REPORT 3

St. Elizabeths Hospital

March 30-April 3, 2009

	V: Integrated Treatment Planning		
MES and RB		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.	**Summary of Status/Progress:** 1. SEH has made some process improvements towards implementation of the infrastructures needed for compliance with different provisions in this section. Although the facility has yet to make progress in actual practice and more refinements are still needed in the foundational processes and the self-assessment system, these improvements provide an adequate basis for further progress in this section. 2. SEH has continued the self-assessment process in reference to all provisions of this Agreement. As in its previous report, the facility's self-assessment was comprehensive and candid. 3. SEH has vacancies in Psychology, Social Work and Rehabilitation Services that continue to impede the development of stable core teams.
			Methodology: <u>Interviewed</u>: 1. Bernard Arons, M.D., Medical Director. 2. Beth Gouse, Ph.D., Chief of Staff. 3. Carmin Delballe, M.D., Staff Psychiatrist. 4. Clotilda Vidoni-Clark, Ph.D. 5. Danillo Garcia, M.D., General Medical Officer. 6. Gerard Fegan, Staff Psychiatrist. 7. Lendicita Madden, M.D., General Medical Officer. 8. Peter Chura, M.D., General Medical Officer. 9. Robert Morin, M.D., Chief Post Trial Division, Forensic Services 10. Sumit Anand, M.D., Medical Director, Civil Service. 11. Syed M. Zaidi, M.D., General Medical Officer. 12. Tehmina Sheikh, M.D., Staff Psychiatrist.

			Reviewed: 1. The charts of the following 52 individuals by Dr. El-Sabaawi: AA, AB, AF, AH, AK, AS, BA, BG, BP, BW, CG, CK, CM, DB, DD, FA, FG, GC, GM, GS, HS, IW, JC, JD, JF, JL, JL-2, JP, JT, KR, LK, LM, MA, MH, MJ, MK, ML, MM, MP, MT, PT, QN, RB, RD, RJ, RM, TH, TN, TP, TS, TVN and TW. 2. The charts of the following 49 individuals by Dr. Boggio: AH, AP, AW-B, BP, CCM, CL, CM, CT, CW, DA, DD, DH, DS, DT, EO, FT, GE, GP, IC, JC, JC-2, JD, JF, JS, KL, KR, LC, LH, LS, ME, MJ, MY, PW, RD, RF, RH, RP, RW, SA, SB, SS, TB, TM, WB, WC, WJ, WK and WM. 3. Saint Elizabeths Hospital (SEH) Self-Assessment Report (February 27, 2009). 4. Person-Centered Planning Training Application for SEH, August 28, 2008. 5. SEH Policy #602.2-04, Interdisciplinary Recovery Planning (IRP), revised effective February 23, 2009. 6. SEH Policy #601-02, Medical Records, revised February 27, 2009. 7. SEH template for the IRP, revised February 19, 2009. 8. SEH IRP Manual (undated draft). 9. IRP auditing data. 10. SEH information regarding instructors providing treatment planning training. 11. Treatment team training records. 12. SEH Policy 111.02-08, Patient Transfers, revised February 24, 2009. 13. SEH Psychology Department manual (draft). 14. SEH Department of Psychology Policy and Procedure for Behavioral Intervention Programs (draft). 15. SEH templates for Behavioral Guidelines, Functional Assessment and Structural Assessment. 16. SEH template for the Comprehensive Initial Psychiatric Assessment, revised February 12, 2009.

			17. SEH template for Initial Psychological Assessment, revised December 3, 2008. 18. SEH template for Social Work Initial Assessment, revised January 15, 2009. 19. SEH IRP Process Monitoring Tool, revised February 06, 2009 20. SEH Process Observation Data (February 2009). 21. SEH Patient Transfer Monitoring Tool, revised February 02, 2009. 22. SEE Patient Transfer Monitoring summary data (January 2009). 23. SEH Inpatient Consumer Survey Form. 24. SEH Seclusion and Restraint Audit Results. 25. SEH Comprehensive Initial Assessment Psychiatric Self-Audit Tool 26. SEH Psychological Assessment Monitoring Tool and Peer review Form. 27. SEH Social Work Initial Assessment Self-Audit Tool. 28. SEH Rehabilitation Services Assessment Self-Auditing Tool. 29. SEH Social Work Reassessment Self-Audit Tool. 30. SEH Tardive Dyskinesia Peer Review Tool. 31. SEH Medication Monitoring Review Form. 32. SEH Medication Monitoring Review summary data (February 2009) 33. SEH template for Clinical Formulation. 34. SEH template for Clinical Formulation Update. 35. SEH Team Checklists and Worksheets for the Comprehensive IRP Meeting and the IRP Review Meetings. 36. SEH template for Clinical Record Therapeutic Progress Note. 37. SEH template for Psychiatric Update, revised February 13, 2009. 38. SEH template for Social Work Progress Note. <u>Observed</u>: 1. IRP team meeting at RMB-3 for review of GC. 2. IRP team meeting at RMB-3 for review of FP. 3. IRP team meeting at RMB-5 for review of ME. 4. IRP team meeting at RMB-6 for review of SB. 5. IRP team meeting at JHP-1 for 60-day review of JC.

			6. IRP team meeting at JHP-3 for review of RJ. 7. IRP team meeting at JHP-6 for review of MK. 8. IRP team meeting at JHP-10 for review of WK.

	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:	Please see sub-cells for findings and compliance.
RB and MES	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;	**Current findings on previous recommendations:** **Recommendations 1 and 2, February 2008:** • Same as in V.A.2 to V.A.5. • Same as in V.B, V.C, V.D and V.E. **Findings:** Same as in V.A.2 to V.A.5, V.B, V.C, V.D and V.E. In summary, the facility has made several process improvements in the following areas relevant to specific provisions of Section V: 1. Initiation of an IRP Manual and other IRP-related instruments; 2. Initiation of training on the principles and practice of Interdisciplinary Recovery Planning (IRP); 3. Development of a policy regarding behavioral interventions and related templates; 4. Initiation of training on the principles and practice of positive behavior supports; 5. Development of templates for the therapeutic monthly progress notes, psychiatric update and social work progress notes; 6. Refinement of IRP self-auditing process observation; 7. Self-auditing process to assess disciplinary initial assessments, inter-unit transfer assessment, some disciplinary reassessments and discharge assessment; and 8. Self-auditing process regarding high risk medication uses and the management of tardive dyskinesia.

			However, this consultant's findings in subsections V.A.2 through V.A.5 and in Sections V.B., V.C, V.D., and V.E illustrate that the facility has yet to make progress in actual practice. The deficiencies outlined in these areas must be corrected to achieve substantial compliance with these requirements. **Compliance:** Partial. **Current recommendations:** 1. Same as in V.A.2 to V.A.5. 2. Same as in V.B, V.C, V.D and V.E.
RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue with current efforts to hire requisite number of psychiatrists and psychologists. **Findings:** Civil Section: Currently four out of 10 units do not have a psychologist functioning in an FTE capacity, and the psychologist who is in an FTE capacity for RMB-3 also serves as head of the Positive Behavior Support team. This dual role impedes the delivery of psychological services to RMB-3. Forensic Section: Currently one of the eight units does not have a psychologist functioning in an FTE capacity. **Recommendation 2, September 2008:** Clarify the differences in responsibilities between clinical administrators and team psychologists when a psychologist fills the

			position of clinical administrator. **Findings:** SEH reported that these differences have been clarified and that psychologists who are clinical administrators are not expected to function as team psychologists. At least one treatment team was observed in which two psychologists were present—one as clinical administrator and one as team psychologist—and the difference in roles and functions was obvious. **Compliance:** Partial. **Current recommendations:** 1. Continue with current efforts to hire requisite number of psychiatrists and psychologists. 2. The psychologist leading the PBS team must **not** have the additional duties of being a unit/treatment team psychologist.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences. **Findings:** Based on a review of the documents provided by the hospital, treatment team observations and chart reviews, a training program has been implemented. The hospital provided training data that indicated that training in person-centered planning began in September 2008 on some units, but that other units will not begin to receive this training

			until May 2009. This data also indicated percentages by departments/disciplines that have completed specific training modules: <u>IRP Overview Training</u> Administration: 77.3% Clinical administrators: 76.5% Nursing: 1.0% Psychiatry: 38.1% Psychology: 75.0% Social Work: 52.9% Rehabilitation: 0% <u>Stages of Change Training</u> Clinical administrators: 23.5% Nursing: 8.7% Psychiatry: 33.3% Psychology: 25.0% Social Work: 17.6% Rehabilitation: 15.8% It was not indicated in the hospital's submission if other specific modules are being planned other than ones in Engagement and Documentation. One treatment team was observed using the Checklist developed by the Hospital's consultants. Unfortunately, the time frames indicated on the Checklist for the three phases of the IRP meeting were not observed. For example, Phase I took 40 minutes to complete while the Checklist indicated that this should be accomplished in "up to 10 minutes." Whether this performance reflects the team's learning curve, an unrealistic time frame or both is not clear at this time, but the Hospital and its consultants will need to refine the Checklist and attendant processes based on their own data when it is available.

			Finally, it appears that the overall treatment planning process and the forms used for the IRP suffer from a lack of conceptual clarity regarding how to best integrate all of the essential elements of interdisciplinary recovery planning at the Hospital. **Recommendation 2, February 2008:** Organize treatment planning conferences around a template that includes: a. Interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness; b. Current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses and how and when to make changes in treatment and risk factors for exacerbation; c. Discharge readiness and barriers to discharge; medication side-effects; and d. If applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness. **Findings:** The Checklist indicated above covers all of these items, but see comments above about a clear problem with the time sequences indicated for each Phase of the IRP conference. **Recommendation 3, February 2008:** Provide treatment teams with training in how treatment planning is different from both assessment and treatment. **Findings:** Very little assessment of the individual during the IRP conferences was observed.

			Recommendation 4, February 2008: Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room. **Finding:** See comments above under Recommendations 1 and 2. **Compliance:** Partial. **Current recommendations:** 1. *Develop and fully implement a training program in interdisciplinary recovery planning that emphasizes the role of the team leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences.* 2. *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of interdisciplinary recovery planning, and add additional training modules as necessary to achieve this goal.* 3. *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference.*
RB	V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide treatment teams with training in effective ways to engage individuals and their families in the treatment planning conference. **Findings:**

			No specific training module about engagement of individuals and their families has yet been implemented. Although improvement in engaging individuals was noted in the observed IRP conferences – perhaps as a result of the overview training module - problems with engagement remained. In fact, in all observed conferences, teams had significantly more difficulty with Phase Two of the conference (once the individual joins the team) than with Phase One. **Recommendation 2, September 2008:** See recommendations in Section V.B.1. **Findings:** See recommendations in Section V.B.1. **Compliance:** Noncompliance. **Current recommendations:** 1. Develop and (or if developed) implement training in effective ways to engage individuals and their families in the treatment planning conference. 2. *Provide a roll out plan for when this training will begin and by what date completion is anticipated.*
RB	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;	**Current findings on previous recommendations:** **Recommendation 1 - 4, February 2008 and September 2008:** Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences. **Findings:**

			See findings in V.A.2.a above. Additionally, it was noted in the observed IRP conferences that teams generally functioned in a genuinely interdisciplinary manner in providing current updates on the individual's current status and progress. **Recommendation 2, September 2008:** Develop and implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: a. The name of the group/individual treatment; b. The name of the group/individual treatment provider; c. The name of the individual patient; d. The short-term goal for which the individual has been assigned to the modality; e. The number of attended sessions and offered sessions; f. The quality of the individual's participation; and g. The individual's progress toward achieving the stated short-term goal. **Findings:** A new template for mall treatment services has been designed and implemented, although hospital staff indicated that it was still "a work in progress" and may undergo further revision. In general, the version presented on the tour meets the requirements addressed above. **Recommendation 4, February 2008:** Develop and implement an auditing tool that monitors for all aspects of the progress note template. **Findings:** Not yet done. **Recommendation 5, February 2008:**

			Train all auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 6, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Other findings:** Despite the use of the new mall progress note template, little alignment was found between interventions written into the IRP and interventions addressed in the progress note. In many cases, no notes were found for the intervention in the IRP. In all but two cases, where both IRP interventions and mall progress notes were found, the progress note was not clearly aligned with the IRP intervention and did not report progress in a manner that the team could use to modify treatment. Additionally, there was no evidence at the observed IRP conferences that teams were referring to these notes in order to update an individual's progress and determine if there needed to be a change in either objective or intervention. **Compliance:** Partial. **Current recommendations:** 1. *Develop and implement an auditing tool that monitors for all aspects of the progress note template.* 2. Train all auditors to acceptable levels of reliability. 3. Provide operational definitions of all terms in a written format to

			aid in data reliability and validity. 4. *Ensure that one of the monitored elements includes the alignment of the progress note with the IRP.*
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences. **Findings:** Based on both a review of the documents provided by the Hospital visit, treatment team observations and chart reviews, a training program has been implemented. The Hospital provided training data that indicated that training in interdisciplinary recovery planning began in September 2008 on some units, but that other units will not begin to receive this training until May 2009. This data also indicated percentages by departments/disciplines that have completed specific training modules: <u>IRP Overview Training</u> Administration: 77.3% Clinical administrators: 76.5% Nursing: 1.0% Psychiatry: 38.1% Psychology: 75.0% Social Work: 52.9% Rehabilitation: 0% <u>Stages of Change Training</u> Clinical administrators: 23.5% Nursing: 8.7%

			Psychiatry: 33.3% Psychology: 25.0% Social Work: 17.6% Rehabilitation: 15.8% It was not indicated in the hospital's submission if other specific modules are being planned other than ones in Engagement and Documentation. One treatment team was observed using the Checklist developed by the Hospital's consultants. Unfortunately, the time frames indicated on the Checklist for the three phases of the IRP meeting were not observed. For example, Phase I took 40 minutes to complete while the Checklist indicated that this should be accomplished in "up to 10 minutes." Whether this performance reflects the team's learning curve, an unrealistic time frame or both is not clear at this time, but the Hospital and its consultants will need to refine the Checklist and attendant processes based on their own data when it is available. Finally, it appears that the overall treatment planning process and the forms used for the IRP may suffer from a lack of conceptual clarity regarding how to best integrate all of the essential elements of person centered planning at the Hospital. **Recommendation 2, February 2008:** Organize treatment planning conferences around a template that includes: a. Interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness; b. Current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses and how and when to make changes in treatment and risk factors for exacerbation;

			c. Discharge readiness and barriers to discharge; medication side-effects; and, d. If applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness. **Findings:** The Checklist indicated above covers all of these items, but see comments above about problem with the time sequences indicated for each Phase of the IRP conference. **Recommendation 3, February 2008:** Provide treatment teams with training in how treatment planning is different from both assessment and treatment. **Findings:** Very little assessment of the individual during the IRP conferences was observed. **Recommendation 4, February 2008:** Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room. **Finding:** See comments above under Recommendation 1 and 2. **Recommendation 2, September 2008:** Be certain that auditing tool is revised according to recommended revisions to Treatment Conference Protocol. **Findings:**

			An IRP Process Monitoring Tool was developed by the Hospital and data was presented for two data collection periods (11/08 and 02/09). It is not appropriate, however, to use "snapshot-in-time" data for the type of monitoring that is required under the Agreement. Rather, auditing data must be presented at monthly intervals so that true trends in compliance or noncompliance can be readily identified and the necessary corrective actions be applied by the Hospital's clinical administration. That said, data from the 02/09 audit indicated, among other things, that 77% of IRP conferences were held as scheduled and that 80% or greater attendance was found for all disciplines except for PNA/FPTs, RNs, and Psychologists. No data was presented on Rehab attendance, but it was noted that a Rehab therapist was only present at 1 of the 4 observed IRP conferences. Data also indicated that for most of the indicators related to the development of the IRP, scores were below 75%. Additionally, it is important to note that, while the auditing tool is called "IRP Process Monitoring Tool," it contains elements both for monitoring the *process* of the IRP conference and for reviewing the *content* of the written IRP after the conference has concluded. Finally, it does not appear that the auditing tool actually provides for an audit of the Checklist. **Other findings:** In general, the observed IRP conferences gave evidence that teams were functioning in a generally interdisciplinary manner **Compliance:** Partial. **Current recommendations:** 1. *Develop and fully implement a training program in person-centered treatment planning that emphasizes the role of the team leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences.*

			2. *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal.* 3. *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference.* 4. *Separate process auditing of the IRP conference from content auditing of the IRP in the medical record.* 5. Audit a sample of all conferences and charts on a monthly basis and present resulting data aggregated by month for the next 6 months. Continue to audit monthly thereafter.
MES and RB	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Develop and implement corrective actions to ensure proper integration of psychiatric and behavioral treatment modalities. • Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this consultant above. **Findings:** Review of SEH records indicated that the facility has taken several important steps to improve the integration of psychiatric and behavioral modalities. The following is a summary: 1. With the assistance of an expert consultant, SEH developed a policy and procedure for Behavioral Intervention Programs (draft), templates for behavior guidelines and structural and functional assessments and a Manual for Positive Behavior Supports (PBS). These instruments meet current generally accepted standards and, if properly implemented, represent a strong foundation for delivery

			of PBS at the facility. 2. The facility's expert consultant has provided training for psychology staff and staff on unit RMB-3 on the new policy and procedure and templates regarding behavioral management as well as overview training of direct care staff hospital-wide on the principles and practice of the Positive Behavioral Support (PBS) model. 3. Structural and functional summaries, which include data on current medications and how they may or may not contribute to the behavior problem, are being developed and several were in draft form. 4. SEH has assigned a psychologist to each civil and forensic unit. 5. SEH has increased attendance of psychologists at the IRP team meetings compared to the last review period. 6. SEH has initiated psychological screening, including risk assessment and cognitive functioning, on the admission units. However, the facility still falls short of compliance with this requirement due to the following: 1. SEH has yet to finalize and fully implement behavioral interventions that meet current generally accepted standards for patients in need of these modalities. 2. SEH has yet to ensure that psychologists attend all IRP meetings to provide input into the IRP reviews that is essential to proper implementation of this requirement. 3. Review of the charts of the individuals who have received behavioral interventions that were developed since the last review found that the facility has yet to document proper integration of behavioral interventions and psychiatric treatment. **Compliance:** Partial.

			Current recommendations: 1. *Implement the draft behavioral interventions policy and templates.* 2. *Ensure consistent training of direct care providers on the principles and practice of PBS.* 3. *Ensure attendance and participation by psychologists in IRP reviews.* 4. *Ensure documentation, in the psychiatric progress notes, of proper integration of psychiatric and behavioral treatment modalities.*
RB	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.	**Current findings on previous recommendation:** **Recommendation 1, February 2008:** Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences. **Findings:** SEH self-assessment data found that 76% of IRPs observed in 02/09 occurred on schedule. This is almost the same as that reported during our visit in 09/08 (73%). **Recommendation 2, February 2008:** Present data graphically as a process monitoring variable that can be trended. **Findings:** Although the hospital indicated that they presented trended data, this was not the case. Rather, "snapshot-in-time" data was presented, and this does not allow for observing data trends over time. Nevertheless, between the data presented in 09/08 and the data presented for 02/09, the increase in on time conferences only improved by 3% (76% vs. 73%), which is not likely to indicate general improvement. Additionally, this underscores the need for the use of monthly audits

			presented as trended data. **Recommendation 3, February 2008:** Make results available to hospital administration, discipline chiefs and treatment teams as a part of an ongoing performance improvement process. **Findings:** SEH self-assessment data indicates that this process is ongoing. **Recommendation 4, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** The Hospital reported that a new PI Director has been hired and that they are working with a consultant to refine the auditing tool and will then have the PID train the auditors. **Compliance:** Partial. **Current recommendations:** 1. Revise audit tool and train auditors. 2. Audit monthly and present trended data.
RB	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;	**Current findings on previous recommendation:** Past Recommendations and Findings: Cf. V.A.2.a **Compliance:** Partial.

			Current recommendation: Same as V.A.2.a.
RB	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	**Current findings on previous recommendation:** **Recommendation 1** Provide data on the hospital's current progress toward achieving stable core team membership. **Findings:** Vacancies in Psychology, Social Work and Rehabilitation services exist such that stable core team membership is not possible on all units/wards. **Compliance:** Partial. **Current recommendation:** *Provide data on the hospital's current progress toward achieving stable core team membership.*
RB	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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences. **Findings:** SEH self-assessment data found that 76% of IRPs observed in 02/09 occurred on schedule. This is almost the same as that reported during our visit in 09/08 (73%). Additional data indicated that in 02/09, only 33% of teams had 30 day IRP conferences as scheduled for the first 30 days, but then had 80% compliance for 30 day-reviews at day 60.

			For the requirement of ongoing 60 day reviews thereafter, the Hospital's data indicated that this was occurring 62% of the time.. **Compliance:** Partial. **Current recommendations:** 1. Audit each type of treatment plan monthly. 2. Present as trended data.

	B. Integrated Treatment Plans		
		By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:	
MES	V.B.1	where possible, individuals have input into their treatment plans;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop and implement an IRP Policy/Procedure/Manual that includes appropriate expectations and operational guidance regarding the process of engagement of individuals in treatment planning. **Findings:** With the assistance of an outside consultant, SEH has developed an IRP Manual. This manual included suggestions for "How to Engage/Connect" with the individual. The suggestions contained basic elements of interacting with the individuals on a daily basis. In a separate section of the Manual (Worksheet for Comprehensive IRP Meeting and IRP Meeting Reviews), there were appropriate instructions regarding the process of interacting with the individuals to elicit their input during the IRP meeting. **Recommendation 2, September 2008:** Develop and implement a training module focused on Engagement of Individuals. This training must ensure that the individuals provide substantive input in the formulation and review and revisions of treatment objectives and interventions. **Findings:** SEH reported that it has implemented a "person-centered treatment planning training" using recently revised IRP forms. The first phase of this training began in September 2008 involving five units and the

			second phase incorporating five additional units began in January 2009. The third phase (eight remaining units) is expected to begin in April 2009. Review by this consultant of the outline of this training found that the training included some appropriate elements relevant to the general principles of engagement of patients. However, the training material did not include adequate lesson plans and outcome measures to ensure appropriate implementation of these elements consistent with the integrated recovery planning model. **Recommendation 3, September 2008:** Provide summary outline of the above training including information about instructors, participants and training process and content (didactic and observational). **Findings:** SEH provided information regarding the instructors who have provided this training. The information indicated that the instructors were well-qualified to provide this training. However, no information was provided regarding the participants (all disciplines that attended the training) or the training process (presentations, in-vivo observation of IRP meetings, process of feedback, post-tests, etc.). **Recommendation 4, September 2008:** Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. **Findings:** SEH has yet to implement this recommendation. The facility has assigned a data analyst to assist the training department in development of the database. **Recommendation 5, September 2008:**

Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies.

Findings:
SEH has revised its IRP Process Monitoring form to address the patient's input into the development and implementation of the IRP. The revised tool included appropriate operational instructions to monitor this requirement. However, the operational instructions did not include updates of the case formulation, objectives and/or interventions, as clinically appropriate, if the patient has identified a cultural preference during the meeting.

Recommendation 6, September 2008:
Monitor this requirement using process observation data based on at least a 20% sample (October 2008 March 2009).

Findings:
SEH has yet to provide adequate data based on the revised tool. The facility reported that the tool is being used to monitor those units that have completed the above-mentioned treatment planning training. The facility presented limited data showing that the individuals have attended 95% of the IRP meetings during this review period and that their participation varied across indicators. Regarding the individual's participation in the IRP meeting, the compliance rates varied, with the lowest rates noted for the following indicators:

1.	The team reviewed the individual's progress in each focus area.	53%
2.	The team provided the individuals with options and choices of interventions for the objectives.	47%
3.	The team reviewed the role of token economies and	50%

			behavioral guidelines/PBS plans in establishing and maintaining wellness for the individual.	

Recommendation 7, September 2008:
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.

Findings:
SEH has yet to implement this recommendation.

Other Findings:
The expert consultants attended six IRP meeting conferences to assess the IRP process, including engagement of the individuals during the meetings. The meetings showed the following positive findings:

1. In general, the meetings started on time;
2. Most of the core disciplines (psychiatry, general medicine, nursing, social work and rehabilitation) were in attendance.
3. The individuals attended all meetings;
4. In most of the meetings, the teams conducted an adequate review of disciplinary assessment results pertaining to the individual's current status and a review of risk factors and a formulation of key questions to be addressed during the individual's presence;
5. In general, the IRP team members made efforts to engage the individuals into the process of the meeting.
6. In general, the teams reviewed the diagnosis with the individuals.
7. One team conducted an overall adequate IRP review process.

However, there continued to be a pattern of deficiencies that must be

			corrected to achieve compliance with this requirement. The following are the main areas of deficiency: 1. Team leadership that facilitates completion of all required tasks; 2. Participation by all core members, particularly direct care staff; 3. Update of the present status of the individuals regarding symptom status (psychiatric and behavioral, including use of restrictive interventions), medical conditions, functional status, cultural issues, other factors contributing to hospitalization that were addressed in other sections of the case formulation and progress towards discharge criteria; 4. Therapeutic interactions with individuals who manifested active psychotic symptoms during the meeting; 5. Review of foci, objectives, and interventions with the individual; 6. Data-based review of the individual's participation in PSR Mall activities; 7. Linkage within the IRP (foci, objectives and interventions) and between Mall activities and objectives in the IRP; 8. Revision of foci, objectives and interventions with input from the individual; 9. Update of the individual's life goals and strengths and utilization of these goals and strengths in the IRP; and 10. Review of progress towards individualized discharge criteria with input from the individual. **Compliance:** Partial. **Current recommendations:** *1. Ensure that the IRP Manual includes appropriate and clear expectations and operational guidance regarding the process and outcomes of engagement of individuals during IRP meetings.* *2. Ensure that each IRP team has a dedicated mentor and that*

			mentors provide feedback to the teams and to facility management regarding the IRP process. 3. *Ensure that the revised IRP Process Observation Monitoring Form includes operational instructions to assess if the team has made clinically appropriate revisions in the case formulation, objectives and/or interventions in response to the individual's expressed cultural preference/needs.* 4. *Develop and implement a training module focused on Engagement of Individuals to ensure that the individuals provide substantive input in the formulation, review and revisions of treatment objectives and interventions. The module should include lesson plans, process outcomes and post-tests.* 5. *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* 6. Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. 7. Monitor this requirement using process observation data based on at least a 20% sample during the review period. 8. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
	V.B.2	treatment planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
MES	V.B.2.a	initial assessments are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1-5, September 2008:**

			• Ensure that Policy and Procedure #602-08 includes appropriate timeframes regarding completion of the psychiatric reassessment s (at least weekly during the first 60 days of admission and monthly thereafter). • Implement revised Policy and Procedure #602.1-08. • Develop self-assessment monitoring tools that include complete indicators and operational instructions to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of the Agreement regarding each disciplinary assessment). • Monitor the timeliness and quality of each disciplinary assessment using the disciplinary assessments monitoring tools based on at least a 20% sample (see corresponding sections of this agreement regarding each disciplinary assessment). • 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. **Findings:** Same as in VI.A.1. **Recommendation 6, September 2008:** Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences. **Findings:** SEH has yet to present the requested information. **Other findings:**

			This monitor reviewed the charts of seven individuals who were admitted during this review period (AB, AF, BP, JP, LM, PT and RM) and eight individuals who have been hospitalized for at least the past year (AS, BA, CM, IW, JT, MJ, MM and TVN). The reviews found that the admission psychiatric assessments were completed within 24 hours of admission in all cases. The facility developed a new adequate template for the initial comprehensive psychiatric assessments and began implementation of this template in January 2009. The facility also developed an initial psychiatric assessment self-assessment tool and has yet to begin implementation of this tool. The chart reviews found that most of the charts utilized the old format of the psychiatric assessments and these charts contained a pattern of deficiencies in content (see Section VI.A.5) that must be corrected to achieve substantial compliance with this requirement **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.1. 2. Same as in VI.2.b, Recommendation 5.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement the revised Policy #602.2-04 regarding this requirement. **Findings:** The facility has implemented the revised Policy #602.2-04, Interdisciplinary Recovery Planning (IRP) effective February 23, 2009. The policy contained a timeframe for completion of the initial IRP

within 24 hours of admission and the comprehensive IRP within seven calendar days of admission or transfer. These timeframes are acceptable.

