determine the timeliness of the response from the information provided. **Compliance:** Partial **Current recommendations:** 1. Include in the Facilities and Environment Monthly Status Report the date elevator problems were reported and the date they were fixed. Also include the date of any elevator inspections by local authorities. 2. Inventory the residential units of individuals using wheel chairs to ensure that whenever possible, these individuals are housed on the first-floor.
BJC	XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	**Findings:** The hospital provided no information about the fire safety and evacuation plans and approval by the local fire authority. **Compliance:** Unable to determine. **Current recommendations:** Take whatever steps are necessary to have the fire safety and evacuation plans approved by local authorities.
BJC	XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair	**Findings:** My review of seven units found unsanitary conditions on several units and disregard for the personal hygiene and clothing needs of individuals

		environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	living on some of the units reviewed. Examples include the following: • 18 individuals reviewed had no personal hygiene items or an inadequate complement (missing toothbrush, etc.); • 17 beds had no, insufficient or dirty bedding; • Four individuals had no clothing in their locker and reported they had only the clothes they were wearing, which they also slept in; • One individual had only a hospital gown and a jacket. He also reported he was wearing the only clothes he had. • Dirty clothes were piled on the bottom of many lockers. This is attributable at least in part to the dearth of washers and dryers---one pair for each 20 individuals. • One toilet was out of order on each of two units and staff could not produce a work order requesting its repair. • Several bathrooms were not stocked with paper towels and toilet tissue. • One unit reported having no supply of men's underwear. The environmental self-assessment executive summary states that beds in dormitories sometimes lacked sheets and blankets. The Environmental and Water Unit Temperature Readings for the John Howard Pavilion for February 2008 generally showed comfortable ambient and water temperatures, with some exceptions. Low ambient temperatures of 52 and 54 degrees on the morning and afternoon of 2/11on Unit 9 were reported to the Help Desk. The hot water was reported as cool in the entire building on 2/9. Cool water temperatures were problematic in Unit 4 on 2/7 and on four units on 2/5. **Compliance:** Noncompliance