Recommendation 2, September 2008:
Revise the IRP Process Observation Monitoring Form to include complete indicators and operational instructions regarding this requirement.

Findings:
SEH has revised its IRP Process Monitoring Form to include operational instructions regarding the timeframes for completion of the initial and comprehensive IRPs. The instructions are inconsistent with the timeframes outlined in the facility's revised Policy mentioned above (regarding the comprehensive IRP).

Recommendation 3, September 2008:
Monitor the timeliness of the comprehensive IRP based on at least a 20% sample (October 2008 to March 2008).

Findings:
SEH has yet to implement this recommendation. However, limited data based on the revised IRP Process monitoring Form (February 2009) showed the following compliance rates:

1.	Initial IRP within 24 hours	43%
2.	Comprehensive IRP within six calendar days of admission and annually	89%
3.	Comprehensive IRP within six calendar days of transfer	50%

Recommendation 4, September 2008:
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. **Findings:** SEH has yet to implement this recommendation. **Other findings:** This consultant reviewed the charts of seven individuals who were admitted during this reporting period (AB, AF, BP, JP, LM, PT and RM). The review found that the initial comprehensive treatment plans were completed within the required timeframe in all cases. Please note that findings regarding the content of these plans are outlined for each corresponding section of the agreement. The findings indicated a pattern of deficiencies in content that must be corrected to achieve substantial compliance with this requirement. **Compliance**: Partial. **Current recommendations**: 1. *Ensure consistent implementation of a timeframe of seven calendar days for completion of the comprehensive IRP and consistency between the IRP Process Monitoring Form and the revised Policy #602.2-04 regarding all timeframes for implementation of the IRPs.* 2. *Monitor the timeliness of the initial and comprehensive IRP based on at least a 20% samples during this review period.* 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. 4. Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop IRP Process Observation Monitoring Form that includes complete indicators and operational instructions that specify the following: a. The required frequency of the reviews, e.g. 24 hours (initial), five business days (comprehensive), monthly (for the next 60 days) and 60 days (thereafter). b. The identification by the team of someone to be responsible for scheduling and coordination of necessary progress reviews. **Findings:** See findings in V.B.2.b regarding the timeframes for the initial and comprehensive IRPs. Regarding the IRP reviews, SEH's revised Policy #206.2/04 and the revised IRP Process Monitoring Form contained appropriate timeframes (and monitoring instructions) for completion of these reviews (monthly during the first 60 days and every 60 days thereafter). The revised Process Monitoring Form also contained an indicator to assess if the IRP meetings were held as scheduled. This form did not include instruction regarding the identification by the IRP team of someone to be responsible for scheduling the reviews. **Recommendation 2, September 2008:** Monitor this requirement using the process observation tool based on at least a 20% sample (October 2008 top March 2009).

			Findings: SEH provided limited data based on the revised IRP Process Monitoring Form. The data showed that 71% of the IRP reviews were held in accordance with the timeframes in the revised Policy and 81% of meetings were held as scheduled. The facility did not present data regarding the identification by the treatment team of someone to be responsible for the scheduling and coordination of the IRP reviews. **Recommendation 3, September 2008:** 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. **Findings:** SEH has yet to implement this recommendation. **Other Findings:** This monitor reviewed the charts of seven individuals who were admitted during this review period (AB, AF, BP, JP, LM, PT and RM) and seven individuals who have been hospitalized for the at least the past year (AS, BA, CM, IW, MJ, MM and TVN). The review found that the treatment plan reviews were implemented within the required timeframes, with only a few exceptions (BA). **Compliance:** Partial. **Current recommendations:** 1. Ensure monitoring instructions regarding the identification by the

			IRP team of some one to be responsible for scheduling the IRP meetings in accordance with the required timeframes. 2. Monitor this requirement using the process observation tool based on at least a 20% sample during the next review period. 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.
MES	V.B.3	individuals are informed of the purposes and major side effects of medication;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement. **Findings:** SEH has yet to implement this recommendation. As mentioned in the previous report, discussion with the individual about purposes and side effects of pharmacotherapy should be part of the psychiatric assessment and reassessments, not the IRP meeting process. Therefore, this item should be monitored using a Clinical Chart Audit focused on the process and content of psychiatric assessment and reassessment. The facility has plans to revise its Clinical Chart Audit to assess implementation. In addition, the Office of Consumer Affairs recently began conducting satisfaction surveys with discharged individuals, including a question to assess if the individual was given information on how to manage medication side effects. **Recommendations 2 and 3, September 2008:** • Monitor this requirement using clinical chart audit based on at least a 20% sample (October 2008 to March 2009).

			• 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. **Findings:** SEH has yet to implement these recommendations. **Recommendation 4, September 2008:** Provide the facility's procedure regarding the process and content of informed consent. **Findings:** SEH has revised its IRP form to make it clear that the psychiatrist will have the responsibility of obtaining informed consent to medications and that other team members will obtain consent for other interventions, as appropriate. The facility did not provide information regarding the content of informed consent for specific medication classes. **Compliance:** Partial. **Current Recommendations:** 1. *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.* 2. *Provide a sample of information regarding the content of informed consent for specific medication classes.* 3. Monitor this requirement using clinical chart audit based on at least a 20% sample during the review period. 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.
MES	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;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Same as in V.D.1, V.D.2 and V.D.3. • Same as in V.D.4 and V.D.5. **Findings:** Same as in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5). **Compliance:** Noncompliance. **Current recommendations:** 1. Same as in V.D.1, V.D.2 and V.D.3. 2. Same as in V.D.4 and V.D.5.
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in XII.E.2. **Findings:** Same as in XII.E.2. **Recommendations 2 and 3, September 2008:** • Develop and implement a mechanism to assess compliance with this

			requirement. • Provide documentation of the purpose and results of the Medical Director's review of the use of seclusion and/or restraints during the reporting period. **Findings:** SEH has developed a Seclusion/Restraint audit tool that contains adequate indicators to assess documentation of the triggers for review by the Medical Director and consultation with (and response from) the Medical Director regarding this consultation. Limited data based on this tool and a review by the facility's Department of Performance Improvement (of a sample of 24 episodes of seclusion and/or restraint) showed noncompliance with this requirement during this review period. **Compliance:** Same as in XII.E.2. **Current recommendations:** 1. Same as in XII.E.2. 2. Provide documentation of the purpose and results of the Medical Director's review of the use of seclusion and/or restraint during the reporting period.
RB	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;	**Current findings on previous recommendations:** **Recommendation 3, February 2008:** Develop a monitoring system to collect, aggregates and analyzes the data necessary to assure that Recommendations 2 and 3 are implemented and reviewed. Make the data from this process available to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement. **Findings:**

			A system has been implemented by the Chief of the Post Trial Division and available data, as well as an independent chart review, indicated that recommendations from the FRP are being followed up appropriately by treatment teams and being appropriately documented. **Recommendation 2, September 2008:** Assure that the Risk Factors section of each FRB submission contains a **list** of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. These should be presented without commentary, but may be introduced by a sentence or two indicating if the risk factors were determined through the use of particular risk assessment tools. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk factor should again be **listed** and updated based on the findings in the body of the report. This section is also the appropriate section to report **current** scores from actuarial risk assessment instruments. **Findings:** While Risk Factors were generally covered appropriately in the reviewed records, none of them presented the Risk Factors as a list. This is the same finding as in September 2008. **Compliance:** Partial. **Current recommendations:** 1. Continue monitoring of treatment team response to FRB recommendations and presentation of data to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement. 2. Revise Risk Factor section and final section of FRB submissions so

			that each FRB submission contains a **list** of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. After each factor, a sentence explaining its relevance to the individual can be added. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk factor should again be **listed** and updated based on the findings in the body of the report. This section is also the appropriate section to report **current** scores from actuarial risk assessment instruments.
MES	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in V.E.3, V.E.4 and V.E.5. **Findings:** Same as in V.E.3, V.E.4 and V.E.5. **Recommendation 2, September 2008:** Same as in VIII. **Findings:** Same as in VIII. **Compliance:** Partial. **Current recommendations:** 1. Same as in V.E.3, V.E.4 and V.E.5. 2. Same as in VIII.
MES	V.B.8	an inter-unit transfer procedure is developed and	**Current findings on previous recommendations:**

		implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and	**Recommendation 1, September 2008:** Ensure that revised policy regarding inter-unit transfers contains additional documentation requirements that include: a. Review of risk factors; b. Barriers to discharge; and c. Plan of care. **Findings:** SEH has revised its Policy #111.02-08 and incorporated the recommended items. **Recommendation 2, September 2008:** Monitor this requirement using the inter-unit transfer assessment tool based on at least a 20% sample (October 2008 to March 2009). **Findings:** During this review period, SEH developed a monitoring tool that contains appropriate indicators regarding inter-unit transfers. Based on limited data, the facility reported that 100% of the transfer progress notes included current diagnosis, review of risk factors and a brief description of the psychiatric course of hospitalization, but none addressed anticipated benefits to transfer, rationale for the transfer or barriers to discharge. **Recommendation 3, September 2008:** 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.

Findings:
SEH has yet to implement this recommendation.

Other findings:
This consultant reviewed the charts of seven individuals who required inter-unit transfers during this reporting period. The following table outlines the reviews:

Initials	Date of inter-unit transfer
BW	12/9/08
DD	12/15/08
JL	11/28/08
JL-2	12/1/08
MH	1/12/09
TN	10/20/08

In the chart of DD, the transfer assessment was completed by a trainee without evidence of review by the attending psychiatrist. This assessment did not provide any information regarding the recent use of restrictive interventions for the individual. The transfer assessment in the chart of TN did not provide any meaningful information to ensure continuity of care. The chart of JL-2 included a transfer assessment that was limited to brief identification data, a listing of current diagnoses and results of some recent laboratory tests. In the other three charts, some improvement was noted in the overall structure of the assessments. However, the assessments were inconsistent in addressing the anticipated benefits of the transfer, risk factors, psychiatric course of hospitalization, barriers to discharge and plan of care.

Compliance:
Partial.

			Current recommendations: 1. *Ensure that the current policy regarding Patient Transfers also addresses the mission of each unit in the hospital.* 2. *Implement corrective actions to ensure that the transfer assessment meets the requirements of the facility's policy.* 3. Monitor this requirement using the inter-unit transfer assessment tool based on at least a 20% sample during the next review period. 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.
MES	V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart.	**Current findings on previous recommendations:** **Recommendation, September 2008:** See corresponding sections of the Agreement that address items 1 through 9 (as follows): 1. Leadership of the IRP meetings/psychiatric participation in these meetings; 2. Timeliness and content requirements of initial/comprehensive admission disciplinary assessments; 3. Timeliness and content requirements of psychiatric reassessments (as documented in progress notes); 4. Timeliness and content requirements of psychiatric transfer notes; 5. Timeliness and content requirements regarding discharge summaries; 6. Individualized guidelines regarding the use of psychotropic medications, including adequate indications and contraindications, and specific screening and monitoring requirements; 7. Drug Utilization Evaluation system including indicators that aligned with the individualized medication guidelines;

			8. Complete indicators and operational instructions for review of high-risk medication uses (benzodiazepines, anticholinergics, new generation antipsychotic agents and Stat medications); and 9. Complete indicators and operational instructions for review of tardive dyskinesia (clinical monitoring and management). **Findings:** See corresponding sections of the Agreement that address the above items. The following is a summary of this consultant's assessment of the facility's current status of implementation of this requirement: 1. The revised IRP Process Monitoring Form included adequate indicators to address the leadership/facilitation of the IRP meeting. The facility began implementation of this tool. 2. The revised IRP Process Monitoring Form adequately addressed the timeliness of the assessments and reassessments. The facility began implementation of this tool. 3. The newly developed self-audit tools for initial/comprehensive disciplinary assessments (psychiatry, psychology, social work and rehabilitation therapy) included adequate indicators and instructions regarding the content of these assessments. The facility began implementation of the psychology, social work and rehabilitation therapy tools, but has yet to implement the psychiatry tool. 4. The Patient Transfer Monitoring Form adequately addressed the timeliness and content requirements of the inter-unit transfer assessments. The facility began implementation of this tool. 5. SEH developed an adequate auditing tool to assess the content of social work reassessments, but has yet to develop and implement similar tools for psychiatry, psychology and rehabilitation therapy. 6. SEH has yet to develop and implement tools to assess nursing assessments and reassessments. 7. SEH has yet to develop and implement indicators regarding

			psychiatric reassessments. 8. SEH developed a Medication Monitoring/Review Form that contained some appropriate indicators regarding high risk medication uses and began implementation of this tool. The facility has yet to refine some of the indicators to ensure the safety and appropriateness of medication uses and clinical and laboratory monitoring of the individuals. 9. SEH developed an adequate Discharge/Outplacement Assessment Tool and began its implementation. The facility has yet to present monitoring data for the entire review period. 10. SEH has yet to develop and implement individualized medication guidelines to serve as the basis for the peer review/self-audit indicators regarding appropriateness of medication uses. 11. SEH has yet to refine some of the indicators regarding high risk medication uses to ensure the safety and appropriateness of medication uses. 12. SEH has developed indicators regarding the assessment and management of tardive dyskinesia. The facility has yet to implement this tool and to refine some of the indicators to provide operational criteria regarding appropriate management. 13. The facility has yet to develop complete monitoring data for all its tools based on adequate sampling and auditing methodology. 14. The facility has yet to delineate patterns and trends and to implement corrective/educational actions, as needed, to improve its performance. **Compliance:** Partial. **Current recommendation:** Ensure adequate completion of items #3-14 outlined in this consultant's summary above.

	C. Case Formulation		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:	Please see sub-cells for findings and compliance.
MES	V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation. **Findings:** The facility has developed an IRP manual that adequately addresses several process deficiencies that were outlined by this consultant in the previous report. Specifically, the manual includes adequate information regarding the following areas: 1. The overall structure and content of each of the 6-Ps (Pertinent History, Predisposing, Precipitating and Perpetuating Factors, Previous Treatment and Present Status); 2. The delineation of the individual's needs that constitute appropriate targets for treatment (to address illness) and enrichment (to address quality of life); and 3. The process of periodic update of the Case Formulation, including update of historical data and the present status of the individuals (symptoms, cognitive status, risk factors, cultural factors, use of restrictive interventions, behavioral guidelines, treatment response and discharge status).

			However, the Manual did not address the domain of social skills/functional status as part of the identification of needs section of the case formulation. In addition, the update of the case formulation did not include any guidance regarding the individual's functional status. A treatment plan that ignores the individual's functional impairments is seriously deficient in addressing the factors that underlie chronic disability and repeated hospitalizations. Based on the IRP manual, SEH developed templates for the Clinical Formulation (Case Formulation) and Clinical Formulation Update. **Recommendations 2 and 3, September 2008:** • Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). **Findings:** SEH provided the same information that was reported in V.B.1 under Recommendations 2 and 3 regarding IRP training during this review period. However, the facility did not provide any specifics regarding the participants (disciplines that attended the training) or the training process (presentations, in-vivo observation of IRP meetings, process of feedback, post-tests, etc.) **Recommendation 4, September 2008:** 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.

			Findings: SEH has yet to implement this recommendation. **Recommendation 5, September 2008:** Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement. **Findings:** SEH has yet to implement this recommendation. **Recommendation 6, September 2008:** Monitor this requirement using the clinical chart audit tool based on at least a 20% sample (October 2008 to March 2009). **Findings:** SEH has yet to implement this recommendation, but expects that this tool will be finalized by March 31, 2009. The facility acknowledged that most of the IRPs at the facility do not currently include case formulations that meet requirements of this Agreement. **Recommendation 7, September 2008:** 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. **Findings:** SEH has yet to implement this recommendation. **Other findings:** All the charts reviewed by this consultant that utilized the facility's

			older format of treatment planning showed the same pattern of deficiencies that was outlined in the previous report. The main deficiency was that the formulation consisted of a rehash of the same information in the disciplinary assessments. None of the charts included a summary that adequately provided an interdisciplinary review and synthesis of the disciplinary assessments as required in the IRP model. As a result, none of the charts reviewed included evidence of adequate delineation of the individual's psychiatric, behavioral, functional skills and quality of life needs. . In the charts that utilized the facility's new IRP case formulation form, the review found that the teams made efforts to present the information in the appropriate format of the 6-P model. However, the content of these formulations showed the following pattern of deficiencies: 1. In general, the present status sections did not include sufficient review and analysis of the following: a. Symptoms; b. Functional status; c. Status of the individual's response to interventions; d. Status of risk factors, including the use of restrictive interventions; and e. Clinical progress towards individualized discharge criteria. 2. In general, there was inadequate linkage within the 6-P components of the case formulation and between the material in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions **Compliance:** Partial. **Current recommendations:**

			1. *Ensure that the IRP manual adequately addresses the individual's needs in the domains of social skills/functional status.* 2. *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.* 3. *Provide summary outline of the disciplines participating in the above training and the training process (didactic, observation, feedback to teams) and content.* 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. 5. *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* 6. Monitor this requirement using the clinical chart audit tool based on at least a 20% sample during the review period. 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.
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Current findings on previous recommendations:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above.

			Compliance: Partial. **Current recommendations:** Same as above.
MES	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;	**Current findings on previous recommendations:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Current findings on previous recommendations**: **Recommendation, September 2008**: Same as above. **Findings**: Same as above. **Compliance**: Partial. **Current recommendations**: Same as above.

MES	V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	**Current findings on previous recommendations:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Current findings on previous recommendations:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	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.	**Current findings on previous recommendations:** **Recommendation, September 2008:** Same as above.

			Findings: Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.

	D. Individualized Factors		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	Please see sub-cells for findings and compliance.
MES	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above. **Findings:** The facility's IRP Manual provided adequate instruction regarding the following: 1. Delineation of foci (goals) of hospitalization in the following domains: psychiatric and psychological, including high risk behaviors, physical health, forensic/legal (if applicable), substance abuse (if applicable), discharge planning/community readiness and enrichment; 2. The individual's strength relative to each focus; and 3. The individual's stage of change relative to each objective. The facility revised its IRP forms to provide foci and objectives in each of the six domains as well as delineation of the individual's strengths for each focus and stage of change for each objective. This outline represents an improvement compared to the previous system. However, the new system contained the following deficiencies: 1. Although the Manual (as part of the steps for IRP review meetings)

			and the revised IRP forms included instruction to the IRP teams to address skill-building interventions, the outline of foci (goals) did not include the critical area of functional status of the individual. 2. The system did not ensure that issues of dangerousness and impulsivity were adequately addressed in the IRP. 3. There was no operational guidance, including clinical examples, to facilitate the following: a. Development of foci, objectives and interventions based on learning outcomes; b. Linkages within the IRP (assessments to case formulation to foci to objectives to interventions); c. Linkage between Mall interventions and IRP objectives; d. Strengths formulation for IRP purposes; e. Revisions of foci, objectives and interventions to align with the changing needs of the individuals; and f. Strategies to overcome barriers to individuals' adherence to their IRPs. **Recommendations 2-4, September 2008:** • Provide training modules dedicated to Foci/Objectives/ Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). • Provide aggregated data on results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions. **Findings:** The facility presented the same information that was reported for similar recommendations regarding the engagement of individuals (V.B.)

			and case formulation (V.C). **Recommendation 5, September 2008:** Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement. **Findings:** The facility has revised its IRP Process Monitoring Form to address this recommendation. The revised form is appropriately focused on the process of obtaining input from the individuals in the development of foci and objectives during the IRP meeting. However, the tool did not adequately address the intent of this requirement (i.e. development of foci and objectives that are aligned with the identified needs in the appropriate domains [as listed in the case formulation], are attainable for the individual and are based on properly formulated strengths that can facilitate the attainment of the stated objectives). SEH has yet to finalize a Clinical Chart Auditing Form to assess this requirement. **Recommendation 6, September 2008:** Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least a 20% sample (October 2008 to March to 2009). **Findings:** SEH did not provide data that align with this recommendation. However, the facility acknowledged that the majority of IRPs were currently not adequately individualized and mostly generic and focused on compliance (e.g. "Patient will accept medications" and "Patient will complete ADLs") and/or unattainable (e.g. "Patient will be free from delusions").

			Recommendation 7, September 2008: 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. **Findings:** SEH has yet to present the requested information. **Recommendation 8, September 2008:** Provide an outline of the following: a. Cognitive remediation interventions that are currently provided and plans to increase these interventions. b. Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population. **Findings:** SEH has yet to present the requested information. The facility reported that it was in the process of redesigning its Treatment Mall to include provision of cognitive remediation interventions for all three divisions of the redesigned Mall. **Recommendation 9, September 2008:** Develop and implement medical care policies and procedures to address the following: a. Requirements for preventive health screening of individuals; b. Requirements regarding completeness of all sections of initial assessments, including a plan of care that specifies interventions for identified conditions;

			c. Requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format; d. Timeliness and documentation requirements regarding period reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks; e. Proper physician-nurse communications to ensure the following: • Timely and properly documented nursing assessments; • Timely and properly documented physician notification; and • Physician response within timeframes that reflect the urgency of the condition; f. Emergency medical response system, including drill practice; g. Consultation and laboratory testing to ensure the following: • Communications of needed data to consultants; • Timely review and filing of consultation and laboratory reports; and • Follow-up on consultant's recommendations; h. Requirements regarding transfer of individuals to outside facilities to ensure the following: • Physician to physician communications upon the transfer regarding the reason for the transfer; and • Communication of appropriate documents to the outside facility relevant to the reason for the transfer; i. Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician: • Obtains information from the outside facility that is sufficient for continuity of care; • Documents a review and assessment of the individual's status and the care provided at the outside facility; and • Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals; j. Parameters for physician participation in the IRP process to

			improve integration of medical and mental health care. **Findings:** SEH reported that it was in the process of developing these procedures and that it had plans to formalize the procedures within the next review period. **Other findings:** Chart reviews by this consultant found some improvement in the organization of foci of hospitalization in the charts that utilized the new formats of the comprehensive IRP and IRP reviews. However, the new IRP format did not include a focus to address individuals' functional status. Early implementation of this format suggested that the teams are not fully informed regarding proper formulation of foci statements. In addition, the format included a focus dedicated to discharge planning. This focus should be more oriented to specific problems with community integration that require specialized interventions (e.g. fears of leaving the hospital, limited placement resources, etc.) while discharge planning should be considered when developing objectives and interventions for all other foci. In addition, most of the charts reviewed by this consultant showed the following general pattern of deficiencies in the formulation of foci of hospitalization: 1. The foci were mostly generic, vague, overinclusive and/or unattainable. 2. The foci were mostly limited to symptom reduction and did not address the individual's needs in other domains. 3. The foci were not appropriately linked to the objectives, interventions and reports of the individual's progress. The following are chart examples:

			1. "Symptoms of mental illness manifested by noncompliance with psychotropic medications and substance abuse while in the community, jail and the hospital related to biochemical imbalance in the brain" (BG); 2. "Symptoms of mental illness" (FG); 3. "Stabilization of symptoms" (FG); 4. "Right CVA, seizures and fall precautions" (JF); 5. "Stabilization of symptoms with increased insight into her mental illness and the need for continued treatment" (TS); 6. "Will be capable of managing her affective, impulsive and psychotic behaviors and learn skills to compensate for any limitations" (CM); This consultant also reviewed the charts of individuals diagnosed with seizure, cognitive and substance use disorders. The purpose of the review was to assess whether foci, objectives and interventions addressed the individuals' identified needs. These reviews found that the facility has maintained some progress in the following areas: 1. Documentation of seizure disorders as a diagnosis, with corresponding foci and objectives and interventions in the IRPs of several individuals (e.g. TVN). 2. Documentation of the focus statement, objectives, interventions and progress towards objectives in some individuals diagnosed with dementia NOS (e.g. TW). 3. Documentation of specialized interventions (e.g. neurological consultation) and follow-up on results of the consultation in an attempt to finalize diagnosis of Dementia NOS (TW). 4. Documentation of foci, objectives, interventions and stage of change for some individuals suffering from substance use disorders (e.g. MJ and JC). This documentation was noted in the IRPs that were completed using the facility's new format for IRP reviews.

			However, the review found a pattern of deficiencies that precludes compliance with requirements of the Agreement in V.D.1 to V.D.6. The following are examples: 1. Individuals diagnosed with seizure disorders (AA, JC, JF, MJ, RM and TVN) : a. In too many charts, the foci and objectives were generic and did not appear to be aligned with the actual needs of the individuals, focusing on compliance with medications (RM and TVN), participation in the management of the disorder (JM) and prescribing medications and assessing their effectiveness, without operational outcomes (JF). b. There was no documentation of any psychiatric progress notes for several months on some of the individuals who were receiving active treatment for seizure disorder (MJ and TVN). c. The objectives did not utilize learning outcomes for the individual in any the charts reviewed. d. The IRPs did not include focus, objectives and/or interventions to assess the risks of treatment with older anticonvulsant medications and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (AA and JF), and/or phenobarbital (MJ and RM). Some of these individuals were at increased risk for adverse effects of treatment due to the presence of cognitive impairments including Dementia due to Cerebro-Vascular Accident (JF), Mild Mental Retardation (MJ) and Borderline Intellectual Functioning (AA). 2. Individuals diagnosed with substance use disorders (GS, JC, MJ, MM, RJ and RM). a. The documentation of the stage of change was not aligned with the stated objectives of treatment (JC and MJ). b. No focus, objectives or interventions were listed for some individuals diagnosed with substance use disorder (e.g. RM).

			c. The IRP included an inappropriate focus statement for an individual diagnosed with Alcohol and Cannabis Abuse (RJ). d. There was no documentation of the individual's stage of change to ensure that documented goals/objectives and interventions were aligned with the individual's readiness for change (MM and RJ). e. The interventions were generic and did not specify who will do what to assist the individual in achieving the stated objective (GS and MM). 3. Individuals diagnosed with cognitive impairments (FA, GM, HS, IW, JD, MJ, ML and RB): a. The IRP did not include a focus statement to address a current diagnosis of R/O Delirium in an individual and no corresponding objectives or interventions were included in the plan (RB). The corresponding psychiatric progress notes did not address this condition. b. There was evidence that the facility's newly revised format for the IRP review, including the update of the present status, was implemented in several individuals diagnosed with cognitive impairments, including Dementia NOS (FA) and Borderline Intellectual Functioning (IW). The format provided an update of the present status consistent with the IRP model. c. The IRP reviews and the psychiatric progress notes did not address/justify the rationale for ongoing high risk medication treatment for an individual diagnosed with Dementia NOS (FA). d. The IRP did not include focus, objective or intervention to address a diagnosis of Dementia NOS (GM, HS and ML). e. Some charts included IRP reviews that did not follow the new format although these IRPs were completed around mid-March 2009 (e.g. CW and GM). f. The focus (problem) statement did not properly address or reconcile the presence of several diagnoses that involve overlapping degrees/types of cognitive dysfunction, including

the following:

i) Dementia NOS, Borderline Intellectual Functioning and Attention Deficit Disorder (HS); and
ii) Mild Mental Retardation and Cognitive Disorder NOS (JD and MJ).

g. In general, the facility did not provide cognitive remediation interventions to meet the needs of individuals diagnosed with cognitive disorders.

This consultant reviewed the charts of several individuals who were transferred to an outside facility for medical care during this reporting period (or had ongoing problems since hospitalization during the last period). The review focused on procedures that facilitate the delivery of medical care that meets the individual's physical needs. The following outlines these reviews:

Initial	Date of evaluation	Date of transfer	Reason for transfer
AH	9/27/08	9/27/08	Bowel obstruction
TH	10/10/08	10/10/08	Hypernatremia
TH	11/26/08	11/26/08	Recurrent hypernatremia
TP	3/30/08	3/30/08	Significant weight loss

In general, the reviews found medical care to be timely and adequate. However, the reviews also found a pattern of process deficiencies that preclude compliance with this requirement at this time. The following are examples:

1. The acceptance note on an individual who returned from hospitalization due to recurrent hypernatremia did not provide any guidance to the interdisciplinary team regarding precautions needed to address poor oral intake in this individual (TH). There was no evidence of formalized behavioral interventions to address

			this individual's needs. The individual required several subsequent hospitalizations for recurrent hypernatremia. 2. The nursing assessment of a change in the status of an individual who complained of abdominal pain did no address timeframes in the development and progression of this condition or specifics regarding physician notification (AH). 3. The physician's transfer evaluation of an individual with questionable bowel obstruction did not address the individual's history of constipation. During the interview, the physician who evaluated the individual was unable to use the AVATAR computerized medication ordering system to review medication changes during the month preceding this individual's condition (AH). This system was in effect at the time of this transfer. 4. There was inadequate documentation by the accepting physician upon the return transfer of an individual S/P abdominal pain due to bowel obstruction (AH). **Compliance:** Partial. **Current recommendations:** 1. *Revise the IRP Manual to ensure the following:* a. *The outline of foci (goals) includes social skills/functional impairments;* b. *Issues of dangerousness and impulsivity are adequately addressed in the IRP;* c. *Operational guidance, including adequate clinical examples, are provided to facilitate the following:* i) *Development of foci, objectives and interventions based on learning outcomes;* ii) *Linkages within the IRP (assessments to case formulation to foci to objectives to interventions);* iii) *Linkage between Mall interventions and IRP objectives;*

			iv) *Strengths formulation for IRP purposes;* v) *Revisions of foci, objectives and interventions to reflect the changing needs of the individuals; and* vi) *Strategies to overcome barriers to individuals' adherence to their IRPs.* 2. *Develop and implement a training module focused on the development of Foci, Objectives and Interventions. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions.* 3. Provide a summary outline of the disciplines participating in the above training and the training process (didactic, observation, feedback to teams) and content. 4. Provide aggregated data on results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions. 5. Develop a Clinical Chart Monitoring Form to include complete indicators and operational instructions to adequately address this requirement. 6. Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least a 20% sample during the review period. 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. 8. *Provide an outline of the following:* a. *Cognitive remediation interventions that are currently provided and plans to increase these interventions.* b. *Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.*

			9. *Develop and implement medical care policies and procedures to address the following:* a. *Requirements for preventive health screening of individuals;* b. *Requirements regarding completeness of all sections of initial assessments, including a plan of care that specifies interventions for identified conditions;* c. *Requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format;* d. *Timeliness and documentation requirements regarding periodic reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks;* e. *Proper physician-nurse communications to ensure the following:* i) *Timely and properly documented nursing assessments;* ii) *Timely and properly documented physician notification; and* iii) *Physician response within timeframes that reflect the urgency of the condition;* f. *Emergency medical response system, including drill practice;* g. *Consultation and laboratory testing to ensure the following:* i) *Communications of needed data to consultants;* ii) *Timely review and filing of consultation and laboratory reports; and* iii) *Follow-up on consultant's recommendations;* h. *Requirements regarding transfer of individuals to outside facilities to ensure the following:* i) *Physician evaluation includes a review of possible contributing factors regarding the individual's status, as clinically appropriate;* ii) *Physician to physician communications upon the transfer regarding the reason for the transfer; and* iii) *Communication of appropriate documents to the outside*

			facility relevant to the reason for the transfer; i. *Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician:* i) *Obtains information from the outside facility that is sufficient for continuity of care;* ii) *Documents a review and assessment of the individual's status and the care provided at the outside facility; and* iii) *Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals* j. *Parameters for physician participation in the IRP process to improve integration of medical and mental health care.*
MES	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);	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Other findings:** The facility has yet to finalize a process of self-auditing to assess compliance with this requirement. **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Current findings on previous recommendation:**

			Recommendation, September 2008: Same as above. **Findings:** Same as above. **Other findings:** The facility has yet to finalize a process of self-auditing to assess its compliance with this requirement. However, a review of a small sample of charts by the facility's compliance officer found that the objectives were often generic, focused on compliance with medications and ward rules or freedom from symptoms or from assaultiveness. The review also found that the objectives did not account for the individual's strengths (e.g. educational levels and work history). The facility concluded that no progress was made since the last review. Chart reviews by this consultant found no progress in the formulation of treatment/rehabilitation objectives. The objectives were not always based on the individual's identified needs, were often vague and/or overinclusive, did not utilize learning outcomes and were not written in behavioral, observable and/or measurable terms. The following are some chart examples: 1. "Self-exploration of behaviors, beliefs, lifestyle" (FG); 2. "Communicate needs to staff" (FG); 3. "Express her concerns as they relate to her recovery to staff" (CG); 4. "Verbalize an understanding of signs and symptoms and treatment options of diagnosed medical problems" (JF and MT); 5. "Will learn about the areas in which she may require treatment or support as evidenced by seeking out help or treatment in those areas and learning skills to manage and compensate for those areas" (CM);

			6. "Will exhibit reduced reaction to internal stimuli, reduced paranoia and modify his behavior to reduce escalation with verbal and physical threats when interacting with family and/or peers and/or staff" (RD); 7. "Productively participate in her treatment plans" (FA); 8. "Engage in a discussion with staff regarding the negative consequences of current behavior and the positive outcome (leaving the hospital) of change" (MK); 9. "Continue demonstrating criteria that suggest she is ready for discharge" (CG); 10. "Continue to take prescribed medications" (FA); and 11. "Take medications as prescribed" (MA). **Compliance:** Noncompliance. **Current recommendations:** Same as above.
MES and RB (PSR/ Mall)	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as above. **Findings:** Same as above. In addition, the revised format of the IRP included information regarding interventions that align with each objective, the type of intervention, its frequency and duration and responsible staff as well as delineation of treatment and skill-building interventions. The facility reported that this format was just being introduced and that no data was available regarding the impact of its use on compliance with this requirement. An earlier review based on the IRP Process Monitoring form (July to September 2008) found that individualized

			interventions for each focus ("problem") were identified in 4% of the cases. **Recommendation 2, September 2008:** Continue with original recommendations. **Findings:** Although training in interdisciplinary recovery planning has been developed and has begun for a number of teams, there was no evidence of specific training regarding the alignment of interventions in the IRP with interventions provided in the treatment malls and the Mall Progress Note. A review of selected records found scant evidence that this alignment is taking place. In over 90% of reviewed records, there was no clear connection between the objective in the individual's IRP, the treatment being provided in the Mall and the progress toward meeting the objective indicated in the IRP. **Recommendation 3, September 2008:** Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective. **Findings:** While this modification has taken place, most reviewed notes merely checked off that progress was not being made without making any suggestions for how to improve the individual's progress toward obtaining the treatment objective. **Recommendation 4, September 2008:** Develop a model for treatment planning that assures that individuals are assigned to particular groups on the basis of assessed needs and Stage of Change rather than simply assigning an individual to a specific

			mall. **Findings:** Not yet begun. **Other findings:** This consultant found that a few charts contained improved formulation of interventions that were linked to appropriately stated strengths (e.g. CM). In addition, there was general evidence of improved documentation of the staff responsible for providing the intervention. However, most charts exhibited a pattern of deficiency regarding this requirement. The following are chart examples of interventions that did not specify who will do what within what timeframes to assist the individual in achieving observable, measurable and/or behavioral objectives: 1. "Health teaching with a focus on the risk factors of diabetes, diet and medication" (JF); 2. "Prescribe meds and assess mental status" (CM); 3. "Supportive counseling" (RD); 4. "Monitor mental status and prescribe and adjust medication as needed" (RD); 5. 1:1 Counseling for encouraging Mr. K to attend all required groups in order to demonstrate his readiness for discharge to a community living setting" (LK); 6. "Encourage patient to participate in groups" (CG); and 7. "Encourage client to take medications and report any untoward side effects" (CG). **Compliance:** Noncompliance.

			Current recommendations: 1. Same as above. 2. *Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Ensure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box.* 3. Make data available both at the individual level, so that progress toward discharge can be appropriately tracked, and at the aggregate level so that performance improvement can be maintained.
MES	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	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Develop and implement a system to track active treatment hours scheduled per week. • Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours. • Provide data regarding the number of active treatment hours per week for all individuals at the facility (October 2008 to March 2009). **Findings:** SEH has yet to utilize its new computerized system (AVATAR) in tracking active treatment hours scheduled and attended. However, the facility presented data regarding individuals attending the Treatment Mall. These data were derived from sign-in sheets that were maintained by group leaders for approximately a one-month period, The data showed that the weekly hours of attendance at the Mall averaged just over three hours and that no one attended the required 20 hours per week.

Recommendations 4-7 September 2008:

- Identify barriers to individuals' attendance at scheduled activities.
- Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.
- Monitor Mall alignment based on at least a 20% sample (October 2007 to March 2009).
- 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.

Findings:
SEH has yet to implement these recommendations.

Other findings:
This monitor reviewed the charts of six individuals to determine the number of active treatment hours per week that the individuals received. The following table outlines the initials of the individuals and the number of intervention hours that were documented in the IRP reviews:

Initials	Number of hours
CK	9.5
DB	6.75
DD	None documented
GS	7.25
MA	9.25
MP	5.5

			The review found that the facility has not made progress in addressing the following: 1. Incomplete documentation of active treatment hours in the IRP reviews; 2. Lack of an adequate system to track the number of active treatment hours per week for all individuals; 3. Lack of information regarding individuals' attendance of and participation in scheduled activities; and 4. Apparent lack of linkage between active treatment hours provided in the Mall and the objectives specified in the IRPs. **Compliance:** Noncompliance. **Current recommendations:** *1. Develop and implement a system to track active treatment hours scheduled per week.* *2. Develop and implement a system to track individuals' attendance of and participation in scheduled active treatment hours.* *3. Provide data regarding the number of active treatment hours per week for all individuals at the facility during the review period.* *4. Identify barriers to individuals' attendance at scheduled activities.* *5. Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.* 6. Monitor Mall alignment based on at least a 20% sample (October 2007 to March 2009). 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.
MES	V.D.6	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in V.D.1 through V.D.5. **Findings:** Same as in V.D.1 through V.D.5. **Compliance:** Noncompliance. **Current recommendations:** Same as in V.D.1 through V.D.5.

	E. Outcome-Driven Treatment Planning		
		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:	Please see sub-cells for findings and compliance.
MES	V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Revise the Policy #602.2-04, Treatment Planning and/or finalize a manual to address this monitor's findings above. **Findings:** The revised policy regarding IRP contained instructions to revise the foci, objectives and interventions to reflect the individual's changing needs. However, the IRP Manual did not provide operational guidance with clinical examples to facilitate implementation of this requirement. **Recommendation 2, September 2008:** Ensure that the training modules regarding Foci/Objectives/ Interventions and Stages of Change provide operational guidance regarding the processes of reviewing and revising the IRPs. **Findings:** The facility presented the same information that was reported under similar recommendations for training of the IRP teams in the engagement of individuals (V.B) and development of case formulation (V.C) and foci, objectives and interventions (V.D). **Recommendation 3, September 2008:** Revise the IRP Process Observation and Clinical Chart Monitoring Forms to include complete indicators and operational instructions to

			adequately address this requirement. **Findings:** The revised IRP Process Observation Form (February 2009) appropriately addressed the individual's input into (and the team leader's facilitation of) the processes of review and revision of the foci, objectives and interventions. However, the facility has yet to develop a Clinical Chart Audit Form to address the appropriateness/content of the revisions in response to the changing needs of the individuals. **Recommendation 4, September 2008:** Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least a 20% sample (October 2008-March 2009). **Findings:** As mentioned above, the revised IRP Process Form was finalized in February 2009. Limited data based on the new tool showed that the individuals provided input into the review/revision of the objectives in 82% of the cases and the review/revision of the interventions in 47% of the cases. The facility has yet to utilize a Clinical Chart Audit to provide information regarding the content of the revised objectives/ interventions. **Recommendation 5, September 2008:** 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.

Findings:
SEH has yet to present the requested information.

Other findings:
This consultant reviewed the charts of eight individuals to assess the process of revising objectives as clinically indicated. The following table outlines the initials of the individuals and the dates of reviews of the IRPs:

Initials	IRP reviews
CG	11/19/08, 1/22/09, 3/18/09
FG	11/25/08, 1/15/09, 2/9/09
AK	12/15/08, 1/16/09, 3/17/09
QV	11/13/08, 1/12/09, 3/9/09
AB	9/12/08, 12/11/08, 3/12/09
KR	10/22/08, 1/23/09, 3/11/09
JD	10/17/08, 1/12/09, 3/13/09
GS	11/6/08, 1/9/09, 3/13/09

There was evidence in most charts that the treatment teams have revised the objectives in an effort to address the changing needs of the individuals. However, the foci/objectives/interventions (initial and revised) contained the same patterns of deficiencies that were outlined in sections V.D.1 through V.D.4.

Compliance:
Partial.

Current 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.*

			2. *Develop a Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement.* 3. Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least a 20% sample during the review period. 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.
MES	V.E.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in V.E.1. **Findings:** Same as in V.E.1 **Recommendation 2, September 2008:** Implement the schedule of IRP reviews as specified in the revised policy. **Findings:** The revised policy regarding IRP required the review of the IRPs on the 14th calendar day of the admission, the 30th calendar day of the admission, the 60th calendar day of the admission and every 60 days thereafter. In addition, the facility required a review of the IRP by the clinical administrator every 30 days (see next recommendation) to ensure compliance with this requirement. Since January 2009, the facility has also required monthly disciplinary notes (nursing is pending)

			to include evaluation of the effectiveness/accuracy of foci, objectives and interventions. The facility conducted a review of the completion of these monthly notes in February 2009 but data were not presented due to methodological errors in data gathering. **Recommendations 3 and 4, September 2008:** • Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines. • Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions. **Findings:** SEH has yet to implement these recommendations. **Other findings:** Chart reviews by this monitor found that the facility has yet to implement monthly reviews of the IRPs. **Compliance:** Noncompliance. **Current recommendations:** 1. Same as in V.E.1. 2. Implement the schedule of IRP reviews as specified in the revised policy. 3. Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines. 4. Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.
MES	V.E.3	review the goals, objectives, and interventions	**Current findings on previous recommendation:**

		more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;	**Recommendation, September 2008:** Same as in V.E.1. **Findings:** Same as in V.E.1. **Other findings:** The revised policy regarding IRP codified this requirement. In February 2009, SEH reviewed a sample of 24 episodes of seclusion and/or restraint. The review found that documentation of debriefing by the IRP teams on the day following seclusion and/or restraint occurred only in 5% of the cases and review and modification of the interventions to reduce the risk of future use of restrictive interventions occurred in none of the cases. SEH has developed a template for the psychiatric reassessment (update) including an evaluation of the use of seclusion and/or restraints. If properly implemented, this form can facilitate updates of the IRP in response to high risk situations. This monitor reviewed the charts of six individuals who have experienced the use of seclusion and/or restraints during this reporting period. The following outlines initials of the individuals, dates of the restrictive intervention(s) and dates of subsequent review of the IRPs:

Initials	Date(s) of seclusion and/or restraints	Date of subsequent review of the IRP
CK	11/14/08	12/1/08
DB	11/8/08	11/19/08
DD	11/7/08	12/19/08
GS	12/17/08	1/13/09

			<table><tr><td>MP</td><td>10/9/08</td><td>12/9/08</td></tr></table> This review found a persistent pattern of deficiencies in the following areas: 1. Documentation of the specific circumstances, including contributing factors that led to the use of the restrictive intervention; 2. Discrepancy between the information documented in the IRP section regarding progress towards goals and the recent use of restrictive interventions following inter-unit transfer of the individual (DD); 3. Documentation of unsuccessful treatments provided in an effort to avert the use of these interventions; and 4. Documentation of modifications to regular treatment (psychiatric and/or behavioral) to decrease the risk of future application of these measures. As a corrective action, the facility developed a new format to ensure proper update of the case formulation. If properly implemented, this format can adequately address the above deficiencies. **Compliance:** Partial. **Current recommendation:** Same as in V.E.1.
MES	V.E.4	provide that the review process includes an assessment of progress related to discharge; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that the treatment planning policy and/or manual provide operational specifics regarding the formulation of discharge criteria and documentation of the present status of individuals in terms of

			progress towards discharge. **Findings:** SEH has implemented the following process improvements: 1. The revised policy regarding IRP contained instructions regarding discharge planning. 2. The IRP Manual contained instructions to review the discharge status of the individual as part of the update of the present status section of the case formulation. 3. The revised IRP format contains a dedicated domain for discharge planning as one of the foci of hospitalization. 4. The newly developed template for the Social Work Initial Assessment includes a format that facilitates the development of individualized discharge criteria in several domains. However, the revised policy did not provide instruction to individualize the discharge criteria. In addition, the Manual did not provide operational guidance with clinical examples to facilitate the development of individualized discharge criteria and did not include strategies to work with individuals who are non-adherent to their IRPs in order to facilitate community reintegration. **Recommendations 2-4, September 2008:** • Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. • Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). • Provide aggregated data regarding results of competency-based training of all core members of the treatment team.

Findings:
The facility presented the same information that was reported under similar recommendations for training of the IRP teams in the engagement of individuals (V.B) and development of case formulation (V.C) and foci, objectives and interventions (V.D).

Recommendation 5, September 2008:
Revise current IRP Process Observation and Clinical Chart Monitoring forms include complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning.

Findings:
The revised IRP Process Observation Form included adequate indicators regarding the processes of discharge planning. The facility has yet to develop to develop a Clinical Chart Monitoring Form to assess the content of discharge planning.

Recommendation 6, September 2008:
Monitor this requirement using both process observation and clinical chart audit tools based on at least a 20% sample (October 2008 to March 2009).

Findings:
Based on limited IRP process data (February 2009), the facility reported the following compliance data:

1.	Discharge barriers were addressed in the IRP meeting	71%
2.	The individual had an opportunity to be active participant in the discharge planning discussion	89%

Recommendation 7, September 2008:

			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. **Findings:** SEH has yet to present the requested information. **Other findings:** This consultant reviewed the charts of six individuals (BW, DD, JL, JL-2, MH and TN). In the charts that utilized the older format of the IRP (BW, DD, JL-2, MH and TN), the review found that the treatment plan section of discharge planning was blank in three cases (BW, DD and MH). In these charts, the social work assessments included discharge criteria. However, the criteria were generic and did not utilize any learning outcomes, e.g. "Patient to present with the ability to manage her activities of daily living and be compliant with medication;" "Patient to be able to control her impulses and aggressive behavior when she has a desire to kick and swing or pace the floor, crashing into the wall;" or "Patient to present with ability to comply with ward rules and policies." The chart of JL-2 included some criteria that reflected an attempt by the team to individualize the criteria In the chart that utilized the facility's new format of IRP (JL) no discharge criteria were documented in the current plan that was reviewed by this consultant **Compliance:** Partial. **Current recommendations:**

			1. *Ensure that the policy regarding IRP provides instruction to individualize the discharge criteria.* 2. *Revise the IRP manual to provide operational guidance with clinical examples to facilitate the individualization of discharge criteria.* 3. *Revise the IRP manual to include strategies to increase the motivation of individuals to participate in their IRPs.* 4. *Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions* 5. Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content. 6. Provide aggregated data regarding results of competency-based training of all core members of the treatment team. 7. Develop Clinical Chart Monitoring form including complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning. 8. Monitor this requirement using both process observation and clinical chart audit tools based on at least a 20% sample during the review period. 9. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:**

			Same as in V.A.1 to V.A.1.5. **Findings:** Same as in V.A.1 to V.A.1.5. **Recommendation 2, September 2008:** Same as in V.B.1. **Findings:** Same as in V.B.1. **Recommendation 3, September 2008:** Same as in V.E.4. **Findings:** Same as in V.E.4. **Recommendation 4, September 2008:** Fully implement the new template for the Monthly Therapy Progress Note. **Findings:** SEH reported that the note was available on the facility's intranet and being implemented. No data were presented regarding completion of this note and integration of the information in the IRP reviews. **Other findings:** SEH developed and began implementation of a standardized progress note that addressed individuals' attendance and participation in Mall groups. However, the consultants' observations of the treatment team meetings indicated that the teams did not conduct a data-based review of the individuals' progress in active treatment provided at the Mall. Other process deficiencies (see other findings in V.B.1) also

			contributed to inadequate implementation of this requirement. **Compliance:** Partial. **Current recommendations:** 1. Same as in V.A.1 to V.A.1.5. 2. Same as in V.B.1. 3. Same as in V.E.4. 4. Fully implement the new template for the Monthly Therapy Progress Note.

	VI. Mental Health Assessments		
MES and RB		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.	**Summary of Progress:** 1. SEH developed Policy #602.1-08, Assessment. With minor exceptions, this policy comports with requirements of this Agreement. 2. SEH developed adequate templates for the comprehensive initial psychiatric assessment and psychiatric update (reassessment). The facility began implementation of these templates in January and February 2009, respectively. SEH also developed an adequate self-auditing tool to assess implementation of the comprehensive initial psychiatric assessment. 3. SEH conducted a follow-up self-assessment that offered a candid assessment of current status and some corrective measures needed towards compliance with requirements of the Agreement. 4. The Initial Psychology Assessment, the Initial Social Work Assessment and the Rehabilitation Services Assessments that have been developed and implemented over the last six months are adequate in meeting the requirements of the Agreement. Some specific recommendations for minor improvement, clearer instructions and the use of audit data can be found in specific sections below.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: 1. Bernard Arons, M.D., Medical Director. 2. Carmin Delballe, M.D., Staff Psychiatrist. 3. Gerard Fegan, Staff Psychiatrist. 4. Sumit Anand, M.D., Medical Director, Civil Service. 5. Tehmina Sheikh, M.D., Staff Psychiatrist. Reviewed: 1. Charts of the following 26 individuals: AB, AF, AS, BA, BP, CG, CK, CM, FA, HS, IW, JH, JP, JT, JW, LM, MJ, MK, ML, MM, PT, RB, RJ, RM, TVN and WK. 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (February 27, 2009). 3. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians. 4. SEH Policy #602.1-08, Assessments, effective February 23, 2009. 5. SEH Policy #601-02, Medical Records, revised February 27, 2009. 6. SEH template for the Comprehensive Initial Psychiatric Assessment, revised February 12, 2009. 7. SEH template for Psychiatric Update, revised February 13, 2009. 8. SEH IRP Process Monitoring Tool, revised February 6, 2009. 9. SEH Comprehensive Initial Assessment Psychiatric Self-Audit Tool. 10. SEH Operational Instructions for Psychiatric Assessment Self-Auditing Tool. 11. Recognizing and Reporting Patient Abuse and Neglect: SEH Mandatory All-Staff Training. 12. SEH data regarding current psychiatric staffing. 13. Memorandum from SEH Directors of Residency Training and Medical Student Education, March 31, 2009.

			Observed: 1. IRP team meeting at RMB-3 for review of GC. 2. IRP team meeting at RMB-3 for review of FP. 3. IRP team meeting at RMB-5 for review of ME. 4. IRP team meeting at RMB-6 for review of SB. 5. IRP team meeting at JHP-1 for 60-day review of JC. 6. IRP team meeting at JHP-3 for review of RJ. 7. IRP team meeting at JHP-6 for review of MK. 8. IRP team meeting at JHP-10 for review of WK.
MES	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Revise and implement Policy #602.1-08 including appropriate timeframes for the completion of the psychiatric reassessments, templates for the comprehensive psychiatric assessment and the psychiatric reassessments and guidelines for the completion of the assessments/reassessments. **Findings:** SEH has revised its policy #602.1-08, Assessments (February 23, 2009). This consultant's review found the following process improvements: 1. As in the previous policy, the revised version contained appropriate timeframes for completion of the initial and comprehensive psychiatric assessments. 2. The revised template for the initial psychiatric assessment met generally accepted standards, including a new section for a plan of care. The facility began implementation of this template in January 2009. 3. The newly developed template for psychiatric updates met generally accepted standards. Implementation of this template

			reportedly began at the end of February 2009. 4. The newly developed Operational Instructions for Psychiatric Assessment Self-Auditing Tool can serve as adequate guideline to practitioners for completion of the initial comprehensive psychiatric assessment. The facility also revised Policy #601-02, Medical Records (February 27, 2009) to include a requirement for documentation of the psychiatric progress notes weekly during the first 60 days of admission and monthly thereafter. These timeframes were appropriate. However, the facility has yet to address the following findings: 1. The revised policy regarding Assessments contained timeframes for completion of the psychiatric reassessments of "at least two business days prior to the scheduled IRP meeting or whenever there has been a change in the patient's status or a lack of expected improvement from clinically indicated treatment." timeframes should align with the required frequency stated in the Medical Records policy. 2. There were no guidelines for completion of the psychiatric update. 3. The newly revised and developed instruments did not ensure the integration of additional information that becomes available following admission to the facility to permit a more complete review/assessment. This information should include but not be limited to psychosocial history, substance abuse history, psychiatric risk factors, strengths, diagnostic formulation, differential diagnosis, and management of identified additional risks. **Recommendation 2, September 2008:** Ensure that the template for the initial psychiatric assessment includes a plan of care that addresses medications (regular and PRN) and precautions to ensure safety of the individual and others pending

			completion of the comprehensive assessment. **Findings:** As mentioned above, SEH has implemented this recommendation. **Recommendation 3, September 2008:** Develop and implement self-monitoring tools, including indicators and operational instructions, that address the timeliness and content requirements for the initial psychiatric assessment (24 hours),admission psychiatric assessment (by fourth day) and psychiatric reassessments. **Findings:** SEH developed an audit tool that reflected the content requirements of the initial comprehensive psychiatric assessment. The facility began implementation of this audit in February 2009. SEH has yet to develop an auditing system for the content of the psychiatric update (reassessment). The revised IRP Process monitoring form addressed the timeliness of the initial assessments and reassessments. However, the timeframe for the reassessments was not aligned with the required frequency as stated in the Medical Records policy. **Recommendation 4, September 2008:** Provide monitoring data regarding psychiatric assessments and reassessments based on at least a 20% sample. **Findings:** SEH has yet to present data based on the revised Assessment and Medical policies. Very limited data (January 2009) showed 100% compliance with the requirement for completion of the initial assessment within 24 hours of admission.

			Recommendation 5, September 2008: 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. **Findings:** SEH has yet to present the requested information. **Other findings:** Chart reviews by this monitor found that in general, the admission psychiatric assessments and the psychiatric reassessment still fall short of compliance with the requirements of the Agreement as illustrated by findings in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. **Compliance:** Partial. **Current recommendations:** 1. *Ensure the revised policy for Assessments contain timeframes for the completion of the psychiatric reassessments that align with the revised policy, Medical Records.* 2. *Develop guidelines for completion of the psychiatric update and self-auditing of these updates.* 3. *Ensure the integration of additional information that becomes available following admission to the facility to permit a more complete review/assessment. This information should include, but not be limited to, psychosocial history, substance abuse history, psychiatric risk factors, strengths, diagnostic formulation,*

			differential diagnosis, and management of identified additional risks. 4. *Ensure consistent and full implementation of the new templates for initial comprehensive assessments and psychiatric updates.* 5. Provide monitoring data regarding the timeliness and content of psychiatric assessments and reassessments based on at least a 20% sample during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures. 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.
MES	VI.A.2	By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as VI.A.1. **Findings:** Same as VI.A.1. **Recommendation 2, September 2008:** Implement an admission risk assessment that integrates the information in the initial psychiatric assessment and psychological screening tools. **Findings:** The facility has revised its templates for the initial psychiatric and psychological assessments, each containing a different risk assessment system. The revised comprehensive IRP form also included an

			assessment of risk factors, apparently based on these two tools as well as other factors. The facility has yet to ensure an integrated risk assessment process to avoid discrepant findings and implications for treatment. **Recommendation 3, September 2008:** Ensure that the monitoring tool regarding the initial psychiatric assessment includes complete indicators and operational instructions to address risk assessment. **Findings:** The new self-auditing tool regarding the initial comprehensive psychiatric assessment includes adequate indicators and operational instructions focused on risk assessment. **Recommendations 4 and 5, September 2008:** • Monitor risk assessment as part of the initial psychiatric assessment m, based on at least a 20% sample (October 2008 to March 2009). • 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. **Findings:** SEH has yet to present the requested information. **Compliance:** Partial. **Current recommendations:**

			1. *Same as VI.A.1.* 2. *Ensure an integrated system of admission risk assessment (psychiatric and psychological).* 3. Monitor risk assessment as part of the initial psychiatric assessment, based on at least a 20% sample during the review period. 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.
MES	VI.A.3	By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in VI.A.1 and VI.A.6. **Findings:** Same as in VI.A.1 and VI.A.6. **Recommendation 2, September 2008:** Develop and implement monitoring tools regarding psychiatric assessments and reassessments, including complete indicators and operational instructions that address diagnostic accuracy. **Findings:** The newly developed audit for the initial comprehensive psychiatric assessment included adequate indicators regarding diagnostic accuracy. The facility began implementation of this audit in February 2009, but has yet to develop a similar system for diagnostic accuracy in the psychiatric reassessments (updates).

			Recommendations 3 and 4, September 2008: • Provide data regarding diagnostic accuracy based on at least a 20% sample of psychiatric assessments and reassessments (October 2008 to March 2009). • 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. **Findings:** SEH has yet to present the requested information. **Other findings:** This monitor reviewed the charts of individuals who have received diagnoses listed as NOS for three or more months during this reportable period. The review found some improved documentation in the following areas: 1. Cognitive deficits in some individuals receiving unspecified diagnoses of cognitive impairments (e.g. JD); and 2. Finalization of diagnoses of impulse control disorder NOS (e.g. AB) and Psychotic Disorder NOS (e.g. BG, JF and JR) in some charts. However, the review found a general pattern of deficiencies in the documentation of efforts to finalize the diagnosis, as indicated; the assessment of the cognitive impairments, as indicated; and/or alignment of the diagnostic information in the current IRP with the corresponding psychiatric progress notes. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the chart reviews:

<table>
<tr>
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<table>
<tr><th>Initials</th><th>Diagnosis</th></tr>
<tr><td>JH</td><td>Psychotic Disorder NOS</td></tr>
<tr><td>JW</td><td>Psychotic Disorder NOS</td></tr>
<tr><td>RJ</td><td>Impulse Control Disorder, NOS</td></tr>
<tr><td>FA</td><td>Dementia NOS</td></tr>
<tr><td>HS</td><td>Dementia NOS</td></tr>
<tr><td>ML</td><td>Dementia NOS</td></tr>
<tr><td>MJ</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>MK</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>MM</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>CM</td><td>Mood Disorder, NOS and Cognitive Disorder NOS</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Same as in VI.A.1 and VI.A.6.
2. Develop and implement monitoring indicators regarding diagnostic accuracy in the psychiatric reassessments.
3. Provide data regarding diagnostic accuracy based on at least a 20% sample of psychiatric assessments and reassessments during the review period.
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.
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<tr>
<td>MES</td>
<td>VI.A.4</td>
<td>By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Same as above.</td>
</tr>
</table>

			Findings: Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	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;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.1 and VI.A.2. **Findings:** Same as in VI.A.1 and VI.A.2. As mentioned earlier, SEH developed an adequate template for the comprehensive initial psychiatric assessment. The template met generally accepted standards, including risk assessment, strengths formulation and plan of care, including high risk medication uses, specific behavioral/psychosocial interventions and specific risk reduction interventions. SEH also developed an adequate self-auditing tool to assess implementation. However, the facility has yet to present data regarding implementation of the comprehensive initial psychiatric assessment. **Other findings:** Chart reviews by this monitor confirmed that the facility began implementation of the new initial comprehensive admission assessment template in January 2009. The reviews found that in general, this template improved the quality of the assessments, but deficiencies

			were noted: 1. No information was provided regarding the individual's thought content in the absence of psychotic symptoms; and 2. The strengths formulation was mostly generic and did not provide information that could be utilized in treatment planning. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.1 and VI.A.2.
	VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
MES	VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.1, VI.A.3 and VI.A.6. **Findings:** Same as in VI.A.1, VI.A.3 and VI.A.6. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.1, VI.A.3 and VI.A.6.
MES	VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist	**Current findings on previous recommendations:** **Recommendations 1, September 2008:**

		must review the content of these assessments and write a note to accompany these assessments;	Provide self-assessment data regarding implementation of this requirement. **Findings:** SEH has yet to present the requested information. The newly developed self-audit tool regarding the comprehensive initial psychiatric assessment did not adequately address this requirement. **Recommendation 2, September 2008:** Ensure that all trainees are properly oriented to the facility's procedures regarding identification and reporting of abuse/neglect. **Findings:** SEH reported that since the last review, it has provided orientation to its trainees regarding the facility's procedures for identification and reporting of abuse/neglect. However, the facility did not present verifying data. **Other findings:** SEH has maintained a facility-based residency training program. In addition, the facility has continued to serve as the primary training site for two forensic psychiatry fellows from Georgetown University. SEH has also continued to provide a core psychiatry rotation for medical students from local universities, including Howard University, Georgetown University and the Uniformed Services University Schools of Medicine. Chart reviews found general evidence that the attending physicians countersigned the notes completed by the trainees. However, there was no evidence of other documentation by the physicians even when the trainees' notes raised diagnostic and treatment questions that required follow-up. In its self-assessment report, SEH acknowledged that it is still common practice for attending physicians to countersign

			the notes without any other documentation. **Compliance:** Partial. **Current recommendations:** 1. *Provide information to specify how all trainees, including students and residents, have been oriented to the facility's policy and procedure regarding the recognition and reporting of patient abuse and neglect.* 2. *Implement corrective actions to ensure that attending physicians follow up on diagnostic and treatment questions/issues raised in notes written by trainees and provide documentation of the follow-up.* 3. Provide self-assessment data regarding implementation of this requirement.
MES	VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4. **Recommendations 2&3, September 2008:** Provide CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders. Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation. **Findings:**

			SEH was in the process of implementing these recommendations at the time of this tour. **Recommendation 4, September 2008:** Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS. **Findings:** The facility established a database to track current diagnoses for its individuals, but did not provide further specific information regarding this recommendation. **Other findings:** Same as in VI.A.3. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.* 2. *Provide CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.* 3. *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliations.* 4. *Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS.*
MES	VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.1 through VI.A.6.a and VI.6.c.

			Findings: Same as in VI.A.1 through VI.A.6.a and VI.6.c. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.1 through VI.A.6.a and VI.6.c.
MES	VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in VI.A.1. **Findings:** Same as in VI.A.1. **Recommendation 2, September 2008:** Develop and implement a standardized format for psychiatric reassessments that addresses and corrects the deficiencies identified above. **Findings:** As mentioned earlier, SEH revised its policy regarding assessments. The new policy included requirements regarding the content of the psychiatric updates (reassessments). The facility also developed a new template for the psychiatric update. The revised policy requirements and the template addressed most of the deficiencies that were outlined in the previous report. The facility has yet to implement the new template and to provide self-assessment data regarding this implementation. SEH used the revised IRP Process Observation Form (February 2009)

			to assess compliance with the timeliness requirements of the psychiatric reassessments. However, the data were not presented due to methodological errors. **Other findings:** This consultant reviewed the charts of 19 individuals (AB, AF, AS, BA, BP, CG, CK, CM, IW, JP, JT, LM, MJ, MM, PT, RB, RM, TVN and WK). The reviews found that most of the charts did not utilize the facility's new template for psychiatric updates. In general, these charts contained reassessments that did not meet most of the required elements. The reassessments showed the same pattern of deficiencies that was outlined in the previous report. The main areas of deficiencies were noted to be: 1. Review of interval history; 2. Delineation of current target symptoms and mental status findings; 3. Update of diagnosis as clinically indicated; 4. Critical review of risks and benefits of current treatment; 5. Review of relevant laboratory findings; 6. Critical review of the use of high risk medication regimens, including benzodiazepines, anticholinergic medications and/or new generation antipsychotics 7. Timely and appropriate modification of interventions in order to minimize the risk of restrictive interventions. 8. Critical review of PRN/Stat medication use; and 9. Integration of pharmacological and behavioral modalities. In the charts that utilized the new template for the psychiatric update, there was general evidence of improved documentation of subjective complaints and current target symptoms, mental status examination findings, review of risks associated with pharmacological treatment, review of PRN/Stat medication, review of the use of restrictive interventions, current diagnosis, current medications and

			plan of care. However, the facility has yet to ensure quality improvements in the content of these reassessments, particularly in the following areas: 1. Adequate review of important events during the interval; 2. Review of relevant laboratory findings and integration of this information in an individualized risk benefit assessment of pharmacotherapy; 3. Timely and appropriate modification of interventions in order to minimize the risk of restrictive interventions; and 4. Integration of pharmacological and behavioral modalities **Compliance:** Partial. **Current recommendations:** *1. Ensure consistent implementation of the new template for the psychiatric update.* *2. Implement corrective actions to ensure that the content of the psychiatric updates meets all requirements of this Agreement.* *3. Same as in VI.A.1.*

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Interview with Rosemary Patterson, Ph.D., Chief of Psychology Reviewed: 1. Psychology Department Draft Manual 2. Psychology Department 3. Psychology Department Performance Improvement Roll Out Schedule 4. Charts of the following 20 individuals: AB, AP, DT, DW, EO, HE, HM, JD, LB, ME, MM, RB, RH, SB, SC, TB, TJ, TM, WJ and WM Observed: 1. Treatment team for JC 2. Treatment team for ME 3. Treatment team for SB 4. Treatment team for WK **5.**
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement a policy governing the appropriate timelines for the completion of referrals for all psychological assessments. Since the monitoring of all psychological assessments falls within the purview of the Psychology Department, the hospital should consider reorganization so that the neuropsychologist reports through the Chief of Psychology. **Findings:** Time frames have been developed for all psychological assessments and a review of records indicates that over 90% are completed in the

			required timeframe. The exception to this is for neuropsychological evaluations. In the case of these evaluations, over 50% of reviewed records found a delay of 30-60 days between the completion of the last testing session and the signing of the report. In several instances, this prevented the evaluation from being returned to the team before the individual was discharged from the hospital. Additionally, in each of these cases, the evaluation was not found in the discharge record. Finally, while a tracking system has been developed to monitor compliance of psychological evaluations with the required timeframes for completion, no systematic reporting of this data is currently occurring. Standard templates have also been developed for all psychological assessments/evaluations that meet the standards of the Agreement. A roll out schedule for monitoring these assessments was presented. Guidelines for all of these templates were adequate except for the Initial Psychological Assessment (IPA), in which the guidelines lacked clarity about the specificity of recommendations that needed to be provided by the psychologist completing the IPA. **Recommendation 4, February 2008:** Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools) that address the psychological assessment process. At a minimum, monitor: a. Timeliness of the assessment process as per yet to be established policy guidelines; b. The quality of each section of the evaluation; c. The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record; and d. The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation.

			Findings: Initial data on the IPA was presented but it did not meet the above recommendations. Timeliness and quality monitoring of other psychological assessments is planned for in the performance improvement roll out schedule for the department. **Recommendation 2, September 2008:** Develop policy and practice guidelines that assure that reading level is reported as a grade level in all psychological evaluations/IPAs. **Findings:** These guidelines were developed and those IPAs dated after the policy had been developed were found to be in compliance. **Recommendation 3, September 2008:** Complete the Psychology Department Manual to assure that guidelines are given for how to meet each relevant item of the agreement as it concerns psychology assessments. **Findings:** Completed. **Recommendation 4, September 2008:** Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment. **Findings:** Although the guidelines for the IPA indicate that this is appropriate to review in the individual's history, no specific prompts for head/brain injury have been included in the IPA itself. **Compliance:**

			Partial. **Current recommendations:** 1. *Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools)* ***according to the planned roll out schedule*** *that address the psychological assessment process. At a minimum, monitor:* a. *Timeliness of the assessment process as per yet to be established policy guidelines;* b. *The quality of each section of the evaluation;* c. *The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record; and* d. *The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation.* 2. Present the above as trended data. 3. *Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment.* 4. *Develop a FTE for neuropsychology that assures full time coverage of this service.*
	VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments shall:	Please see sub-cells for findings and compliance.
RB	VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue present practices. **Findings:**

			Compliance: Substantial. **Current recommendation:** Continue current practice.
RB	VI.B.2.b	be based on current and accurate data;	**Findings:** All reviewed assessments appeared to be based on both current and accurate data. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
RB	VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Findings:** Acceptable level of practice continued to be found on this item. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop clear guidelines for the Conclusions and Recommendations sections of all psychological assessments and screenings. **Findings:** Completed satisfactorily for all psychological assessments except the

			IPA. **Compliance:** Partial. **Current recommendation:** *Develop clear guidelines for the Conclusions and Recommendations sections of the IPA.*
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue all past recommendations. **Findings:** The guidelines for the various psychological assessments/evaluations include appropriate instructions for indicating the empirical basis of conclusions. **Compliance:** Substantial. **Current recommendation:** Continue current level of practice.
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement a timeline for the completion of this item of the agreement. **Findings:** Timeline has been developed. Process is supposed to be completed by

			08/31/09. **Recommendation 2, February 2008:** Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment (see cell VI.B.1). **Findings:** Not yet begun. **Compliance:** Partial. **Current recommendations:** 1. *Implement developed timeline.* 2. *Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment.*
RB	VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Current findings on previous recommendations:** The policy has been developed. **Recommendation 2, September 2008:** Assure that reading levels reported in the IPA use grade level equivalencies. **Findings:** Policy was implemented and charts of individuals reviewed following policy change had reading level expressed as a grade level.

			Compliance: Substantial. **Current recommendation:** Continue current level of practice.
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop policies and procedures that address the process by which psychological assessment results are directly communicated to the treatment team and such communication is noted in the individual's medical record. **Findings:** Each psychological assessment template now includes a section for the psychologist to document the reporting of the assessment results to the treatment team. **Recommendation 2, February 2008:** Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments other than the IPA, including whatever rationale might exist for not following those recommendations. **Findings:** Not yet begun. **Recommendation 3, February 2008:** Monitor through chart auditing tools for fidelity to these processes. **Findings:** Not yet begun.

			Compliance: Partial. **Current recommendations:** 1. *Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations.* 2. Monitor through chart auditing process that treatment teams document their response to the results of psychological assessments other than the IPA.

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: 1. Crystal Robinson, Forensic Rehabilitation Services Chief 2. Michelle Coleman, Civil Rehabilitation Services Chief Reviewed: 1. Charts of the following 16 individuals: AH, AL, AW-B, FM, JC, JH, MC, ME, PD, PW, SB, SG, TT, WB, WC and WK 2. Rehabilitation Services Therapeutic Progress Note Self Auditing Tool 3. Rehabilitation Services Therapeutic Progress Note Operational Instructions 4. Rehabilitation Services Therapeutic Progress Note Self Auditing Data – Civil Side Observed: 1. Treatment Team Conference for JC 2. Treatment Team Conference for ME 3. Treatment Team Conference for SB 4. Treatment Team Conference for WK
RB	VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement 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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Implement the newly revised Rehabilitation Services Assessment (RSA) across all admission units. The newly designed assessment provides important material for the functional assessment of individuals that is critical to determining their level of care while in the hospital and upon discharge. **Findings:**

			The new RSA has been implemented across all admission units; however, lack of full staffing impedes it consistent use. **Recommendation 2, February 2008:** Develop and implement an auditing tool that monitors the medical record for the presence, timeliness and quality of the Initial RT Assessment. **Findings:** An auditing tool was developed and implemented. The Hospital's data indicated that the RSA had been found and satisfactorily completed in 90% of reviewed records for the civil division. Data from the forensic side was not provided. This consultant's review found a similar rate of compliance for the civil division. **Recommendation 3, February 2008:** Auditors must be trained to reliability. **Findings:** Reliability data was presented and found to be acceptable. **Recommendation 4, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Completed. **Other findings:** There is not adequate RT staff to assure that RSAs are completed on all newly admitted individuals according to timelines in hospital policy. RT staff are expected to provide the majority of group treatments in the malls and, while discussion about required treatment hours for the

			other disciplines has begun, there is not yet a policy addressing the required number of mall treatment hours for the other clinical disciplines. As a result, RT staff are providing mall groups at the times that most teams have scheduled their treatment planning conferences. **Compliance:** Partial. **Current recommendations:** 1. *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* 2. Audit and present data from forensic charts as well. 3. *Develop policies so that all clinical disciplines are providing a required number of mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.*
RB	VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	Please see sub-cells for compliance findings.
RB	VI.C.2.a	be accurate as to the individual's functional abilities;	**Findings:** The newly implemented RSA provides for an accurate assessment of the individual's functional ability, and both the Hospital's data and an independent chart review found that this section of the RSA is being completed accurately. Improvements in compliance rating await increase to staffing levels so that RSA can be routinely utilized with all civil and forensic individuals. **Compliance:** Partial. **Current recommendations:**

			1. *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* 2. *Audit and provide data for forensic as well as civil units.*
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Findings:** The newly implemented RSA provides for an accurate assessment of the individual's life skills prior to, and over the course of, the mental illness or disorder, and both the Hospital's data and an independent chart review found that this section of the RSA is being completed accurately. Improvements in compliance rating await increase to staffing levels so that RSA can be routinely utilized with all civil and forensic individuals. **Compliance:** Partial. **Current recommendations:** 1. *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* 2. *Audit and provide data for forensic as well as civil units.*
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Findings:** The newly implemented RSA provides for an accurate assessment of the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses, and both the Hospital's data and an independent chart review found that this section of the RSA is being completed accurately. Improvements in compliance rating await increase to staffing levels so that RSA can be routinely utilized with all civil and forensic individuals. **Compliance:**

			Partial. **Current recommendations:** 1. *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* 2. *Audit and provide data for forensic as well as civil units.*
RB	VI.C.2.d	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	**Findings:** The newly implemented RSA provides for a recommendation for specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive. While the hospital's auditing data indicated 100% compliance for this in their review of records, this consultant found that compliance was only achieved in 80% of reviewed records. While this may reflect sampling error, both of the RS chiefs were clear that better instruction about how to complete this section may be helpful. Additionally, further improvements in compliance rating await increase to staffing levels so that SRA can be routinely utilized with all civil and forensic individuals. **Compliance:** Partial. **Current recommendations:** 1. *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of RSAs.* 2. *Revise that section of the instructions for the RSA to indicate the need for recommendations to include specific and individualized strategies.* 3. *Audit and provide data for forensic as well as civil units.*
RB	VI.C.3	By 24 months from the Effective Date hereof,	**Current findings on previous recommendations:**

		rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment.	**Recommendation 1, February 2008:** Develop and implement a plan to address this issue. **Findings:** A timeline has been developed and implementation is expected to be complete by 12/31/08. **Recommendation 2, February 2008:** Utilize some version of the audit tool referenced in cells VI.C.2.a through VI.C.2.d for use in this review process. **Findings:** Audit tool has been developed. **Recommendation 3, February 2008:** Develop and implement a plan for the provision of treatment mall services to all forensic individuals. **Findings:** Some individuals with forensic status continue to attend treatment malls on the civil side, and a clear plan for the implementation of treatment mall services for all individuals with forensic status has been developed with estimated completion by 08/29/08. **Compliance:** Partial. **Current recommendations:** 1. *Continue to implement timeline for providing an RSA for all individuals previously admitted to the Hospital.* 2. *Continue to implement timeline for development of forensic mall services.*

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Daisy Wilhoit, Social Work Chief, Civil Division 2. Rafaela Richardson, Social Work Chief, Forensic Division Reviewed: 1. Reliability auditing project for SWIA 2. Charts of the following 18 individuals: AL, BP, BS, CC, DA, ED, FM, JM, KC, MC, ME, MK, MP, PD, RK, RM, SG and WK Observed: 1. Treatment Team Conference for JC 2. Treatment Team Conference for ME 3. Treatment Team Conference for SB 4. Treatment Team Conference for WK
RB	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	**Current findings on previous recommendations:** The SWIA adequately addresses the issue of resolving discrepancies in social history. Both auditing data presented by the Hospital and an independent record review found that this section of the SWIA is being appropriately addressed in over 90% of reviewed records. An auditing tool has been developed and, through a process initiated at the last visit (see below), has shown an adequate level of reliability. Finally, the tool has been simplified to include three choices: "Not present, inadequate and adequate." **Recommendation 3, September 2008:** The social work chiefs need to develop reliability around the scoring of Questions 13, 14, 15 and 17 according to the following methodology: a. Each of the SW chiefs will select 5 charts from their division for a total of 10 charts.

			b. Both SW chiefs will audit the 10 chosen charts with careful attention to Questions 13, 14, 15 and 17. c. Each of the audits will be compared for consistency/inconsistency in scoring and the SW chiefs will discuss discrepant findings until there is agreement between them on how to reliably score all questions. d. The results of this discussion should lead to the development of operational definitions for all questions on the auditing tool. e. Based on the operational definitions, revise as necessary the Social Work Initial Assessment (now Comprehensive Assessment) Guidelines to assure that all staff have an adequate understanding of the appropriate way to fill out all sections of the CSWA. f. This reviewer will use the newly designed tool and the operational definitions to review CSWA during the next monitoring visit. **Findings:** This process was completed during the course of the current visit and adequate levels of reliability were found. **Compliance:** Partial. **Current recommendations:** 1. *Begin to audit a 20% sample of all newly admitted individuals using the new audit tool.* 2. Present trended data analysis as part of an overall performance improvement initiative.

	VII. Discharge Planning and Community Integration		
RB		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The adaption of curricula regarding Wellness and Recovery Action Planning developed by Mary Ellen Copeland is a promising development. 2. While some progress in the integration of discharge planning into the IRP has been noted, there appears to be a lack of conceptual clarity regarding the flow from assessment to foci of treatment to discharge criteria to specific objectives that would allow individuals to meet discharge criteria.
			Methodology: <u>Interviewed</u>: 1. Clo Vidoni-Clark, Director of Civil Programs 2. Daisy Wilhoit, Social Work Chief, Civil Division 3. Rafaela Richardson, Social Work Chief, Forensic Division 4. Sue Sepehri, Deputy Director of Civil Programs 5. Sumit Anand, M.D., Supervising Psychiatrist, Civil Division <u>Reviewed</u>: 1. Presentation by Jana Berhow: "The Division of Integrated Care" 2. Protocol for Initiation of Discharge Planning and Continuity of Care When Consumers are Admitted to St Elizabeths Hospital, Draft 3. Social Work Discharge Group Curriculum 4. Hospital's Discharge Record Review Data, May 2008 – December 2008 5. Difficult to discharge list 6. Records of the following 10 individuals: AM, BR, EA, JL, KH, MD, PV, RE, RS and SS

RB	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:	**Current findings on previous recommendations:** **Recommendation 2, February 2008:** Provide guidelines on how to integrate the above information from SWIA into the case formulation and long term goals of the individual's initial IRP. Utilize later treatment planning conferences to incorporate goals and objectives consistent with the development of a written Wellness and Recovery Action Plan (WRAP) that at a minimum addresses: the individual's strengths and acquired skills, warning signs for relapse regarding any and all aspects of the individual's diagnoses or risk factors; strategies to put in place when warning signs are encountered; supports and services which the individual will be provided upon discharge. **Findings:** There is a lack of congruence between the SWIA and the IRP around discharge planning that appears due to a lack of conceptual clarity among both trainers and treatment teams about how to develop discharge criteria and foci of hospitalization. Thus, the addition of a Discharge Planning Focus actually makes this issue **more** rather than less confusing. Briefly, interdisciplinary assessments must lead to the developments of foci of hospitalization (treatment areas). Some foci will have obvious discharge criteria (e.g., psychiatric conditions that must be stabilized before discharge to a less restrictive setting, psycho-legal issues such as competency to stand trial that must be resolved prior to discharge) while others may not (e.g., medical problems that will require ongoing care in the community but are not in themselves barriers to discharge to a less restrictive setting). Finally, it may be appropriate to have a Community Integration Focus in the IRP to be opened only for those individuals who are clinically ready for discharge but are not motivated to transition to a less restrictive level of care.

			The Social Work Discharge Group curriculum is heavily based on WRAP principles developed by Mary Ellen Copeland and its use, provided in conjunction with a more conceptually clear approach to the integration of discharge planning and IRP development, holds significant promise. **Compliance:** Partial. **Current recommendation:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.*
RB	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Findings:** The SWIA includes discussion of the individual's strengths, preferences, and personal goals that likely would result in successful discharge. While these are being addressed in the IRP, there appears to be a lack of conceptual clarity among both trainers and treatment teams about how to develop discharge criteria and foci of hospitalization that utilize these strengths and preferences in discharge planning. Additionally, the SWIA audit tool appropriately address this issue for the SWIA. There appears to be no tool for auditing the integration of discharge planning in the IRP. **Compliance:** Partial. **Current recommendations:** 1. *Modify treatment team training to clearly identify how to develop discharge criteria and foci of hospitalization that utilize an individual's strengths and preferences in discharge planning.* 2. *Once training is completed, develop appropriate audit to monitor the implementation of this integration in both the IRP conference*

			and the written IRP.
RB	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Findings:** The current SWIA identifies these issues and the current IRP addresses them under Focus One, but the lack of conceptual clarity concerning the relationship between foci of treatment/hospitalization and discharge criteria hinders the development of appropriate and measurable discharge criteria related to an individual's mental illness. **Compliance:** Partial. **Current recommendation:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.*
RB	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	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Revise the SWIA to address those barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known. Provide integrative analysis of this issue in the SWIA. **Findings:** Both the SWIA and the IRP contain sections on barriers to discharge, but the successful implementation of these is hampered by the conceptual clarity referenced above concerning the integration of discharge planning, foci of treatment and treatment objectives. **Compliance:**

			Partial. **Current recommendation:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.*
RB	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Findings:** The SWIA includes documentation of the skills necessary to live in a setting in which the individual may be placed, but these are not meaningfully implemented in the IRP. **Compliance:** Partial. **Current recommendation:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria and the skills necessary for successful community tenure, and how to document this in the IRP.*
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide hospital staff with training in how to effectively engage individuals in their own treatment and discharge planning. **Findings:** According to the Hospital's self-assessment report, this training is part of the Overview training in Interdisciplinary Recovery Planning that has been received by 5 units. **Recommendation 2, February 2008:**

			Provide hospital staff with training in how to run effective and organized treatment planning conferences. **Findings:** Attended treatment planning conferences evidenced better organization than during the last visit. However, this improvement appeared limited to Phase One of the IRP conference – the pre-meeting before the individual joins the team. Teams routinely had difficulty with the integration of discharge criteria, foci of treatment and treatment objectives once the individual joined the team. **Compliance:** Partial. **Current recommendation:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to specific treatment objectives, and how to document this in the IRP.*
RB	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Findings:** While discharge is broadly addressed in the IRP, clear and concise Discharge Criteria are not found, and indeed, there is not a section of the plan that specifically delineates the measurable discharge criteria that an individual must meet in order to be discharged from the Hospital. **Compliance:** Noncompliance. **Current recommendation:** *Revise IRP to include a section specifically on Discharge Criteria.*
RB	VII.C.1	measurable interventions regarding his or her	**Findings:**

		particular discharge considerations;	The Hospital's own self-assessment data indicated that in the past 6 months, the highest level of compliance for this item was 41%. **Compliance:** Partial. **Current recommendation:** *Revise IRP training module as needed to assure that this item is routinely addressed by all treatment teams.*
RB	VII.C.2	the persons responsible for accomplishing the interventions; and	**Findings:** Reviewed records found that the IRP clearly indicated the person who was responsible for any treatment modality, but it is not clear that this requirement of the Agreement is monitored by any existing tool. **Compliance:** Partial. **Current recommendation:** *Include this item as part of the clinical chart audit of the IRP.*
RB	VII.C.3	the time frames for completion of the interventions.	**Findings:** The revised IRP form clearly indicates that the frequency and duration of all interventions is to be documented directly in the IRP. However, the Hospital's self-assessment data indicated that this was only occurring 42% of the time. It was unclear if this mean that it was addressed 42% of the time in the IRP conference or that documentation of frequency and duration of interventions was found in 42% of reviewed charts. Auditing data would be clearer if **process** (conduct of the IRP conference) and **content** (the written IRP in the chart) audits were separated. **Compliance:**

			Partial. **Current recommendations:** 1. *Modify IRP training to assure that this item is covered.* 2. *Develop separate process and content audits for the IRP.*
RB	VII.D	By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Provide an assessment of the discharge placements to which the hospital refers individuals to determine the specific skills that will be necessary for successful community living in those placements. **Findings:** An inventory of housing and community support services was completed on 10/31/08, but this inventory did not indicate the specific skills necessary for successful discharge to each placement. **Recommendation 2, February 2008:** Provide an adequate number of mall groups that teach these skills with manual based curriculum. **Findings:** A revision of mall treatment services into three Therapeutic Learning Centers (TLC) has been undertaken. TLC was in operation as of 03/16/09, with TLC2 scheduled to begin operation on 04/27/09 and TLC3 scheduled to begin operation on 04/13/09. The curriculum for TLC1, which serves more short-term individuals, has been developed and appears to adequately target the treatment and rehabilitative needs of this subset of individuals. **Recommendation 3, February 2008:** Develop and implement an auditing tool that monitors progress in the

			establishment and success of these skills-based interventions. **Findings:** Scheduled to be completed by 05/12/09. **Recommendation 4, February 2008:** Train auditors to acceptable levels of reliability. **Findings:** Not yet done. **Recommendation 5, February 2008:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. 2. Train auditors to acceptable levels of reliability. 3. Provide operational definitions of all terms in a written format to aid in data reliability and validity. 4. Report as trended data analysis.
RB	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the	**Current findings on previous recommendations:** **Recommendation 2, September 2008:** The Hospital must develop a clinical review system that tracks

		acceptance of the individual for the services, and the discharge of the individual.	individuals who are ready for but resisting discharge. The recommendations from high level case review meetings must be documented in the individual's medical record, and specific objectives and interventions related to those recommendations must be added to the individual's IRP. Follow up must then take place to determine if these interventions have been successful in helping the individual move closer to discharge, and if not, what changes have been made. This must be part of an ongoing clinical review process for these individuals. Data must be aggregated and trended so that those objectives/interventions that prove to be the most effective can be readily implemented in similar cases. **Findings:** The Hospital has developed and monitors a list of individuals ready for but resisting discharge to a less restrictive setting, as well as a list of individuals who are ready for discharge but lack some systemic support that would enable discharge. Meetings are held regularly to address this latter group and it is the responsibility of the team social worker to document progress or lack of progress toward overcoming these systemic barriers. Less has been done with the first group of individual, where a more in depth clinical case review is needed. **Compliance:** Partial. **Current recommendations:** 1. *Develop a method for auditing the social work documentation of follow up meetings on systemic discharge barriers.* 2. *Institute a regular clinical case review for those individuals who are ready for but resisting discharge that assures that interdisciplinary collaboration occurs in determining how best to help these individuals transition to a less restrictive level of care.* 3. Develop a method to document the recommendations and follow up

			to these reviews in the individual's record. 4. Develop a method for auditing the above documentation.
RB	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:	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop and implement policies and procedures that specify which staff members are responsible for this aspect of community placement follow up, the timeliness by which data is to be collected and aggregated and an auditing tool that monitors compliance. **Findings:** The Hospital's self-assessment report indicates that a review of guidelines in this area is underway and that a target implementation date of 04/30/09 is expected. Various audits are being conducted but integrated findings, to the extent that they exist, are not being reported in a meaningful manner. **Compliance:** Noncompliance. **Current recommendations:** 1. *Present an overview of the completed monitoring system including audit instruments and key indicators.* 2. Develop a plan to train auditors to reliability. 3. When system is implemented, assure distribution of audit findings to key stakeholders.
RB	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Findings:** The only data reported in the Hospital's self-assessment was data concerning the percentage of discharged individuals that were seen at an outpatient appointment within 7 days of their discharge from the Hospital. The figure varied from 3% to 76% for fiscal 2008 and no

			analysis of these findings was presented. However, the cell asks for monitoring to assure that "discharged individuals are receiving the care that was **prescribed** for them at discharge." Even if 100% of individuals had an initial appointment within 7 days of discharge, this is not an indicator that they are receiving the "care prescribed for them at discharge." **Compliance:** Noncompliance. **Current recommendation:** *As part of the overall quality improvement monitoring system referenced in VII.F (above), the Hospital must determine how it is going to effectively monitor this portion of the Agreement.*
RB	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Findings:** According to the hospital's self-assessment report, this task will be provided by the newly created Division of Integrated Care, and they have indicated that the division is staffed. **Compliance:** Substantial. **Current recommendation:** Utilize staff from the Division of Integrated Care to provide audit data for the quality improvement instruments developed in conjunction with VII.F (above).

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Progress:** 1. SEH has made progress in the recruitment of psychiatry staff since the last review. 2. SEH initiated the development of adequate individualized medications guidelines. 3. SEH developed an adequate adverse drug reaction policy and procedure and presented preliminary analysis of patterns of ADRs. 4. SEH developed an adequate policy and procedure regarding Drug Utilization Evaluation. 5. The use of a consultant in behavioral treatment has led to the development of a number of draft behavioral interventions that hold promise when fully implemented. 6. SEH conducted a self-assessment to serve as a follow-up evaluation of the status of implementation of this agreement. The facility's report included a candid assessment of current status and some corrective measures needed to move towards compliance. 7. A Chief Nurse Executive was hired in October 2009. Nurse Educator positions have been established and filled. 8. A concerted effort to fill nursing positions has resulted in a 7% vacancy rate in nursing as of February 2009. 9. Nearly all AVATAR issues that impacted medication administration have been resolved. 10. There are beginning signs of enhanced nursing engagement with patients. 11. A number of nursing recommendations from the last two visits have been acted upon.

	A. Psychiatric Care		
MES		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.	**Methodology:** Interviewed: 1. Bernard Arons, M.D., Medical Director. 2. Farooq Mohyaddin, M.D., Director, SEH Residency Training Program in Psychiatry. 3. Michael Hartley, Director, Performance Improvement. Reviewed: 1. Charts of the following 43 individuals: AS, AT, BP, BW, CF, CG, CK, CS, DB, DC, DD, DH, DL, DS, EG, FA, FG, GC, GS, HJ, IW, JM, JN, JP, JT, KR, LF, MA, MK, ML, MM, MP, OM, PM, PS, RB-1, RB-2, SD, TT, WC, WK, WL and WW. 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (February 27, 2009). 3. SEH database regarding individuals receiving benzodiazepines. 4. SEH database regarding individuals receiving anticholinergic treatments. 5. SEH database regarding individuals receiving polypharmacy. 6. SEH database regarding individuals receiving treatment with new generation antipsychotic medications. 7. SEH Medication Monitoring and Chart Review results (February 2009). 8. SEH Medication Guidelines, Draft. 9. SEH Pharmacy Drug Interventions and Recommendations (September 17, 2008 to February 23, 2009). 10. SEH Policy #203-05, Adverse Drug Reactions (ADRs), February 23, 2009. 11. SEH ADR Form. 12. SEH data regarding Adverse Drug Reactions (June 2007 to February 2009). 13. SEH Policy #205-09, Drug Utilization Evaluation (DUE), February

			11, 2009. 14. SEH Policy #202-05, Medication Variance Reporting and Assessment, March 02, 2009. 15. SEH data regarding Medication Variances (May 2007 to December 2008). 16. SEH Policy #302.3-05, Patient Death Review, March 2, 2009. 17. SEH Policy #302.2-204, Sentinel Events/Root Cause Analysis, March 2, 2009. 18. SEH Substance Use Disorders Chart Audit Tool. 19. SEH Policy #112-09, Co-occurring Substance Use Screening, Assessment, Treatment and Service Referrals. 20. List of all psychiatrists at SEH with their case loads and FTE status, February 18, 2009. 21. Tardive Dyskinesia (TD) Peer Review Tool, February 25, 2009. 22. Ten completed Reports of Suspected Adverse Drug Reactions. 23. Ten completed Medication Variance (Error) reports. 24. Minutes of the P&T Committee meetings (October 8, November 12 and December 10, 2008 and January 14 and February 11, 2009). <u>Observed</u>: 1. IRP team meeting at RMB-3 for review of GC. 2. IRP team meeting at RMB-3 for review of FP. 3. IRP team meeting at RMB-5 for review of ME. 4. IRP team meeting at RMB-6 for review of SB. 5. IRP team meeting at JHP-1 for 60-day review of JC. 6. IRP team meeting at JHP-3 for review of RJ. 7. IRP team meeting at JHP-6 for review of MK. 8. IRP team meeting at JHP-10 for review of WK.
MES	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	Please see sub-cells for findings and compliance.

		address physician practices regarding:	
MES	VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. **Recommendation 2, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments; same as in VI.A.7 regarding psychiatric reassessments. **Current 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 xxx 2. Same as in VI.A.7.
MES	VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7.

			Compliance: Partial. **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.

MES	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;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7.and VI.A.2. **Findings:** Same as in VI.A.7.and VI.A.2. In addition, SEH reported that a review of a small sample of assessments using the comprehensive initial psychiatric assessments suggested the following: 1. Practitioners were not fully completing the risk assessment portion of the template; 2. Mitigating circumstances were rarely addressed; and 3. Precautions were not completed in some cases when the individual had been rated at risk. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.and VI.A.2.
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. In addition, the facility acknowledged that practitioners were not consistently documenting the side effects of treatment. Proper implementation of the new templates for the assessments and reassessments should improve compliance with this

			requirement. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. In addition, the facility acknowledged that practitioners were not consistently documenting the rationale for using or changing medications. Recent corrective actions included implementation of Phase I of the new computerized system AVATAR and a new chart review process by the Pharmacy Department. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.7.
MES	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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in VI.A.7 **Findings:** Same as in VI.A.7

			Recommendation 2, September 2008: Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications. **Findings:** SEH developed draft guidelines regarding the use of Stat medications. By policy, the facility does not permit the use of medications on a PRN basis. **Recommendation 3, September 2008:** Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff. **Findings:** SEH developed a medication monitoring and chart review process that included indicators regarding the number of PRN and Stat medication administrations. The tool did not address requirements relating to documentation by medical and nursing staff. **Recommendation 4, September 2008:** Provide monitoring data based on 20% sample (October 2008 to March 2009). **Findings:** SEH has yet to implement this recommendation. The facility presented limited data based on the current medication monitoring and chart review process (February 2009). The data provided potentially useful information regarding the number of PRN/Stat administrations, including individuals who have received four or more PRN/Stat administrations during a 30-day period. However, as mentioned above,

			this process did not include indicators that aligned with this requirement. **Recommendation 5, September 2008:** 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. **Findings:** SEH has yet to implement this recommendation. **Other findings:** This consultant reviewed the charts of five individuals who required the use of restrictive interventions and Stat medications during this review period (CK, DB, DD, GS and MP). The review found that the facility has yet to make progress in addressing the following deficiencies: 1. The occasional prescription of PRN medications for behavioral indications in violation of the facility's procedure that prohibits this practice; 2. The occasional prescription of PRN medications for generic indications, e.g. "agitation;" 3. Inconsistent face-to-face evaluation of the individuals by the treating psychiatrist following the administration of Stat medications. 4. Inadequate documentation in the psychiatric progress notes of a review of the use of PRN/Stat medications and the use of this information in the update of diagnosis and regular treatment, as clinically indicated; and

			5. Inconsistent documentation by nursing of the circumstances of the use of PRN/Stat medications and the individual's response to the administration. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.7.* 2. *Implement corrective actions to ensure compliance with the requirements regarding the use of PRN/Stat medications.* 3. Develop and implement a clinical chart audit tool to assess compliance with the new template for the psychiatric update. The tool must include indicators to assess the following: a. Face-to-face assessment of the individual following the administration of Stat medications; b. The prescription of PRN medications for specified behavioral indications; c. Critical review by practitioners of the use of PRN/Stat medications during the interval, including the circumstances leading to the use, the individual's response and the appropriateness of the medication order; d. The adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval. 4. Provide monitoring data based on 20% sample during the review period. 5. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

MES	VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a.i	clinically justified;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop and implement monitoring tools with indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications). **Findings:** The Pharmacy Department has initiated a medication monitoring review process that included some potentially useful indicators regarding the use of benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications. However, the indicators were not aligned with quality standards based on individualized medication guidelines (see VIII.A.2.b.i). **Recommendation 2, September 2008:** Provide monitoring data regarding high-risk medication uses, based on at least a 20% sample (March to August 2008). **Findings:** Using the medication monitoring chart review process, the facility

			presented limited data based on an audit in February 2009. However, the facility has yet to finalize indicators based on the medication guidelines in order to better inform performance improvement in the area of medication management. **Recommendation 3, September 2008:** 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. **Findings:** SEH has yet to implement this recommendation. **Recommendation 4, September 2008:** Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation). **Findings:** Same as in VI.A.2.b.i and VI.A.2.b.iv. **Other findings:** This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and

4. Various forms of polypharmacy.

This monitor also reviewed the charts of individuals receiving the above types of medication uses.

The reviews found that the facility has not decreased the overall number of individuals receiving long-term treatment with benzodiazepines and/or anticholinergic medications since the last review period. The charts of too many individuals included examples of long-term treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented diagnostic justification and/or assessment of the individuals for the risks associated with this practice. These practices must be corrected in order to achieve substantial compliance with this requirement.

The following tables outlines the reviews (diagnoses are listed only if they signified conditions that increase the risk of use):

Benzodiazepine use

Individual	Medication(s)	Diagnosis
CS	Clonazepam	Polysubstance Dependence and Mild Mental Retardation
DS	Clonazepam	Polysubstance Dependence and Mild Mental Retardation
GS	Clonazepam	Polysubstance Dependence, Mild Mental Retardation and HIV+
KR	Lorazepam (and diphenhydramine and chlorpromazine and **amantadine**	Mild Mental Retardation

MA	Lorazepam	Alcohol Dependence and Dementia NOS (small vessel disorder)
ML	Lorazepam	Dementia Due To Creutzfeldt-Jacob Disease
MM	Lorazepam (and zolpidem and diphenhydramine)	Alcohol abuse, cocaine dependence and AIDS
PM	Lorazepam	Mild Mental Retardation
TT	Clonazepam (and zolpidem)	Mild Mental Retardation
WW	Lorazepam	Vascular Dementia

Anticholinergic use

Individual	Medication(s)	Diagnosis
DC	Amantadine	Tardive Dyskinesia
FA	Benztropine	Dementia NOS and Amnestic Disorder NOS
OM	Benztropine	Mild Mental Retardation
RB-1	Benztropine	Mild Mental Retardation
WK	Benztropine and Diphenhydramine	Borderline Intellectual Functioning

Polypharmacy use

Individual	Medication(s)	Diagnosis
AT	Olanzapine, risperidone, paliperidone, haloperidol decanoate, divalproex and benztropine	
HJ	Quetiapine, aripiprazole, ziprasidone, haloperidol decanoate, buproprion, benztropine and hydroxyzine	

JM	Olanzapine, risperidone, fluphenazine (HCL), doxepine and buspirone	
JT	Clozapine, aripiprazole, quetiapine and buproprion	
LF	Risperidone, quetiapine, aripiprazole, clorimipramine, benztropine and trazodone	
WL	Thioridazine, paliperidone, quetiapine, doxepine, divalproex and benztropine	Borderline Intellectual Functioning

This consultant reviewed the charts of 14 individuals who were receiving treatment with new generation antipsychotic medications and most of them were diagnosed with diabetes mellitus, dyslipidemia and/or obesity. The reviews are outlines as follows:

Individual	Medication(s)	Diagnosis
AS	Olanzapine	Diabetes Mellitus and Hypercholesterolemia
BW	Olanzapine	Diabetes Mellitus
CF	Quetiapine	Diabetes Mellitus
CG	Quetiapine	Diabetes Mellitus and Hypercholesterolemia
CK	Olanzapine	Diabetes Mellitus and Hypercholesterolemia
DH	Risperidone	
DL	Olanzapine	Diabetes Mellitus
FG	Clozapine	
JN	Clozapine	Diabetes Mellitus and Hyperlipidemia
JP	Risperidone	Diabetes Mellitus
RB-2	Risperidone	Diabetes Mellitus and

		Hyperlipidemia
SD	Risperidone	Diabetes Mellitus and Obesity
WW	Clozapine and ziprasidone	Diabetes Mellitus and Hypercholesterolemia

The following were positive findings based on this review:

1. In general, the facility has maintained adequate laboratory monitoring of the blood counts and vital signs in individuals at risk.
2. The facility has improved the frequency of laboratory monitoring of serum lipids for individuals receiving high risk medications.
3. The facility has improved its practice regarding the documentation of weight status for individuals receiving high risk medications.
4. The recent implementation of the facility's new format of the psychiatric update appeared to have improved the psychiatric documentation of specific risks associated with high risk treatment.

However, there were some persistent process deficiencies that must be corrected in order to achieve substantial compliance. The following outlines areas of deficiency:

1. The laboratory and clinical monitoring of the endocrine risks related to hyperprolactinemia in female individuals receiving high risk treatment was generally inadequate.
2. The assessment of the risks and benefits of treatment and the integration of significant recent laboratory findings in this assessment were inadequate in some charts (e.g. CF).
3. There was general evidence of inadequate documentation of laboratory monitoring regarding the risk of pancreatic dysfunction for some individuals receiving high risk medications.
4. There was evidence of inadequate frequency of the laboratory

			monitoring of serum lipids in some individuals who were diagnosed with Diabetes Mellitus and/or Dyslipidemia and receiving high risk treatment with clozapine (JN), olanzapine (BW) and quetiapine (CF). 5. In general, there was evidence of inadequate or delayed attention to safer antipsychotic treatment alternatives for individuals diagnosed with a variety of metabolic disorders and receiving high risk treatments. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).* 2. *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* 3. *Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).* 4. Provide monitoring data regarding high risk medication uses, based on at least a 20% sample during the review period. 5. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
MES	VIII.A.2.	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.

	a.ii		
MES	VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	Same as above.
MES	VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	Same as above.
MES	VIII.A.2.a.v	evaluated for side effects; and	Same as above.
MES	VIII.A.2.a.vi	documented.	Same as above.
MES	VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	Same as above.
MES	VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Current findings on previous recommendations:** **Recommendations 1-3 September 2008:** • Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and specific clinical and laboratory screening and monitoring requirements. • Revise the clozapine guideline to ensure alignment with current generally accepted standards. • Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. **Findings:** SEH reported that individualized medication guidelines were under development by the facility's medical and pharmacy staff in an effort to address the process and content deficiencies that were outlined by

			this consultant in the previous report. The draft guidelines addressed the following medications/medication classes: 1. Clozapine; 2. Mood-stabilizing agents: lithium, divalproex, carbamazepine and lamotrigine; 3. Conventional antipsychotic agents: chlorpromazine, haloperidol, fluphenazine, trifluoperazine and perphenazine; 4. New generation antipsychotic agents (other than clozapine): olanzapine, ziprasidone, aripiprazole, quetiapine and risperidone; 5. Anticholinergic agents; 6. Polypharmacy; and 7. Stat medications. **Other findings:** This consultant's review of the draft guidelines found that the current versions were a significant step in the right direction. However, before these guidelines are finalized, the facility must ensure the following: 1. A guideline for the use of benzodiazepines is developed including the risks of long-term use for individuals with substance use and/or cognitive disorders and parameters for appropriate use in some individuals with substance use disorders; 2. The clozapine guideline is revised further to ensure a more complete set of indications (including use for suicidal individuals and/or individuals suffering from tardive dyskinesia),specific monitoring for metabolic risks and the risk of myocarditis, blood level interpretation, interactions with diet and tobacco and strategies for use in individuals who fail to respond satisfactorily. 3. The guidelines for the use of new generation antipsychotics other than clozapine are revised further to provide laboratory and clinical monitoring requirements that reflect the individualized risk profile of each medication and to ensure that these requirements align

			with current literature; and 4. The guideline regarding anticholinergic medications is revised to address the risk of long-term use for individuals suffering from tardive dyskinesia. **Compliance:** Partial. **Current recommendations:** 1. *Finalize and implement individualized psychotropic medication guidelines that address Other Findings 1-4 by this consultant above.* 2. *Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.*
MES	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;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VIII.A.1.h. **Findings:** Same as in VIII.A.1.h. **Compliance:** Partial. **Current recommendations:** Same as in VIII.A.1.h.
MES	VIII.A.2.b.iii	establish a system for the pharmacist to communicate drug alerts to the medical staff; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:**

			Present information regarding drug alerts that were communicated to the medical staff (October 2008 to March 2009). **Findings:** SEH presented data regarding FDA alerts that were communicated by the Pharmacy Department to the medical staff during the period February 20 to April 8, 2009. A total of nine alerts were reported including both general issues of drug use and issues related to specific drugs (efalizumab, zonisamide, metoclopramide, phenytoin and fosphenytoin, insulin pens and transdermal drug patches with metallic backings). **Recommendation 2, September 2008:** Present documentation of review by the P&T Committee of drug alerts. **Findings:** The facility acknowledged that this review did not occur consistently during this reporting period. **Compliance:** Partial. **Current recommendations:** 1. Present aggregated data regarding all drug alerts that were communicated by the Pharmacy Department to the prescribing practitioners. 2. Present documentation of review by the P&T Committee of drug alerts.
MES	VIII.A.2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** ADRs:

		Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	a) Develop and implement a policy and procedure regarding ADRs that includes an updated data collection tool and instructions to staff regarding proper methods in the reporting and investigating of ADRs. The procedure and the tool must correct the deficiencies identified in the previous report. b) Present data to demonstrate the number of ADRs reported October 2008 to March 2009, compared to the previous six month period. c) Provide an aggregated summary of ADRs by severity outcome. d) Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. e) Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations. f) Provide documentation of reviews by the P & T committee and Medical Staff Executive Committee to assess trends and patterns related to ADRs and to recommend systemic corrective/educational actions. **Findings:** a. SEH developed a policy and procedure regarding ADRs effective February 24, 2009. The policy included adequate definition and severity and probability scales. A new data collection tool was developed to align with the policy. However, the current system did not address some of the previously described deficiencies in the following areas: i) Additional circumstances surrounding the reaction, including how the reaction was discovered, relevant history, allergies, etc.; ii) Information about all medications that were suspected or could be suspected of causing the reaction and a system to determine the medication more likely responsible for the

			reaction if more than one medication was suspected; iii) Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc.); iv) Information regarding future screening; and v) Instruction to staff regarding proper methods in reporting and investigating ADRs. b. SEH presented data showing that a total of 89 ADRs were reported from June 2007 to December 2008. The information was derived from the facility's MEDMARX database. The data did not specify the number of reactions during this review period (October 2008 to March 2009) compared to the previous six-month period. The data indicated that four ADRs were classified as being life-threatening, four required hospitalization and 29 caused other medically significant conditions. The number of ADRs that were reported by the facility represented serious underreporting of ADRs given the census of the facility and the number of complex medication regimens used for its individuals. In its self-assessment report, the facility acknowledged that accurate reporting continued to be problematic and that there was possible underreporting of ADRs. c. Same as in b). d. SEH reported that efforts are underway to improve tracking logs. The facility presented data regarding the following patterns: location of the ADR, severity of the ADR, type of the ADR and type of medication(s) responsible for the ADR. However, no analysis or corrective actions were presented. e. SEH reported that the P&T Committee has developed an intensive case analysis process that will be led by the Risk Manager and will include a committee member, the director of performance improvement and a member. The facility has yet to implement this process. f. SEH has yet to implement this recommendation.

			Recommendation 2, September 2008: DUEs: a) Ensure systematic review of all medications, with priority given to high-risk, high-volume uses b) Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. c) Perform DUEs and present summary of the methods, findings, conclusions and recommendations in these DUEs. d) Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** SEH developed an adequate policy and procedure regarding Drug Utilization Evaluation (DUE). The procedure specified that the Pharmacy and Therapeutics (P&T) Committee will provide oversight to ensure a systematic review of medications based on guidelines and that priority will given to high-risk and high-use medications. The facility has yet to implement recommendations b) through d). **Recommendation 3, September 2008:** MVR: a) Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. b) Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. c) Provide instruction to all clinicians regarding the significance of and proper methods in MVR. d) Present data to demonstrate the number of variances reported October 2007 to March 2009, compared to the previous six month

			period. e) Provide an aggregated summary of ADRs by category of variance (prescription, documentation, administration, ordering, procurement, dispensing, monitoring and medication security), severity outcome and actual vs. potential variances. f) Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. g) Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. h) Provide documentation of reviews by the P & T Committee and the Medical Staff Executive Committee to analyze trends and patterns and recommend systemic corrective/educational actions regarding MVR. **Findings:** a. SEH developed a policy and procedure regarding Medication Variance Reporting and Assessment (March 2, 2009). The policy included more appropriate elements compared to the previous Pharmacy Department and facility-wide procedures. However, the current procedure and data collection tool did not ensure adequate correction of the deficiencies that were previously reported by this consultant. The following are examples: i) The procedure did not address some categories of potential variances, including monitoring variances and medication security variances. ii) The system did not facilitate the provision of information regarding additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, description of the full chain of events involving the variance, etc.

			iii) The data collection tool confused contributing factors with types of variance. iv) The procedure requires staff completing the variance report to make decisions about critical breakdown points and contributing factors although such decisions require a higher level of clinical review and investigation. v) The data collection tool did not include information that facilitates the aggregation of data regarding critical breakdown points. vi) The procedure was not accompanied by instructions to clinical staff regarding proper methods for review, investigation and analysis of variances. In its present form, the procedure and accompanying data collection do not provide adequate basis for a process of reporting and investigating of variances that meaningfully informs performance improvement. b. Same as in a). c. The facility has yet to implement this recommendation. The facility provided education that consisted of general information about variances, but did not specifically address the proper methods of reporting and investigating variances, including instructions regarding the use of data collection tools. In its self-assessment, SEH did not adequately address recommendations d) through h). The supporting documents provided information on variances that were reported between May 2007 and December 2008 and some analysis of the types of variances and the units reporting the variances. However, these data were based on a system of reporting and investigating that was previously assessed to be inadequate.

			Recommendation 4, September 2008: Mortality reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: a. Definitions of expected and unexpected deaths; b. Delineation of first response activities, including the roles/ responsibilities of different parties in the facility; c. An outline of the process, content requirements and roles/responsibilities in the first level of interdisciplinary reviews of special investigator reports and medical and nursing death summaries; d. An outline of the process, content and roles/responsibilities in the final level of interdisciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and e. Tracking mechanisms to ensure that interdisciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate. **Findings:** SEH revised its policies regarding Patient Death Review and Sentinel Events/Root Cause Analysis. The revised policies include more appropriate elements compared to the previous policies regarding the process of mortality review. However, the revised policies did not address the following: 1. The integration of the special investigator's report regarding possible abuse/neglect by staff as a contributing factor in the first level review; 2. The performance of an independent external medical mortality review and the integration of information from this review in the final level interdisciplinary review; and 3. Tracking mechanisms to ensure that interdisciplinary

			recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate. **Compliance:** Partial. **Current recommendations:** 1. *Adverse Drug Reactions: Present summary information to address the following:* a. *Development of written instructions to guide staff in the proper use of the data collection tool;* b. *Number of ADRs reported during the review period compared with the number during the previous period;* c. *Classification of ADRs by outcome category compared with the number during the previous period.* d. *Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;* e. *Information regarding any intensive case analysis (ICA) done for each reaction that was classified as severe and for any other reaction. Also provide a summary outline of each analysis including the following:* i) *Date of the ADR;* ii) *Description of the ADR;* iii) *Outline of ICA recommendations; and* iv) *Outline of actions taken in response to the recommendations.* f. *Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.* 2. *Drug Utilization Evaluation (DUE):*

			a. *Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.* b. *Perform DUEs and present a summary outline of the following:* 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.* c. *Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends and provide a summary of corrective/educational actions taken to address these trends/patterns.* 3. *Medication Variance Reporting (MVR): Present summary information to address the following:* a. *Revisions of the data collection tool to ensure:* i) *Reporting of all possible categories of variances: prescribing, transcribing, ordering/procurement, dispensing/storage, administration, documentation and medication security;* ii) *Assessment of critical breakdown points; and* iii) *Assessment of contributing factors.* b. *Development of written instructions to assist staff in the proper use of data collection tool;* c. *Total number of actual and potential variances during the review period compared with numbers reported during the previous period;* d. *Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;* e. *Clinical information regarding each variance (category E or above) and the outcome to the individual involved;* f. *Information regarding any ICA conducted for each reaction*

			that was classified as category E or above and for any other reaction; and g. *Outline of ICAs, including description of variance, recommendations and actions taken.* 4. *Mortality review: Ensure that the revised policies/procedures regarding mortality reviews address the following:* a. *The integration of the special investigator's report regarding possible abuse/neglect by staff as a contributing factor in the first level review.* b. *The performance of an independent external medical mortality review and the integration of information from this review in the final level interdisciplinary review.* c. *Tracking mechanisms to ensure that interdisciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate.*
MES	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Identify and resolve barriers to recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units. • Provide summary data of case loads of psychiatrists currently serving in all admission and long-term units. The case loads should be based on FTE status. **Findings:** SEH has made progress in recruiting psychiatrists since the last review. The following is a summary of the current status of the ratios of FTE psychiatrists to individuals: 1. Civil programs have average case loads of one FTE psychiatrist per

			11.5 beds (acute care units) and one FTE psychiatrist per 21.4 beds (long-term units). 2. Forensic programs have average case loads of one FTE psychiatrist per 16.25 beds (acute care units) and one FTE psychiatrist per 21.2 beds (long-term units). 3. In addition, each program has a full time Medical Director reporting to the facility's full-time Medical Director. **Compliance:** Partial. **Current recommendation:** *Ensure compliance with this requirement in all acute care and long-term care units in the facility.*
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in V.A.2.e and VI.A.7. **Findings:** Same as in V.A.2.e and VI.A.7. The facility's self-assessment report acknowledged minimal progress in this area. **Compliance:** Same as in V.A.2.e and VI.A.7. **Current recommendations:** Same as in V.A.2.e and VI.A.7.
MES	VIII.A.	ensure that psychiatrists review all proposed	Same as above.

	4.a	behavioral plans to determine that they are compatible with psychiatric formulations of the case;	
MES	VIII.A. 4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	Same as above.
MES	VIII.A. 4.c	integrate psychiatric and behavioral treatments.	Same as above.
MES	VIII.A. 5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Findings:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Compliance:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Current recommendations:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.
MES	VIII.A. 6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement the revised initial psychiatric assessment (see VI.A.1). **Findings:** SEH has included an adequate substance abuse screening tool as part of the new initial comprehensive psychiatric assessment. The facility began implementation of this tool in January 2009.

			In addition, the facility developed a policy #112-09, Co-Occurring Substance Use Screening, Assessment, Treatment and Service Referrals. This policy included expectations regarding the screening for substance abuse and management of individuals with these disorders. As mentioned earlier, the revised IRP included a focus dedicated to substance use disorders and the facility has provided training to staff regarding the stages of change model as part of the new IRP training. **Recommendations 2-4, September 2008:** • Develop and implement a substance use chart audit tool with complete indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. • Provide monitoring data based on at least a 20% sample (March to August 2008). • 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. **Findings:** SEH has developed a self-auditing tool regarding the initial comprehensive psychiatric assessment that includes an indicator regarding initial substance abuse screening. Implementation of this tool began in February 2009. The facility also developed a Substance Abuse Disorders Chart Audit tool that addressed the integration of substance abuse in the case formulation and the IRP. The facility has yet to present data related to this audit.

			Recommendation 5, September 2008: Same as V.D.1. **Findings:** Same as V.D.1. **Other findings:** See this monitor's findings in V.D.1 regarding the management of substance use disorders at SEH. **Compliance:** Partial. **Current recommendations:** 1. Ensure implementation of substance recovery services consistent with the transtheoretical model of change. 2. Ensure that substance abuse self-assessment indicators also address the following: a. There is at least one objective related to the individual's stage of change; b. The interventions are appropriately linked to the objective and are aligned with the Mall schedule; and c. The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms. 3. Provide monitoring data based on at least a 20% sample during this review period. The data should include and initial screening and the IRP management of substance use disorders. 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.
MES	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2 September 2008:** • Implement the policy and procedure regarding TD. • Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement. **Findings:** SEH has developed an adequate self-audit tool, including operational instructions, to address these recommendations. The instructions included appropriate guidance regarding the management of individuals suffering from this disorder. The facility has yet to implement this tool. The Medical Director has refined the facility's database that identifies individuals with a current diagnosis of TD. The newly developed database identified 36 individuals (compared to nine individuals as of January 2009). **Recommendations 3 and 4, September 2008:** • Provide monitoring data based on a review of a 100% sample (October 2008 to March 2009). • 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. **Findings:** The facility has yet to implement these recommendations.

			Other findings: This monitor reviewed the charts of six individuals (BP, EG, IW, ML, PS and WC) who were diagnosed with tardive dyskinesia (TD) per the facility's database. This review found that SEH has maintained the progress noted during the last review as evidenced by the following: 1. The admission AIMS tests were completed in all the charts reviewed. 2. The quarterly AIMS tests were completed in most charts (BP, EG< IW, ML and PS). 3. The IRP documented a diagnosis of TD in all the charts reviewed (in the charts of BP and ML, late entries regarding the diagnosis were made without proper authentication). 4. There was no evidence of unjustified long-term use of anticholinergic medications in most charts reviewed (EG, ML, PS and WC). However, the review also found a number of deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. The psychiatric progress notes did not address the status of TD in some individuals (IW, ML and PS). 2. The WRP did not include diagnosis, focus or interventions to address a diagnosis of TD in any of the charts reviewed. 3. The AIMS tests were not documented quarterly as required in one chart reviewed (CW). **Compliance:** Partial.

			Current recommendations: 1. *Develop and implement corrective actions to address the deficiencies outlined by this consultant regarding the monitoring and management of individuals suffering from TD.* 2. *Implement the self-auditing tool for TD.* 3. Provide monitoring data based on a review of a 100% sample during the review period. 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.

	B. Psychological Care		
RB		By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological supports and services to individuals who require such services.	**Methodology:** Interviewed: 1. Rose Patterson, Ph.D., Chief of Psychology Services 2. Michelle Marsh, Psy.D., PBS Psychologist and Psychologist for RMB3 Reviewed: 1. Psychology Department Draft Manual 2. Charts of the following 23 individuals: AP, AW-B, BP, CL, CT, DA, DD, DH, DS, DT, EO, IC, JD, JS, KR, ME, RD, RP, SB, TB, TM, WJ and WM Observed: RMB 3
RB	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:	Please see sub-cells for findings and compliance.
RB	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;	**Findings:** The IPA contains a section to assess whether or not a newly admitted individual might require the assistance of specific behavioral interventions, and a review of selected records indicated that this section was being appropriately completed by admitting psychologists. The Hospital also decided that all individuals who were in need of Positive Behavior Support (PBS) Plans would be transferred to RMB 3, where the unit psychologist also serves as the PBS psychologist. However, of the 17 individuals so identified and referred to that unit,

			none has a functioning PBS plan, and the unit has the highest rate of seclusion/restraint in the hospital. A review of the charts of the top five utilizers of seclusion and/or restraint in a recent month found that only one of those individuals had active behavioral interventions in their chart. On a positive note, the Hospital has hired a consultant in behavioral treatment who has begun training psychologists in the development of PBS plans and Behavioral Guidelines, and the work to date looks quite promising. **Compliance:** Noncompliance. **Current recommendations:** 1. *Discontinue the process of transferring to RMB 3 those individuals in need of PBS plans and provide that service on the ward on which the individual currently resides.* 2. *Free the PBS psychologist from unit/ward/treatment team duties as the first step in developing a stand-alone PBS service. Fill out the PBS team with the addition of at least one RN and two PNAs.* 3. *Within the next 6 months, transfer at least 50% of those individuals on RMB 3 due to the need for more intensive behavioral treatment to other units and provide the behavioral treatment on those units.* 4. *Within the next 6 months, develop PBS plans for at least 50% of the remaining individuals on RMB 3 who are in need of intensive behavioral treatment.*
RB	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	**Current findings on previous recommendations:** **Findings:** Training with the consultant, Angela Adkins, has begun and reviews of Structural/Functional summaries, Behavior Guidelines and draft PBS plans indicates that this training has been helpful and is promising for

		individual were chosen and what input the individual had in their development, and the system for earning reinforcement;	increased implementation of behavioral treatment strategies. Reviewed records found that description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement were adequately presented. Improvements in compliance await the implementation of a significant number of Behavior Guidelines and PBS plans. **Compliance:** Partial. **Current recommendations:** 1. *Continue training with consultant.* 2. *Implement a significant number of Behavior Guidelines and PBS plans.* 3. Present quantifiable and trended data on all auditing of behavioral interventions.
RB	VIII.B. 1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;	**Findings:** The draft Psychology Department Manual makes clear that aversive contingencies, including the use of seclusion and restraint, are not part of any behavioral intervention, and none were found in reviewed records. However, problems exist with the current token economy practice on RMB 3, which does not provide tokens immediately upon performance of the appropriate prosocial behavior and appears to be top-heavy with fines rather than reinforcers. The Hospital indicated that the token economy would be refined with consultation from Angela Adkins. Further compliance will be demonstrated when a significant number of PBS plans are in active use and the token economy process has been refined.

			Compliance: Partial. **Current recommendations:** 1. *Continue training with consultant.* 2. *Refine token economy process so that it is in line with current best practices.* 3. Present quantifiable and trended data on all auditing of behavioral interventions.
RB	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;	This cell repeats cell VIII.B.1.a
RB	VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Develop a policy that directs psychology staff about when and how to monitor and document an individual's therapeutic progress (or lack thereof) when they are making use of Positive Behavior Support Plans/Behavioral Guidelines. At a minimum this documentation must occur monthly and most directly document the individual's progress toward achieving the behavioral goals for which the plan was created, including the decrease in targeted maladaptive behaviors and increase in adaptive behaviors. **Findings:** In process, and some current examples were provided that were quite good.

			Recommendation 2, February 2008: Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans. **Findings:** Consultant Angela Adkins has provided training on RMB 3. **Recommendation 3, February 2008:** Develop and implement a Behavior Consultation Committee (BCC) for the regular review of individuals who are placed on Positive Behavior Support Plans. The BCC will also serve as a consultative committee to which treatment teams may come for clinical advice and consultation regarding individuals who are having difficulty progressing in treatment. The membership of the BCC is such to ensure that clinical and administrative decision makers are present so the necessary resources and support can be provided to help treatment teams implement suggested clinical strategies. At a minimum, membership would include the Executive Director (or delegate); the Medical Director (or delegate); the Chiefs of Psychology, Social Work, Nursing and Rehabilitation Therapy, and representatives of the Positive Behavior Support Team. **Findings:** The hospital's self-assessment report indicated that this process is underway and that a chair was chosen and a committee identified as of 02/13/09, but the committee has not begun to function. **Compliance:** Partial.

			Current recommendations: 1. Include monitoring data about progress notes in auditing data discussed in Cell VIII.B.1.c (above). 2. *Implement training of unit staff on any unit that has an individual receiving intensive behavioral treatment interventions.* 3. *Implement the BCC in consultation with training/consultation provided by Angela Adkins.*
RB	VIII.B.1.f	ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs.	**Findings:** Staffing records provided by the Hospital indicate that currently there is not one full time psychologist per unit/ward and that the PBS psychologist is also functioning as a unit psychologist. **Compliance:** Noncompliance. **Current recommendations:** 1. *Assure that the PBS service is a stand-alone service, whose psychologist does not also have unit/ward/treatment team responsibilities.* 2. *Continue to recruit and hire psychologists so that there is at least one psychologist per ward/treatment team.*
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, February 2008:** Assure that the initial assessments of all disciplines include an assessment of the types of group interventions from which the individual would most clearly benefit based on diagnosis, symptoms status, functional level and discharge setting. **Findings:** All initial assessments now contain sections that are related to the

			assessing clinician providing some recommendations about specific interventions that may benefit the individual. The Comprehensive Nursing Assessment lacks guidelines, however, about how the relevant sections (VIII. Interventions for Recovery) is supposed to be completed. **Recommendation 2, February 2008:** Determine, based on the hospital's current census, the type and number of the various groups that must be offered in each of the treatment malls. **Findings:** Treatment mall services are being realigned into three Therapeutic Learning Centers, and this process is supposed to be incorporated into the new TLCs. **Recommendation 3, February 2008:** Develop a process for assigning individual clinicians as group leaders for those therapeutic modalities for which they are adequately trained. **Findings:** Not yet done except for some initial training for some nursing staff and promise to include it in the credentialing process for psychologists. **Recommendation 4, February 2008:** Develop group treatment offerings that are manual-based., empirically validated and part of a curriculum development process. **Findings:** A manual-based and empirically validated curriculum has been adopted for TLC1, borrowing in part from curricula developed by SAMHSA. **Recommendation 5, February 2008:**

			Develop an auditing process to assure that clinicians are appropriately trained in all therapeutic modalities they are providing and that there is adequate fidelity to the curriculum and the manual for the group. **Findings:** Not yet done. **Recommendation 6, February 2008:** Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not yet done. **Recommendation 7, February 2008:** Periodically, conduct a needs assessment based on current census to determine necessary changes to the mall curriculum. **Findings:** Not yet done. **Compliance:** Partial. **Current recommendations:** 1. *Develop guidelines for the completion of the Comprehensive Nursing Assessment that give clear direction on how to complete Section VIII: Interventions for Recovery.* 2. *Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3.*
RB	VIII.B.	By 18 months from the Effective Date hereof,	**Findings:**

	3	SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.	See Findings for Cell VIII.B.2 (above). **Compliance:** Partial. **Current recommendation:** *Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3.*
RB	VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
RB	VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	**Findings:** See cell VIII.B.1.c **Compliance:** Partial. **Current recommendation:** See cell VIII.B.1.c.
RB	VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Assure that assignments to specific groups are based on individualized assessment and not simply by virtue of being eligible for the Dual Disorders Mall. **Findings:** The new treatment mall reorganization plan that divides the Hospital's civil division into three Therapeutic Learning Centers (TLC) provides for a better opportunity for individualized assessment. Additionally, the treatment protocols adopted from SAMHSA and others on co-

			occurring mental illness and substance abuse provide lesson plans aimed at individuals who have been appropriately assessed. Improvements in compliance awaits the implementation of all three TLCs. **Recommendation 2, September 2008:** Develop specific group offerings that are aligned with the different Stages of Change. **Findings:** Not yet done. **Compliance:** Noncompliance. **Current recommendations:** 1. *Implement treatment mall realignment project.* 2. Develop substance abuse treatment options based on the individual's stage of change.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Current findings on previous recommendation:** **Recommendation, February 2008:** Undertake a systematic analysis of the care needs and community placement supports and services required for all individuals with cognitive impairments, and where appropriate develop community living plans for these individuals that optimize community tenure. **Findings:** An inventory of available community housing for individuals with cognitive disorders has been completed, but no inventory of community supports has been undertaken. Additionally, all new admissions are administered a cognitive screen and the Initial Psychological Assessment involves the use of appropriate standardized testing to aid

			in the diagnosis of cognitive disorders or the need for further assessment. Unfortunately, the fact that the results of neuropsychological evaluations sought for diagnostic clarity either do not get completed prior to discharge, or when completed are seldom integrated into the IRP diagnosis stands as an ongoing obstacle in meeting this requirement of the Agreement. **Compliance:** Noncompliance. **Current recommendations:** 1. *Complete a survey of community supports for individuals with cognitive impairment.* 2. *Audit the integration of neuropsychological findings with the IRP diagnosis, objectives and interventions.*
RB	VIII.B. 4.d	programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;	**Findings:** Appropriate programs exist and are functioning. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VIII.B. 4.e	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;	**Findings:** This reviewer once again agrees with the findings of the hospital's self-assessment that "documentation continues to be inadequate on this requirement" and that "staff do not routinely or comprehensively document the individual's response to particular treatment interventions, so it is not clear…which interventions are effective." Additionally, problems with the content of the IRP form contribute to this problem, as does what appears to be a lack of conceptual clarity

			regarding the integration of all elements of integrated recovery planning. Observed IRP conferences never discussed these issues, and no documentation related to this issue was found in reviewed records. **Compliance:** Noncompliance. **Current recommendations:** 1. *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal.* 2. Assure that this item is audited on both the IRP conference process auditing tool and the IRP chart review tool.
RB	VIII.B. 4.f	clinically relevant information remains readily accessible; and	**Current findings on previous recommendation:** **Recommendation 2, September 2008:** Modify Mall Progress Note template to assure that the specific objective for which the individual was assigned to the group appears on the note and that there is a place for the provider to indicate progress toward achievement of that objective. **Findings:** While this modification has taken place, most reviewed notes merely checked off that progress was not being made without making any suggestions for how to improve the individual's progress toward obtaining the treatment objective. **Compliance:** Noncompliance. **Current recommendation:**

			Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Assure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box.
RB	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.	**Findings:** The behavioral consultant has begun this training process and the behavioral analysis and draft documents developed by individual clinicians that were presented for review show significant promise. Additionally, some general training in behavioral management was provided for nursing staff on RMB 3. Quantitative audits have not yet begun. **Compliance:** Partial. **Current recommendations:** 1. *Continue work with consultant.* 2. *Continue providing overview training in PBS for all clinicians.* 3. *Implement, monitor and audit several PBS plans in the next 6 months.* 4. *Train nursing staff in the implementation of specific behavioral plans and guidelines.*

	C. Pharmacy Services		
MES		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:	**Methodology:** Interviewed: 1. Ermias Zerilassie, Chief Pharmacist. 2. Robert Ganes, Assistant Chief Pharmacist. Reviewed: 1. SEH Pharmacy Services/Standard Operating Procedures-File Number 7.8, Pharmacy Verification of Medication Orders Utilizing Worx, February 24, 2009. 2. SEH data regarding recommendations made by the pharmacists based on drug regimen reviews (September 17 2008 to February 23, 2009). 3. SEH AVATAR Issues List.
MES	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	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments. **Findings:** SEH developed a system for pharmacy review of medication orders as an interim step until necessary software changes can be made in the AVATAR system. The categories of review adequately addressed the recommendation. **Recommendations 2 and 3, September 2008:**

			• Develop 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. • Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2. **Findings:** SEH did not address these recommendations. **Other findings:** SEH presented data regarding recommendations sent by the pharmacists to the prescribing practitioners during this review period (September 17, 2008 to February 23, 2009). The recommendations addressed the following categories: drug-drug interactions, allergies, contraindications, dose and frequency/rate of drug administration, duplicate orders and orders requiring clarification. However, some categories were described vaguely without operational definitions, e.g. "activities, drug information, pharmacist clinical counseling, therapeutic consultation and no change." **Compliance:** Partial. **Current recommendations:** 1. *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department. The recommendations should include, but not limited to, the following categories:* a. *Drug-drug interactions;* b. *Side effects;* c. *Need for laboratory testing;* d. *Indications;* e. *Contraindications;*

			f. *Drug allergy;* g. *Dosage issues;* h. *Polypharmacy;* i. *Drug-food interactions;* j. *Incomplete orders; and* k. *Orders that need clarification.* 2. *Provide operational definitions and an explanation of the significance of pharmacists' recommendations in the categories of ""activities, drug information, pharmacist clinical counseling and therapeutic consultation and no change."* 3. *Develop tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from drug regimen reviews.* 4. Develop and implement a self-monitoring mechanism regarding the requirements of VIII.C.1 and VIII.C.2.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Compliance:** Same as above. **Current recommendation:** Same as above.

	D. Nursing and Unit-Based Services		
LDL		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:	**Summary of Progress:** 1. A Chief Nurse Executive was hired in October 2008. Nurse Educator positions have been established and filled. 2. A concerted effort to fill nursing positions has resulted in a 7% vacancy rate in nursing as of February 2009. 3. Nearly all AVATAR issues that impacted medication administration have been resolved. 4. A comprehensive Medication Variance policy has been developed. 5. There are beginning signs of enhanced nursing engagement with patients. 6. A number of recommendations from the last two visits have been acted upon. **Methodology:** <u>Interviewed</u>: 1. Andre Nichols, PT 2. Bernard Arons, MD, Medical Director 3. Brenda Lateef, RN, Nurse Educator 4. Calvin Jones, PT 5. Carolyn Fox, PT 6. Daniel Gayell, Dietary Staff 7. Edith Watson, LPN 8. Emmanuel Dzokwlu, LPN 9. Funmilayo Olugbmeni, RN 10. Gladys Nebafu, RN 11. Joyce Gaino, Dietary Staff 12. Kevin Oneukwusi, RN 13. Laverne Plater, RN, Nurse Consultant, Civil Services 14. Laverne Robinson Bobo, RN 15. Lewis Mayon, RN, Nurse Educator 16. Malcolm Cook, RN, Infection Control Chief

			17. Mamerta Benzon, RN, NUM RMB 1 18. Moliki Agbor, RN 19. Omar Okojie, PT 20. Reba Brothers, RN, NUM RMB 6 21. Regina Michael, RN 22. Rosylin Yesudian, RN 23. Serah Flavia, RN 24. Shirley Quarles, RN, Nurse Consultant, JHP 25. Tyrone Hampton, PT 26. Veronica Parham-Dudley, RN, CNE 27. Walter Valliere, Chief Administrative Officer 28. Yi-Ling Tu, RN, NUM RMB 2 <u>Reviewed</u>: 1. Medical records of the following 28 individuals: AH, AP, AW-B, CK-1, CK-2, CW, DC, DW, GM, GS, HH, JM, JR, KC, LB, ML, MM, MP, MW, RG, RJ, RM, SS, TH, TJ, TT, VE and VG SEH Compliance Report, March 2, 2009 2. SEH Trend Analysis: December 2008 3. SEH Policy: Interdisciplinary Recovery Planning for In-Patient Services, 602.2-04; revised February 23, 2009 4. Clinical Record, Initial Interdisciplinary Recovery Plan form; revised February 19, 2009 5. Clinical Record, Interdisciplinary Recovery Plan form; revised February 19, 2009 6. Draft Interdisciplinary Recovery Manual 7. Draft Interdisciplinary Recovery Plan Process Monitoring Tool, February 6, 2009 8. IRP Chart Review and Process Observation Results, February 2009 9. SEH Policy: Assessments, 602.1-08; new issuance, February 23, 2009 10. Comprehensive Nursing Assessment Form; revised March 23, 2009 11. Draft Comprehensive Nursing Assessment Self-Audit Tool, March

			25, 2009 12. Draft Operational Instructions Self-Auditing Tool for Nursing Comprehensive Assessment, (undated) 13. SEH Policy: Restraint and Seclusion for Behavioral Reasons, 101.1-04; revised February 24, 2009 14. SEH Seclusion and Restraint Audit Results, February, 2009 15. Draft Nursing Procedure: Using eMAR for Medication Administration, MED-501; revised February 18, 2009 16. Environmental Survey Report, 4th Quarter, 2008 and draft 1st Quarter, 2009 17. SEH Policy: Medication Variance Reporting and Assessment, 202-05; new issuance, March 2, 2009 18. SEH Policy: Medication Ordering and Administration, 206-09; new issuance, February 11, 2009 19. AVATAR Issues List 20. Medication Monitoring and Chart Review Results, February, 2009 21. Pharmacy and Therapeutics Committee Minutes, July 9, 2008 – February 11, 2009 22. Draft Nursing Procedure: Physical Observation, NCP 600.24; revised March, 2009 23. Draft Clinical Record Physical Observation Form; revised March 23, 2009 24. Draft Nursing Procedure: Nursing Basic Skills and Competency Assessment, SDR-300-2; revised March, 2009 25. Draft Change of Shift Report form (undated) 26. Draft Nursing Procedure: Change of Shift Report, GNA-109; revised March, 2009 27. Nursing Case Study Conference (description, outline, and forms; undated) 28. Draft Training and Professional Development at SEH, April 1, 2009 29. Nursing Procedure: Insulin Administration, MED-504; reviewed September, 2008 30. List of New or Revised Nursing Forms (indicating those that only an

			RN can complete, and those that can be completed by all nursing staff; instructions to access forms, and instructions for use (undated) 31. Nursing Procedure: Guidelines for Choking/Swallowing Assessment, NCP 600.25; effective June, 2008 32. Clinical Record, Choking/Swallowing Assessment Form; revised February 5, 2009 33. SEH Policy: Medical or Protective Measures, Devices and Techniques, 101.2-08; revised February 24, 2009 34. SEH Labor Management Analysis, February 1 – 15, 2009 35. SEH "Using a Daily Labor Management Report" (undated) 36. SEH Forensic and Civil Programs, Nurse (sic) Staffing, 12/21/08 – 2/15/09 (actually reflects all nursing staffing worked hours) 37. SEH Nursing Labor Management Summaries, Daily Labor Management Report, February 1 – 22, 2009 38. SEH Daily Labor Management Report, Civil and Forensic Daily Summary, February 1 – 7, 2009 39. SEH Policy: Involuntary Medication Administration, 201-05; revised February 23, 2009 40. Advanced Instructions/Personal Comfort Planning form; revised February 11, 2009 41. Levels of Observation Flowsheet form; revised February 24, 2009 42. Doctor's Order for Restraint and Seclusion form; revised February 20, 2009 43. List of Patients given PRN/STAT Medications between 8/20/2008 and 2/20/2009 44. Department of Nursing, Course and Attendance (undated) 45. Nurse Training – FY 09 to Date (undated) 46. Nursing Education, Nursing Core Competencies (list and brief paragraph describing unit based training, undated) 47. Department of Nursing Course Curricula for: Therapeutic Communication; Introduction to Group Process; 2008-2009 Annual Medication Update, Psychotropic Medications, Medication

			Variances, and Adverse Drug Reactions; Physical Assessment for FPTs and PNAs; Physical Assessment for RNs and LPNs; Stages of Change; Documentation; Involuntary Medication Administration. 48. Draft SEH Nursing Action Plan, March 25, 2009 <u>Observed</u>: 1. IRP Conference: RJ, JHP 3; FP, RMB3; 2. Meal Observations: RMB 1,2 (units); 3,4 (Dining Room) 3. Change of shift report: RMB 3, 5 4. Med pass: RMB 5; JHP 2 (discussed process); RMB 3 (discussed process)
LDL	VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on staff interviews and document review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** *"Training and Professional Development at SEH" (draft, 4/1/09)* differentiates training responsibilities among three offices: Office of the Chief of Staff; Office of Nursing; and the Office of Training and Professional Development. The Nursing component is incomplete, indicating that subject matter will be added as final competency lists are developed. Without this component, it is difficult to evaluate if there is clear differentiation of content and if all required content is addressed. *"Nursing Training – FY 09 To Date"* reflects that 27.5% of nursing staff have been trained in Mental Health Diagnoses. It was reported that these classes were suspended in order to complete Abuse and

			Neglect training. The above referenced report reflected aggregate percentages of nursing staff trained in nine (9) categories as follows: CPR (68.4% trained); Psychotropic Medication Update for RNs and LPNs (96.9% trained); Physical Assessment for RNs and LPNs (20.6% trained); Physical Assessment FPT/PNA (16.5% trained); Therapeutic Communication (3.9% trained); Documentation (3.1% trained); Restraint and Seclusion (78.3% trained); Group Process (3.9% trained). However, it is not clear if this report reflects training and/or competencies achieved. Because revised nursing competency policies/procedures do not clearly articulate the competency program structure, it is not possible to know whether or not training represents competency achievement. It is also not possible to know the percentage of staff who achieved competency during orientation, and maintained competency during annual update training. CPI content has not been augmented as previously recommended. This recommendation will be revised. **Recommendation 2, September 2008:** Clarify if the treatment plan is to be called a treatment plan, a person centered plan, or an individual recovery plan then develop competency based training to be conducted during orientation and annually thereafter. **Findings:** Treatment plans are being called Individual Recovery Plans (IRP). The Nursing Training Modules for the IRP have not been completed. **Recommendation 3, September 2008:** Assure that all nursing staff attend mental health diagnoses training and achieve competency by December 31, 2008.

			Findings: *"Nursing Training – FY 09 To Date"* reflects that 27.5% of nursing staff have been trained in Mental Health Diagnoses. It was reported that these classes were suspended in order to complete Abuse and Neglect training. The CNE indicated that the combination of the nursing unit staffing levels and the need to reduce overtime prohibited staff from leaving the units for training. Subsequently, the training has been reduced from eight (8) to four (4) hours and training is reportedly being conducted at the unit level to engage more staff. Another report titled *"Department of Nursing, Course and Attendance"* (undated but references a completion target date of 12-31-09) has a column titled "Failure/Incomplete". For the "Mental Health Diagnosis" course, this column shows the numbers 2/10, presumably reflecting 2 failures and 10 incomplete. There is no indication what action was taken in response to this. **Recommendation 4, September 2008:** Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications. **Findings:** This has not been completed. The "Action Steps and Status" listed the SEH Compliance Report do not directly relate to this recommendation. The recommendation will be revised. **Recommendation 5, September 2008:** Nursing Unit Managers and/or Nurse Consultants should conduct weekly Nursing Care Conferences on the unit that focus on an individual whose behaviors are challenging for nursing staff and an individual with whom nursing staff work effectively. These conferences should integrate training on mental health concerns/diagnoses, should contrast

			effective/ineffective interventions, and should result in recommendations for the IRP. **Findings:** A *"Nursing Case Study Conference"* document that included a Case Study Outline, forms for *List of Nursing Care Conferences Planned* and *List of Nursing Care Conferences Completed*, a *Nursing Case Study Conference Performance Tool* (to rate the nurse who presents the case study), a *Nursing Department Case Study Training Referral Form*, and a *Case Study Sign-In Sheet* were provided. SEH indicated that these conferences cannot be held on a weekly basis, and will more likely be held monthly or bi-monthly. The somewhat academic and cumbersome process is a likely contributor to this and to the fact that few conferences have been held. Nursing Care Conferences do not need to be this complicated. Such conferences should stimulate a dialogue among staff and help them to discover why some interventions support individuals' recovery and others do not. Open dialogue is a key element to learning. Because of this, performance evaluation should not be an element of these conferences. With the assistance of the very capable Nurse Consultants, every Nursing Unit Manager could initiate these dialogues immediately. **Recommendation 6, September 2008:** Develop and implement a unit-based training experience on non-confrontational limit setting. **Findings:** This has not been done. The Action Step and Status in the SEH Compliance Report, reflects a far more complicated, time consuming, and un-focused plan than is necessary to act on this recommendation. The *"Therapeutic Communication"* training module that was reviewed during the February, 2008 tour, can easily be used as a foundation for a practical approach to talking about the concept of limit-setting, when

			it is necessary, and how to do it effectively. Staff can contribute their experiences or interactions they have heard on the unit and begin to contrast confrontational versus non-confrontational statements. **Recommendation 7, September 2008:** Develop a basic competency based training program for nursing staff who conduct rehabilitative and enhancement groups. Utilize staff who are competent in running these groups to train other nursing staff. **Findings:** A basic program has been established. *"Nursing Training – FY 09 To Date"* reflects that 3.9% of nursing staff have been trained in Group Process. An un-dated *"SEH Department of Nursing, Introduction to Group Process, Course Curriculum"* reflects that the basic content is present. Although teaching strategies are specified, the method for determining competency is not specified and needs to be included. **Other findings:** A CNE was hired and began in mid October 2008. Nurse Educators have been hired. There are now two Nurse Consultants, one for Civil and one for Forensics. Both of these individuals can make substantial contributions to training and coaching, provided that they have the proper authority to do so e.g. are actively involved and supported by those in line authority positions. There appears to be minimal systematic progress on the orientation and training program structure and specific competency based training. Documents that were presented were undated, in draft format, and/or do not provide sufficient information. For example, a draft *Nursing Procedure, Nursing Basic Skills and Competency Assessment (SDR-300.2; revised 03/09)* was presented for review. The policy details "general provisions" and "responsibilities" of various nursing management staff. However, the policy does not specify exactly which

			competencies are required during orientation and on an annual basis; it does not specify clear timelines, methods, and accountability for achieving these competencies. It also does not provide clarification regarding the relationship between trainings attended and competencies achieved. The two terms are not interchangeable. Reports need to clearly reflect whether training, competency achievement, or both are being reported. The policy also does not describe a specific mechanism for assuring that staff who are not currently competent in a specific function are not assigned duties that require this competency. The CNE stated that she is working on an infrastructure to enhance competency-based training. Nurse educators are actively organizing curricula, using pre and post testing for some, and experimenting with alternative methods to deliver training programs to unit staff. Unit based training has reportedly been well received. The highest percentage of training attendance was achieved for "Psychotropic Medication Update for RNs and LPNs". An on-line approach was reportedly used for this. Application to other routine training should be explored. Using technology based learning for routine trainings will free valuable and scarce face-to-face training time for topics needed to support the changes SEH is introducing. *SEH Department of Nursing Course Curriculum* were reviewed for the following topics: Therapeutic Communication; Introduction to Group Process; 2008 – 2009 Annual Medication Update; Restraint and Seclusion for Behavioral Reasons; Psychotropic Medications, Medication Variances, and Adverse Drug Reactions; Physical Assessment for FPTs and PNAs; Stages of Change; Documentation; Physical Assessment for RNs and LPNs. With the exception of Physical Assessment for RNs and LPNs, and Restraint and Seclusion for Behavioral Reasons, the outlines appear to cover the basic components (see details below for these two curricula). However, only the Restraint/Seclusion outline appears to

			specifically address related SEH policies and procedures. This is fine, as long as these items are covered in some other orientation/annual update curriculum. No curriculum outline specifies competency assessment. Competency assessment methods and measurement tools need to be specified. The Physical Assessment outline does not include areas of potential risk for patients served at SEH. For example, GI issues (bleeding, bowel obstruction), infection, delirium, and diabetes are not addressed. Restraint and Seclusion for Behavioral Reasons seems to address SEH policies and procedures, but not the larger issues of the factors that contribute to use, how to prevent use, impact of use, and nothing relative to trauma informed care is covered. As with the CPI content, it is critical that SEH address the larger culture change that must take place in order to minimize restraint and seclusion use. Psychotropic medication reflects discussion about managing side effects. However, content that addresses all side effects must be added. No curriculum appears to adequately cover monitoring of symptoms and target variables, and documenting and reporting the individuals' status. This needs to be clearly addressed. The SEH Compliance Report references the development of a "strategic plan" for nursing, designed to improve the pace and type of reforms. However, both the draft plan and the general narrative that is described in the Compliance Report need to be much more focused, with specific action steps and deadlines consistent with the requirements of this agreement. **Compliance:**

			Partial. **Current recommendations:** 1. *Review the course outlines/content of hospital-wide orientation and nursing department orientation. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine competency.* 2. *Review the course outlines/content of hospital-wide annual update training and nursing department annual update training. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine if competency has been maintained.* 3. Review all competency assessment tools to determine if competency measures meet the requirements of this agreement and generally accepted practice standards, and if the measures are currently applicable. Assure that RN competencies address RN judgment as it relates to physician order transcription, medication administration, seclusion and restraint use, and notifying a physician when a patient's physical status changes. 4. *Develop a nursing policy and procedure template that will assure that each policy/procedure (p/p) is in the same format and that it addresses: the purpose of the p/p; the policy statement that expresses the standard; definitions as needed; general information as needed to address context and integration with other p/p; and procedures. The procedures should be step-by-step directions addressing: who does what; when or at what intervals; where as applicable; how as applicable; and documentation requirements. Align forms and p/p as each of these are developed.* 5. *Develop a policy that describes 1 – 3 above and specifies actions taken when a staff member does not achieve or maintain competency.*

			6. Implement the policy. 7. *Report aggregate percentages of staff who attended training.* 8. Report aggregate percentages of staff who achieved or maintained competency. 9. *Develop and implement Nursing IRP training.* 10. *Add content to the physical assessment curricula related to GI issues (bleeding, bowel obstruction), infection, delirium, and diabetes.* 11. Review and consider addressing other comments in the findings above. 12. At this time, consider using the requirements in this agreement as a nursing strategic plan rather than spend time developing/revising the draft plan.
LDL	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;	**Current findings on previous recommendations:** SEH reports no progress in this area. However, based on document review, record review, and unit observations, I believe that some progress has been made. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Previous recommendations that have been completed include: Nursing Diagnoses were discontinued; standardized areas of assessment/goal focus for the IRP were developed; physical/environmental changes were completed that provide nursing staff with a private work area. **Recommendation 2, September 2008:** Clarify the time intervals and content of Nursing Assessments that occur within 8 hours of admission and those that occur in preparation for the IRP. If there is no additional assessment prior to the IRP,

			establish a process to review and update the admission assessment information. **Findings:** *A Comprehensive Nursing Assessment form (3/23/09)* has been developed, but not yet implemented. The CNE indicated that the assessment must be completed within 24 hours of admission. No accompanying policy/procedure has been finalized that describes the process for linking the assessment to the initial IRP, the process for using "screens", and the process for evaluating/updating information that emerges during the time interval between admission and the IRP. **Recommendation 3, September 2008:** Establish a Nursing Assessment Policy/Procedure that emphasizes the purpose of the initial nursing interviews rather than form completion. The existing Nursing Admission Assessment Guidelines can be used to guide form completion, with additional details specified. **Findings:** No policy has been developed to accompany the new assessment form. **Recommendation 4, September 2008:** Revise the Comprehensive 8-Hour Nursing Assessment using more interview questions that actively involve the patient, that uncover strengths, and that focus on his/her lived experience e.g. how his/her physical or psychiatric status impacts daily life and what s/he would want to change. **Findings:** The Comprehensive Nursing Assessment includes some excellent interview questions that actively involve the patient. **Recommendation 5, September 2008:**

			Revise and implement nursing assessment monitoring. **Findings:** It was reported that no progress has been made. However, a draft *Comprehensive Nursing Assessment – Self-Audit Tool, 3/25/09* was provided. Both the audit tool and instructions will need to be modified to match the new assessment e.g. there is no section in the assessment form for "treatment recommendations" yet that section is referenced in the tool/instructions. The audit tool should be finalized only after a policy/procedure for the assessment is written in order to assure that critical components are included. The time frame for the admission assessment also needs to be clarified e.g. the tool says eight (8) hours, the CNE reported 24 hours. **Recommendation 6, September 2008:** Clarify the treatment model. Revise the nursing portion of the hospital *Assessments* policy so that it is more aligned with the discipline's focus and contribution. **Findings:** The revised policy contains a general description of content in the Nursing Assessment. Of the risk areas that nursing is responsible to address, three that are listed in the hospital policy are not specifically assessed in the *Comprehensive Nursing Assessment*: fire setting, elopement, sexual acting out. The policy also reflects that the nursing admission assessment must be completed in eight (8) hours. The CNE indicated it is completed within 24 hours. **Recommendation 7, September 2008:** Establish a mentoring system to support treatment teams to conduct treatment planning sessions according to the protocol. **Findings:**

			A list of treatment team mentors was provided and the hospital has indicated that mentoring is taking place. The Action Steps and Status in the SEH Compliance Report under this recommendation reflect the need for nursing to be better integrated with overall facility actions relative to the IRP processes. There is no need for nursing to have separate mentoring at this time. **Recommendation 8, September 2008:** Establish a process for nursing staff to prepare for treatment planning sessions in advance in order to present relevant information/observations. **Findings:** Nursing staff were prepared and provided relevant input during the observed treatment planning sessions. One RN in particular did an excellent job bridging treatment team expectations and the individual's expectations. She offered a creative approach that took the individual's stage of change into consideration. This approach was enthusiastically accepted by all. According to the most recent treatment team attendance monitoring snapshot data (February 2009), RNs were present 75% and PsychTechs 35%. Assessment summaries were presented by RNs 58%. Lastly, nursing progress notes were reportedly present 76% prior to the IRP (July – September monitoring data). Chart reviews revealed that although there was variability in the presence and quality of nursing interventions in the IRPs, some contained specific individualized nursing interventions. **Other findings:** Change of shift report templates have been revised. During shift change, the report contained information relative to the patient's

			response to medication and behavioral interventions. Relevant medical/physical health information as well as a review of the patient's symptoms was presented as required. There is beginning evidence during meetings and in patient records of an organized interdisciplinary approach to treatment. Nursing assessments, the development of relevant objectives and interventions, and evaluation of the effectiveness of the interventions in progress notes will be strengthened as more units are trained in the IRP. During unit observations, there was some evidence of increased nursing engagement of patients during their unstructured time. Nursing staff were observed interacting and playing games with patients. Although these were rarely evidenced in the IRPs, reviews of nursing chart notes revealed a number of examples of individualized interventions e.g. anger coping strategies, preferred foods/fluids identified. Some nursing progress notes provided excellent summaries of nursing interventions and the patient response. Patient teaching and progress in self care e.g. fingersticks for blood glucose was also documented. Other record entries continued to reflect the need to enhance understanding of how behavior is impacted by mental illness. **Compliance:** Partial. **Current recommendations:** 1. *Clarify expectations/align the Comprehensive Nursing Assessment with the content and timeline expectations reflected in the hospital policy.* 2. *Using the nursing p/p template, develop a nursing p/p that provides step-by-step guidance to conduct and document the comprehensive assessment. Assure that the policy addresses: the process for*

			linking the assessment to the initial IRP, the process for using "screens", and the process for evaluating/updating information that emerges during the time interval between admission and the IRP. 3. *Implement the policy and the Comprehensive Nursing Assessment.* 4. Finalize the monitoring tool, begin audits, act to resolve trends and monitor the effectiveness of actions. 5. Develop a template for nursing progress notes that includes prompts to meet documentation requirements in this agreement. 6. Develop a policy for nursing progress notes that meets the documentation requirements in this agreement.
LDL	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;	**Current findings on previous recommendations:** SEH reports no progress in this area. However, based on document and record review, I believe that there has been some progress. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** A draft *Change of Shift Report* form was observed to be in use during shift change from days to evenings. Although relevant information related to physical and psychiatric status was shared verbally, progress on IRP objectives was not specified. Effective individualized interventions were sometimes mentioned, especially as it related to dealing with patients presenting challenging behaviors. The columns in the form were not being utilized. Rather, narrative statements were written across all columns. The draft nursing procedure, *Change of Shift Report (GNA-109),* does not provide guidance for completion of the form, and contains very general statements about what "arriving" and "departing" nursing staff members do together e.g. "environmental rounds" is referenced, but not specified; accountability is not clear.

			A real time monitor of documentation related to physical status was not developed. This recommendation will be revised. Policies to address RN to MD interface when patients experience a medical emergency, are transferred to and from other treatment settings, and when they experience changes in physical status have not been developed. (See below). This recommendation will be consolidated and revised. **Recommendation 2, September 2008:** Revise the Physician Notification Policy and issue it as a Joint Medical Nursing Policy. Include clear operational definitions and response timelines for emergent, urgent, and non-urgent situations. Consider using the SBAR approach (situation, background, assessment, recommendation) to structure the RN assessment, documentation, and report to the physician. **Findings:** Although the SEH Compliance report indicates that this action is complete, it is not. The Physician Notification Policy that was revised in June 2008 does not provide adequate direction. A policy that meets the above requirements has not been completed and needs to be prioritized. In most instances, vital signs were well documented although other medically necessary measurements were inconsistently present, most notably intake and output. When patients were transferred to or returned from other hospital settings due to a change in physical status, some RN assessments were complete and included relevant assessment information such as lung sounds. However, most of the documentation in these instances is incomplete e.g. the time of the physical status change was not

			documented, the time of physician notification was not documented, notes that explained the patient's transfer in or out were entirely missing, and assessments were incomplete. Equally concerning is the fact that some patients have repeated visits to EDs or repeated acute hospitalizations. These patients typically do not adhere to requirements necessary to stabilize their physical status e.g. do not eat/follow prescribed diet, do not increase or decrease fluid intake as required. In these situations, there was no evidence that the treatment team explored, or addressed, barriers to adherence. In a situation that involved significant changes in a patient's physical status (poor hand/mouth coordination, difficulty arousing, drooling, incontinence) there was no evidence that the RN did a thorough assessment and notified the physician in a timely manner. The patient was hospitalized for pneumonia within a week of these presenting symptoms. **Recommendation 3, September 2008:** Revise the Physical Observation form or develop another form to document precise intake and output as well as treatments such as dressing changes. **Findings:** A draft *Physical Observation* form (3/23/09) was reviewed. It does not address the need for precise intake and output and does not contain prompts for documenting specific other treatments that would require such actions as wound assessment. The accompanying draft nursing procedure, *Physical Observation (NCP-600-24),* does not contain adequate specific direction. The current intake and output form requires documentation on an hourly basis. Intake and output does not need to be monitored on an hourly basis for most situations involving the patients served at SEH. Therefore, requiring hourly documentation is cumbersome for staff and may contribute to the observation that the form is rarely completed.

			Recommendation 4, September 2008: Develop a monitoring instrument and monitor documentation, analyze trends, take action when improvement opportunities are identified, monitor the effectiveness of actions taken. **Findings:** No actions have been undertaken. **Other findings:** Documentation of patients' intake and output, including for those with Diabetes Insipidus, was absent and/or incomplete. Blood sugar levels were sometimes missing from chart records. When I inquired about this, staff stated that the RN documents blood sugars in AVATAR as well as on hard copy record in the chart. This duplicate documentation was reportedly required by GMOs who do not want to use AVATAR. This should be resolved so that there is one place that contains all documentation relative to blood sugar levels. **Compliance:** Partial. **Current recommendations:** 1. *Revise the Physical Observations form and the Intake and Output form. Use the nursing p/p template to develop a p/p to accompany each form.* 2. *Implement the forms and policies/procedures.* 3. *Develop a joint medical nursing policy that at a minimum addresses: assessment data that the RN will provide to the MD; joint determination of the level of urgency of a physical status change; expected response times based on the level of urgency (emergent, urgent, and non-urgent); RN and MD follow up actions; assessments and documentation prior to transfer to an ED or acute care*

			hospital; assessments, notifications, and documentation upon return from an ED or acute care hospitalization. 4. Resolve barriers to using the draft Change of Shift Report template as designed; revise the form as necessary; finalize the procedure; implement the form and procedure. 5. Consider developing templates to document nursing assessments for physical status change, and transfers to and from EDs or acute care hospitalizations. 6. Develop a monitoring instrument; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, record review, staff interviews, and unit observations, I believe that progress has been made. **Recommendations 1-3, September 2008:** • Take action on previous recommendations that are currently incomplete and monitor implementation. • Determine and define terms for medication variances and/or medication errors. • Develop a hospital policy that will cast a wide net for reporting and that reflects a contemporary understanding of the factors that contribute to medication variances/errors.

			Findings: A revised *Medication Variance Reporting and Assessment* policy (202-05) became effective March 2, 2009. However, the facility has yet to develop written instructions to staff to ensure accurate description of events in each possible category of actual and potential variances, assessment of critical breakdown points (prescription, transcription, ordering/procurement, dispensing/storage, administration, documentation or medication security) and assessment of factors that may contribute to the occurrence of variances. **Recommendation 4, September 2008:** Eliminate duplicate reports. Assure that the form used to report medication variances/ errors takes into account the process changes associated with AVATAR. Assure that the form provides sufficient structure and well-differentiated categories necessary to identify breakdowns in any/every part of the medication administration process. **Findings:** SHE has yet to implement this recommendation. **Recommendation 5, September 2008:** Resolve AVATAR issues. **Findings:** SEH is to be commended for resolving the majority of issues related to AVATAR and medications. A work group involving pharmacy, physician, nursing, and IT representation met twice weekly to identify issues,

			differentiate "business process issues" from "system issues", and propose solutions. Trouble-shooting continues, although all critical issues have been resolved. Those that remain have a clear plan in place for resolution. **Other findings:** During one medication observation, it took approximately four minutes for an RN to access a patient's MAR on AVATAR. In another situation, a covering physician spent nearly the same amount of time attempting to order a medication that was being administered late. In the latter instance, nursing staff made five phone calls, back and forth between two physicians, before one agreed to handle this issue. It is likely that the lengthy and complicated AVATAR requirements to complete this order contributed to the difficulty in clarifying which physician would provide the order. These observations are important because they illustrate the kind of unintended consequences, and risks for secondary systems, that will emerge if busy clinicians cannot access AVATAR more quickly. SEH needs to monitor this very closely. The SEH December 2008 Trend Analysis reflects beginning capability to identify trends and systemic issues associated with medication variation. Of the types of reported medication variances (May, 2007 – December, 2008) 43% were prescribing errors, 30% omissions, and 17% improper doses. Causes of error for the same time period revealed that 27% were due to system safeguards and computer related issues, 22% were due to workflow disruption. and 16% were due to knowledge deficit. The reporting periods suggest that the introduction of AVATAR alone may not account for these trends. Although reporting increased, the September 2008 – December 2008 data revealed that not all units are reporting consistent with requirements. There was not

			evidence in P &T Committee minutes that these data trends were analyzed or that any action is underway. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VIII.A.2.b.iv* 2. *The P&T Committee should analyze aggregate data, identify trends, take action to address improvement opportunities, and monitor the effectiveness of actions taken.* 3. *Revise the Medication Variance Reporting and Assessment policy to ensure direct coding for undocumented medications.* 4. Consider potential to eliminate duplicative reporting. 5. Finalize the policy on monitoring patient response to first dose of medication. 6. Continue to develop processes to analyze and act on medication variances.
LDL	VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review and

		the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	unit observations I believe that some progress has been made. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** SEH reports that a training database has been completed. This database has the capacity to track courses and competency exam scores. Data entry processes are under discussion and will reportedly be finalized within the next few weeks. Procedures to limit practice when competency is not met have not been developed. No information was presented that reflected that content and competency measures for patient teaching, side effects monitoring and exploring barriers to adherence have been developed. **Recommendation 2, September 2008:** Revise medication administration training content and competency measures to reflect implementation of AVATAR. **Findings:** A draft nursing procedure, *"Using eMAR for Medication Administration" (MED 501, Revised 2-18-09)* provides clear direction relative to use of the AVATAR system for administering medications and documenting the administration. It does not address how to handle evidence that a medication was not documented and may not have been administered. Evidence of these type occurrences was observed on MARs that were reviewed. The nursing curriculum outline, 2008-2009 Annual Update for Psychotropic Medications, does not address AVATAR.

			Recommendation 3, September 2008: If control drugs are going to be counted in the nursing station, both doors need to be closed and access to the area limited until the count is completed. **Findings:** There was general access to the nursing station while control drugs were being counted at change of shift. No policy or memo was provided that addressed this issue. **Recommendation 4, September 2008:** Develop a competency for RNs on critical thinking/judgment as it relates to physician orders and medications. **Findings:** No competency was provided and there was no evidence that this was integrated into other training content or competency measure. This recommendation will be revised. **Recommendation 5, September 2008:** Examine processes for preparing and administering medications using the AVATAR system. Establish clear practice standards and manage the surrounding environment to support RNs to adhere to these standards. **Findings:** Workflow disruption was reportedly the cause of 22% of reported medication variances. No drill down was presented in order to determine if the issue involved the work environment in which RNs prepare and administer medication.

			Other findings: When queried, staff members responsible for administering medications were able to check on med status in the AVATAR system and were able to describe the purpose and actions of medications administered. On one occasion, an LPN from an agency, who works regularly at SEH, gained access to the system using a borrowed password. This is reportedly against the policy. **Compliance:** Partial. **Current recommendations:** 1. *See recommendations for VIII.D.1, items 1-3, 5, 7 and 8.* 2. *Review practice and p/p for change of shift narcotic count.* 3. *Using the nursing p/p template, finalize the "Using eMAR for Medication Administration" (MED 501, Revised 2-18-09), assuring integration of requirements specified in this agreement.* 4. The P&T committee should drill down the top three causes of medication variances to determine actions needed to reduce medication variances.
LDL	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;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D. 4 and 5. The Medication Variance and Reporting policy does not explicitly

			address failures to complete the MAR and does not include this category in the options for type of variance. Although "documentation inaccurate/lacking" is an option for cause of variance, there is not clear direction relative to defining and categorizing indications on the MAR that reflect that a medication was either omitted or the MAR was not accurately completed. This should be addressed in the policy. The draft nursing policy, *Using e-MAR for Medication Administration* (Med-501) also does not address this issue. The definition of medication variance, as well as the designation of nursing staff members who are authorized to administer medications, differs from the hospital policy. This needs to be resolved. **Recommendation 2, September 2008:** See VIII.D.4. **Findings:** See VIII.D.4. **Other findings:** See VIII.D.4. **Compliance:** Partial. **Current recommendations:** 1. *Resolve differences between SEH policy and Draft Nursing policy relative to who can administer medications and relative to the different definitions for medication variances.* 2. *See VIII.D.4, Recommendation 2.*
LDL	VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side	**Current findings on previous recommendation:** SEH reports no progress in this area. Based on document review, I

		effects they may be experiencing and document responses;	believe there is minimal progress. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** The *Medication Ordering and Administration policy (206-09)* does not address this requirement. Although the draft nursing procedure*, Using e-MAR for Medication Administration (Med-501; 2/18/09),* states that following administration of medications, the medication staff will monitor the patient's perceptions of efficacy or side effects, it is not sufficiently specified to assure that this will happen on a regular basis. **Other findings:** In change of shift reports and in treatment planning sessions, response to medications and side effects were discussed by nursing staff as applicable. There was occasional reference to a discussion of side effects in nursing chart entries. **Compliance:** Partial. **Current recommendation:** See VIII.D.5. Recommendation 3.
LDL	VIII.D.8	Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;	**Current findings on previous recommendation:** SEH reports no progress in this area. Based on document review, record review, staff interviews and unit observations, I believe that some progress has been made. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete

			and monitor implementation. **Findings:** See VIII.D.2. **Other findings:** See VIII.D.2. **Compliance:** Partial. **Current recommendations:** 1. *See D.1. Recommendation 9* 2. *See D.2. Recommendation 1-4 and 7.*
	VIII.D.9	Ensure that each individual's treatment plan identifies:	Please see sub-cells for findings and compliance.
LDL	VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, record review, staff interviews and unit observations, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Nursing diagnoses were discontinued, although that deficit based language still occasionally appears in the records e.g. knowledge deficit, deficient self care, ineffective coping. A single Initial Interdisciplinary Recovery Plan (IIRP) has been developed that both the RN and MD will use to direct initial treatment

			and nursing care. (See discussion below). Nursing training relative to diagnoses has begun. A dysphagia assessment has been implemented, though triggers are not well specified. **Recommendation 2, September 2008:** Develop a policy that guides implementation of the Initial Treatment Plan that includes a focus on priority issues pending completion of the IRP. **Findings:** An Initial Interdisciplinary Recovery Plan (IIRP) has been developed that will reportedly be completed by the psychiatrist with input from the general medical doctor and nursing staff. Guidelines for implementation were not provided. It will be important that these are developed and that the Registered Nurse be directly involved in the development of the IIRP. The expectation for linking with the Comprehensive Nursing Assessment will also need to be made explicit. **Recommendation 3, September 2008:** Monitor ITP implementation. **Findings:** SEH currently monitors several aspects of the ITP and the treatment team planning process. This recommendation will be revised. **Recommendation 4, September 2008:** See VIII.D.2. **Findings:** See VIII.D.2.

			Recommendation 5, September 2008: Develop a comprehensive interdisciplinary dysphagia program that involves dentistry, dietary, and rehabilitative therapies. **Findings:** A *Choking/Swallowing Assessment* form has been developed and was revised on 2/5/09. While some records contained these assessments, they were sometimes incomplete and the linkages to nursing interventions were not always made explicit in the IRP. *Guidelines Choking/Swallowing Assessment* (NCP 600.25) does not provide adequate guidance for consistently thorough assessments, integration into the IRP, implementation of relevant interventions, and documentation in the record. Although there was sometimes evidence of referrals to the physician and dietary, there is no indication in the records that dentistry or rehabilitative therapy are involved. **Other findings:** 100% of the staff queried during patient meal times were able to identify all patients who were at risk for choking. SEH is to be commended for the emphasis that they have placed on this issue. Assuring that patients are observed at levels consistent with their risk is the necessary next step. Greater specificity in the nursing procedure should support efforts in this regard. A number of Nursing Admission and Annual assessments were late and/or incomplete and did not provide a sound foundation for developing nursing interventions and for integrating nursing fully into the IRP. With some exceptions, IRPs rarely have relevant and individualized nursing interventions. Patients at risk for or who have experienced such situations as choking, incontinence, MRSA infections or aggression have either no nursing interventions or have vague and general monitoring requirements. Interventions continue to: lack

			relevant individualization; are compliance focused, or only call for continued monitoring. Nursing IRP training, implementation of the *Comprehensive Nursing Assessment,* and regular attendance at IRPs by RNs and Psych Techs should support greater consistency in this area. **Compliance:** Partial. **Current recommendations:** 1. *See D.1. Recommendation 9* 2. *See D.2. Recommendation 1-4,* 6 and 7 3. *Using the nursing p/p template, revise the Guidelines Choking/Swallowing Assessment (NCP 600.25), re-titling this as Dysphagia Assessment. Provide clear direction for what information/behavior will trigger an assessment, what the assessment will entail, what referrals will be made, and what interventions will be provided.* 4. *Align the Choking/Swallowing Assessment form with the policy. Change the title to Dysphagia Assessment. Review risk factors to assure that all relevant to the population at SEH are included.* 5. Clarify how the RN will be directly involved in developing the IIRP.
LDL	VIII.D. 9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on my review of the records, unit observations and interviews with staff, I believe there is minimal progress. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:**

			Nursing flowsheets to document on newly admitted patients have not been revised. A Change of Shift Report template has been developed and implemented that contains prompts for reporting on IRP progress. Nursing documentation continues to be tied to "problems" rather than IRP focus, and sometimes continues to use the language of nursing diagnoses. **Recommendation 2, September 2008:** Consider the potential for flowsheets that would include IRP objectives/interventions that could serve as a basis for notes. **Findings:** Although there is an Action Step and Status in the SEH Compliance Report, no progress has been made in this area. The recommendation will be consolidated and revised. **Recommendation 3, September 2008:** Differentiate RN and Psych Tech documentation expectations in a way that limits duplication yet maximizes opportunities to reflect relevant observations, interventions, and patient response. **Findings:** The Action Step and Status in the SEH Compliance report is directed toward determining who is authorized to complete which form rather than the relevance of the documentation. The intent of the recommendation is to limit duplication and maximize relevant documentation. The recommendation will be consolidated and revised. **Recommendation 4, September 2008:** See VIII.D.2.

			Findings: See VIII.D.2. **Other findings:** See VIII.D.2. Some nursing progress notes specifically described the nursing interventions provided and the patients' progress on the IRP objectives. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.1. Recommendation 9.* 2. See VIII.D.2. Recommendations 6 and 7 3. Using the nursing p/p template, revise the nursing documentation policy/procedure.
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Current findings on previous recommendations:** SEH Compliance Report reflects minimal progress in this area. Based on document review, record review, and unit observations, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Previous recommendations have been implemented. For example, posters depicting the Heimlich maneuver were present in all eating areas and patients at risk for choking were identified. Consistent integration of nursing interventions in the IRP should improve as IRP training for nursing staff is completed.

			Nursing staff continue to stand on the periphery of the dining room, surrounding the long tables where patients are eating. Staff talk with each other rather than with the patients. In a recovery informed environment, nursing staff would be observed sitting at tables with patients, interacting in the way people in the community interact with one another at mealtime. **Recommendation 2, September 2008:** Evaluate how diabetic diets are calculated including food and fluids provided during meal times and on the unit. **Findings:** There is no evidence that this has been done. Documentation in the records reveals that this is an urgent priority. For example, a patient who received additional insulin for "coverage" because of an elevated blood sugar also received eight (8) ounces of orange juice at the same time on two (2) consecutive days. Discussions with staff revealed that they do not have a good understanding about diabetes and the implications for nursing care. **Recommendation 3, September 2008:** Identify barriers to adhering to a scheduled dining room mealtime and resolve identified issues. **Findings:** Although the SEH Compliance Report indicates that there is a plan to have Nurse Consultants meet with Dietary Department to address this issue, it has not been done. **Recommendation 4, September 2008:** Establish clear processes for monitoring the status of patients who have received insulin and whose mealtime is delayed.

			Findings: Based on document reviews, record reviews, staff interviews and unit observations, this has not been accomplished. Furthermore, the nursing procedure *Insulin Administration* (Med-504; Reviewed 09/08) does not provide sufficient direction for this issue but rather focuses on the technical aspects of order transcription, checking the dose etc. **Other findings:** On RMB 3, at 6:30 AM, a patient received her regular dose of insulin. By physician order, and at the same time, she received additional insulin because her blood sugar was within a range that required this "coverage". Patients on this unit were scheduled to go to the dining room at 8 AM. The patients did not go to the dining room until 8:50 AM. However, rather than go to the dining room, this patient was required to remain on the unit because she was "an elopement risk". By 9 AM the patient still had not eaten and was not provided a tray on the unit. When asked, food service personnel indicated they could easily prepare a tray but that nursing staff had not requested that a tray be delivered quickly for this patient. By 9:15, the patient still had not had breakfast. Moreover, the staff seemed unconcerned about the situation. When queried they made several statements, sometimes conflicting, relative to whether or not the patient had food or beverage while waiting for late breakfast. They also emphasized the "routine" e.g. night staff always gives insulin, dining room times are frequently late, they have no protocol for how to handle the long period between administration of insulin and a meal, and no special observations of the patient were required. The patient reported that she had no milk (as was originally reported by staff). The RN was unable to describe the symptoms of hypoglycemia, stating that she supposed that the patient would be sleeping. None of this meets generally accepted practice standards. **Compliance:**

			Partial. **Current recommendations:** 1. *Based on the planned dining room hours for each unit, immediately clarify when insulin should be administered.* 2. *Immediately review the signs of hypo and hyperglycemia with all nursing staff.* 3. *Using the nursing p/p template, develop policies that comprehensively address the care of patients with diabetes, including actions to take when meals are delayed.* 4. See VIII.D.1 recommendation 10.
	VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	Please see sub-cells for findings and compliance.
LDL	VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, I believe that minimal progress has occurred. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** During my meeting with the Medical Director and the newly hired Infection Control Chief (ICC) it was apparent that they were familiar with previous findings and are prepared to rapidly undertake necessary actions to resolve identified issues. Some previous recommendations will be revised. **Recommendation 2, September 2008:**

			Develop a clear structure for the IC Program that includes a description of the ICC responsibilities. **Findings:** No progress was reported. **Recommendation 3, September 2008:** Develop a TB Control policy consistent with generally accepted standards. **Findings:** No progress was reported. This will be a priority area of attention for the new ICC. **Recommendation 4, September 2008:** Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level, and across the hospital. **Findings:** Although volume counts relative to MRSA, Hepatitis B and C, and HIV/Aids were reported in the SEH Trend Analyses for December 2008, actions were not identified. There is no data analysis and no monitoring that would reflect whether or not the required precautions/treatment is being implemented and/or if the required IRP interventions have been developed and implemented. Chart reviews revealed timely and appropriate follow up on positive PPDs and positive MRSA cultures. **Other findings:** The former ICC resigned in October 2008. This has reportedly delayed progress in program reforms. The revised Infection Control Manual was not available for review during the visit reportedly because the consultant did not adequately customize the manual specific to

			SEH. SEH should be commended for the consistent implementation of environmental surveys that involve many SEH staff as well as consumers and family members. Actions to address survey findings are clearly prioritized. Findings as well as required follow up are reported to relevant department directors as well as senior management. **Compliance:** Partial. **Current recommendations:** 1. *The Medical Director should pursue his current plan to review the Infection Control Program. Consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload.* 2. *Develop a clear structure for the IC Program that includes a description of the ICC responsibilities and that addresses each requirement in VIII.D.10. of this agreement.* 3. Develop a TB Control policy/program based on generally accepted standards and CDC guidelines, including those related to risk level. 4. *Develop policies and procedures to identify cluster outbreaks.* 5. Develop policies and procedures for food borne illness, flu, and noro virus. 6. Identify categories of data to be collected with initial focus on those data that relate to risks for this population. 7. Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level and across the hospital.
LDL	VIII.D. 10.b	assess these data for trends;	**Current findings on previous recommendations:** SEH reported no progress in this area. Based on document review

			related to the Environmental Survey, I believe that some progress has occurred. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.10.a. **Recommendation 2, September 2008:** See VIII.D.10.a. **Findings:** See VIII.D.10.a. **Recommendation 3, September 2008:** Assure that all housekeeping carts have working locks to store chemicals and that they are not left unattended in patient areas. **Findings:** No actions to resolve this were reported. No unlocked carts were observed. **Recommendation 4, September 2008:** Assure that the proper dilution of bleach is utilized. **Findings:** No actions to resolve this were reported. There was notable odor of bleach on some units. **Other findings:** See VIII.D.10.a.

			Compliance: Partial. **Current recommendations:** 1. *See VIII.D.10.a* 2. The Infection Control Committee should review data/data analysis no less than quarterly.
LDL	VIII.D. 10.c	initiate inquiries regarding problematic trends;	**Current findings on previous recommendation**: SEH reports no progress in this area. Based on document review involving Environmental Surveys, I believe that some progress has been made. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.10.a. **Other findings:** See VIII.D.10.a. **Compliance:** Partial. **Current Recommendations**: 1. *See VIII.D.10.a.* 2. The Infection Control Committee should determine areas for further "drill down" based on trends in data.
LDL	VIII.D.	identify necessary corrective action;	**Current findings on previous recommendations:**

	10.d		SEH reports minimal progress in this area. Based on document review and unit observations, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.10.a. **Recommendation 2, September 2008:** See VIII.D.10.a. **Findings:** See VIII.D.10.a. **Other findings:** The Safety Officer began monthly inspections of all patient occupied areas in September 2008. Although some elements of these inspections relate to infection control, not all do. There are times when the terms "monthly safety inspections" and "environmental survey" seem to be used interchangeably. It will be very important to clearly identify and differentiate the findings, reporting routes, and actions relative to these two different, but important and potentially related, surveys. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.10.a.* 2. Differentiate "monthly safety inspections" and "environmental survey", clarifying purpose, method, reporting routes, responsibility

			for taking and documenting actions as well as evaluating effectiveness of actions taken. Assure involvement of the ICC and the Infection Control Committee as applicable.
LDL	VIII.D.10.e	monitor to ensure that appropriate remedies are achieved;	**Current findings on previous recommendation:** SEH reports no progress in this area. Based on document review, I believe that minimal progress has occurred. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.10.a. **Other findings:** Findings from the Environmental Surveys (4th Quarter, 2008 and 1st Quarter, 2009) reflect systematic improvements, prioritization of required actions, and evaluation of the effectiveness of actions taken. 87% of the findings were "acceptable" and only 7% unacceptable. Reports by unit enable staff to take action to resolve identified issues in a timely manner. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.10.a.* 2. Include in the Infection Control Program/Policy/Procedures how actions will be monitored, and the effectiveness of actions evaluated. 3. Assure that the Infection Control Officer review Environmental Survey findings that relate to Infection Control.

LDL	VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Current findings on previous recommendation:** SEH reports no progress in this area. Based on document review, I concur. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.10.a. **Other findings:** A Director of Performance Improvement was recently hired. **Compliance:** Noncompliance. **Current recommendation:** The Director of Performance Improvement and the Infection Control Chief should determine how to achieve integration. This should be described in Infection Control Program/Policies/Procedures.
LDL	VIII.D. 10.g	ensure that nursing staff implements the infection control program.	**Current findings on previous recommendations:** SEH reports no progress in this area. Based on document review, record review, staff interviews, and unit observations, I think some progress has occurred. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:**

			Nursing staff no longer wear gloves routinely in the dining room. A policy that clearly defines precautions, directs steps to implement specific precautions, and addresses documentation requirements needs to be developed. **Recommendation 2, September 2008:** See VIII.D.2 and VIII.D.10.a. **Findings:** See VIII.D.2 and VIII.D.10.a. **Other findings:** Some nursing staff were knowledgeable about the location and use of Personal Protective Equipment (PPE); others were not. Some crash carts were not stocked with all PPE that could be required in an emergency. Some crash carts had virtually no supplies, reportedly waiting for Pharmacy to decide how to stock these carts. Documentation in patient records reflecting implementation of relevant infection control requirements was inconsistently present. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D. 2 and VIII.D.10.a.* 2. *Develop a policy that clearly defines precautions, directs steps to implement each type of precaution, and specifies documentation requirements.* 3. Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions.

LDL	VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services.	**Current findings on previous recommendations:** SEH reports minimal progress in this area. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** A CNE was hired and considerable effort has been made to reduce nursing vacancies. Nursing Unit Manager positions were prioritized for filling as well as the Forensic Nurse Consultant position. DON and ADON roles have been distinguished. Other previous recommendations have not been acted upon and alternative strategies have not been developed to address the purpose of the recommendations. For example, an RN has not been on duty at all times on all units (see discussion below), a SEH Plan for Nursing services has not been revised, and the Staffing Standards policy (GNA – 100.4) has not been revised. These recommendations will be revised and consolidated. **Recommendation 2, September 2008:** Report NCHPPD by unit on a monthly basis. **Findings:** SEH Compliance Report reflected that the CEO, CNE, CAO, COO and other executive staff are studying a way to accurately determine the NCHPDD by unit and capture the information daily, however, no actions have been taken. This should be easily done since it appears that staffing reports are already being produced and the daily census could be readily obtained. During a meeting with the CAO to clarify terms and methods for "labor analysis" reports, it was apparent that there

			was confusion about NCHPPD. Subsequent to this visit, this consultant provided a formula and general guidelines to the CNE and CAO relative to calculating NCHPPD. **Recommendation 3, September 2008:** Evaluate both the numbers and mix of nursing personnel against the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required numbers and mix of nursing personnel. **Findings:** This has not been done and there is no action plan. The recommendation will be revised. **Recommendation 4, September 2008:** Monitor the numbers of patients on 1:1 observations and the length of time that they remain on this intensive observation. Establish triggers that require IRP review and revision to address behaviors that require this level of observation. **Findings:** This has not been done and there is no action plan identified. In addition to the impact on staffing, 1:1 observations suggest a level of acuity requiring an intrusive and restrictive level of observation. This should be monitored routinely by SEH to assure that the IRP addresses the clinical issues requiring 1:1 in a timely manner. **Recommendation 5, September 2008:** Establish regular meetings involving all Nursing Unit Managers from both civil and forensic units. The purpose of the meetings would be to systematically evaluate progress toward necessary improvements, share

			strategies for success, and provide mutual support. **Findings:** The CNE reported that the Nurse Managers and other nursing leaders meet on a weekly basis. It is not clear if they are systematically reviewing progress on meeting the requirements of this agreement. **Recommendation 6, September 2008:** Consider hiring Ward Clerks for each unit. **Findings:** Three ward clerks were hired and began work in February 2009. **Recommendation 7, September 2008:** Evaluate processes associated with off-unit appointments. Examine personnel resources for accompaniment. Limit nursing staff accompaniment to situations that require unit staff based on the patient's clinical status. **Findings:** It was reported that a time study of all off ward escorts was conducted and that recommendations would follow. The target date was 2/27/09. **Other findings:** Currently, SEH reports a 7.3% nursing vacancy rate, (3.2% counting pending new hires). The Human Resources Status of Clinical Positions report (8/1/2008 – 1/31/2009) reflects a net gain of 4 NUM, 1 RN, 4 LPNs, 0 PNA, and 3 FPT (total of 12). Given the fact that there were 39 hires during this period, turnover needs to be closely monitored. Between 12/21/08 and 2/15/09, there were 279 instances when there was no RN on duty for the entire shift on one or more units.

			Specifically, in the civil program, there were 85 shifts without an RN on duty on each unit. This included admission units, units for patients with serious behavioral challenges, and units caring for medically frail individuals. In the forensic program, there were 194 shifts without an RN on duty on one or more units. There were times when there was not a single RN on a unit for the full 24 hour period. It is not clear if this was being monitored or addressed by anyone. This jeopardizes patient health and safety and needs to be resolved immediately. In an effort to reduce overtime, the CNE indicated that an extensive number of meetings were being held. At my request, she provided copies of various "Labor Management Analysis" reports. These detailed reports were constructed by the CAO and the CNE does not understand some of the variables. Reports reference "labor standards", a number that resulted from an unknown method that in all likelihood does not represent a standard associated with nursing care requirements in a 24/7 setting. There are "Daily Labor Management Reports" with accompanying "considerations" that provide direction for Nursing Unit Managers. They are expected to attend to a greater than 5% variance on either side of "required hours" (the methods/standards for establishing these hours are not clear). In most instances, a 5% variance is less than an 8-hour shift. In a 24/7 setting, during the course of the workweek, even normal variation is typically above 5%. Nursing Unit Managers should not be required to analyze normal variation. Furthermore, these same "considerations" state that if a unit is "overstaffed", the extra personnel could be assigned to other units rather than incur overtime. This may not be possible for many reasons, but as a routine practice it seriously disrupts continuity of care, a necessary component for patients' recovery. This should not be the first choice of action, especially if the determination of "overstaffing" is not clear and if the reasons for "understaffing" have not been systematically examined. Lastly, the statement is made that "understaffing" is "frequently caused by approving excessive amounts

			of PTO "(I assume this is "personal time off"). It is difficult to understand how this conclusion is drawn when the staffing requirements have not been clearly established, monitored over time, and evaluated for trends. The "labor" reports represent a considerable amount of time and effort that do not address priority issues and do not uncover meaningful trends that can be readily acted upon. This time and expertise could be better utilized by implementing a conventional, and easy to use, approach that would yield reliable, actionable, information. **Compliance:** Noncompliance **Current recommendations:** 1. *Evaluate the factors that have contributed to not having an RN on duty on each unit on all shifts. Address these factors in order to assure that an RN is on every unit, on every shift, at all times.* 2. *Determine the targeted NCHPPD standards for each unit.* 3. *Report the actual NCHPPD delivered on a monthly basis by unit. Include in this report the number of shifts, by unit, that did not have at least one RN on duty.* 4. Evaluate and adjust as necessary the mix of nursing personnel (RNs, LPNs, PTs) considering the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required number of RNs. 5. Revise a SEH Plan for Nursing Services that at a minimum: articulates the NCHPPD with rationale; establishes the mix of nursing personnel; describes scheduling models/policies; provides a guiding decision framework for alternatives when additional staffing is required. 6. If there are currently insufficient numbers of nursing positions to

			meet the targeted NCHPPD, develop an interim plan to assure the best use of resources, while long term planning is underway to secure the required positions.

	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. SEH has revised *Advanced Instructions/Personal Comfort Planning form, the Levels of Observation Flowsheet form, and the Doctor's Order for Restraint and Seclusion form*. Once fully implemented these forms will support SEH to meet the requirements of this agreement. 2. The *Restraint and Seclusion for Behavioral Reasons, Medical or Protective Measures, Devices and Techniques,* and the *Involuntary Administration of Medication* policies have all undergone revisions and incorporated necessary changes. 3. There has been an overall reduction in the number of episodes and hours of seclusion or restraint, and the number of patients who experience repeated episodes of seclusion and restraint. This is especially commendable in light of the markedly improved reporting that captures nearly all episodes. 4. A seclusion and restraint monitoring tool was drafted, piloted, revised, and an additional draft developed.
LDL			**Methodology:** <u>Interviewed</u>: 1. Andre Nichols, PT 2. Bernard Arons, MD, Medical Director 3. Brenda Lateef, RN, Nurse Educator 4. Calvin Jones, PT 5. Carolyn Fox, PT 6. Daniel Gayell, Dietary Staff 7. Edith Watson, LPN 8. Emmanuel Dzokwlu, LPN 9. Funmilayo Olugbmeni, RN 10. Gladys Nebafu, RN 11. Joyce Gaino, Dietary Staff

			12. Kevin Oneukwusi, RN 13. Laverne Plater, RN, Nurse Consultant, Civil Services 14. Laverne Robinson Bobo, RN 15. Lewis Mayon, RN, Nurse Educator 16. Malcolm Cook, RN , Infection Control Chief 17. Mamerta Benzon, RN, NUM RMB 1 18. Moliki Agbor, RN 19. Omar Okojie, PT 20. Reba Brothers RN, NUM RMB 6 21. Regina Michael, RN 22. Rosylin Yesudian, RN 23. Serah Flavia, RN 24. Shirley Quarles, RN, Nurse Consultant, JHP 25. Tyrone Hampton, PT 26. Veronica Parham-Dudley, RN, CNE 27. Yi-Ling Tu, RN, NUM RMB 2 <u>Reviewed</u>: 1. Medical records of the following 28 individuals: AH, AP, AW-B, CK-1, CK-2, CW, DC, DW, GM, GS, HH, JM, JR, KC, LB, ML, MM, MP, MW, RG, RJ, RM, SS, TH, TJ, TT, VE and VG 2. SEH Compliance Report, March 2, 2009 3. SEH Trend Analysis: December, 2008 4. SEH Policy: Interdisciplinary Recovery Planning for In-patient Services, 602.2-04; revised February 23, 2009 5. Clinical Record, Initial Interdisciplinary Recovery Plan form; revised February 19, 2009 6. Clinical Record, Interdisciplinary Recovery Plan form; revised February 19, 2009 7. Draft Interdisciplinary Recovery Manual 8. Draft Interdisciplinary Recovery Plan Process Monitoring Tool, February 6, 2009 9. IRP Chart Review and Process Observation Results, February 2009

			10. SEH Policy: Assessments, 602.1-08; new issuance, February 23, 2009 11. Comprehensive Nursing Assessment Form; revised March 23, 2009 12. Draft Comprehensive Nursing Assessment Self-Audit Tool, March 25, 2009 13. Draft Operational Instructions Self-Auditing Tool for Nursing Comprehensive Assessment, (undated) 14. SEH Policy: Restraint and Seclusion for Behavioral Reasons, 101.1-04; revised February 24, 2009 15. SEH Seclusion and Restraint Audit Results, February, 2009 16. Draft Nursing Procedure: Using eMAR for Medication Administration, MED-501; revised February 18, 2009 17. Environmental Survey Report, 4th Quarter, 2008 and draft 1st Quarter, 2009 18. SEH Policy: Medication Variance Reporting and Assessment, 202-05; new issuance, March 2, 2009 19. SEH Policy: Medication Ordering and Administration, 206-09; new issuance, February 11, 2009 20. AVATAR Issues List 21. Medication Monitoring and Chart Review Results, February, 2009 22. Pharmacy and Therapeutics Committee Minutes, July 9, 2008 – February 11, 2009 23. Nursing Procedure: Physical Observation, NCP 600.24; revised March, 2009 24. Draft Clinical Record Physical Observation Form; revised March 23, 2009 25. Draft Nursing Procedure: Nursing Basic Skills and Competency Assessment, SDR-300-2; revised March, 2009 26. Draft Change of Shift Report form (undated) 27. Draft Nursing Procedure: Change of Shift Report, GNA-109; revised March, 2009 28. Nursing Case Study Conference (description, outline, and forms; undated)

			29. Draft Training and Professional Development at SEH, April 1, 2009 30. Nursing Procedure: Insulin Administration, MED-504; reviewed September, 2008 31. List of New or Revised Nursing Forms (indicating those that only an RN can complete, and those that can be completed by all nursing staff; instructions to access forms, and instructions for use (undated) 32. Nursing Procedure: Guidelines for Choking/Swallowing Assessment, NCP 600.25; effective June, 2008 33. Clinical Record Choking/Swallowing Assessment Form; revised February 5, 2009 34. SEH Policy: Medical or Protective Measures, Devices and Techniques, 101.2-08; revised February 24, 2009 35. SEH Labor Management Analysis – February 1 – 15, 2009 36. SEH "Using a Daily Labor Management Report" (undated) 37. SEH Forensic and Civil Programs, Nurse (sic) Staffing 12/21/08 – 2/15 09 (actually reflects all nursing staffing) 38. SEH Nursing Labor Management Summaries, Daily Labor Management Report, February 1 – 22, 2009 39. SEH Daily Labor Management Report, Civil and Forensic Daily Summary, February 1 – 7, 2009 40. SEH Policy: Involuntary Medication Administration, 201-05; revised February 23, 2009 41. Advanced Instructions/Personal Comfort Planning form; revised February 11, 2009 42. Levels of Observation Flowsheet form; revised February 24, 2009 43. Doctor's Order for Restraint and Seclusion form; revised February 20, 2009 44. List of Patients given PRN/STAT Medications between 8/20/2008 and 2/20/2009 45. Department of Nursing, Course and Attendance (undated) 46. Nurse Training – FY 09 to Date (undated) 47. Nursing Education, Nursing Core Competencies (list and brief

			paragraph describing unit based training, undated) 48. Department of Nursing Course Curricula for: Therapeutic Communication; Introduction to Group Process; 2008-2009 Annual Medication Update, Psychotropic Medications, Medication Variances, and Adverse Drug Reactions; Physical Assessment for FPTs and PNAs; Physical Assessment for RNs and LPNs; Stages of Change; Documentation; Involuntary Medication Administration. 49. Draft SEH Nursing Action Plan, March 25, 2009 <u>Observed</u>: 1. IRP Conference: RJ, JHP 3; FP, RMB3; 2. Meal Observations: RMB 1,2 (units); 3,4 (Dining Room) 3. Change of shift report: RMB 3, 5 4. Med pass: RMB 5; JHP 2 (discussed process); RMB 3 (discussed process)
	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.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record reviews, I concur. **Recommendation 1, September 2008:** Revise the *Restraint and Seclusion for Behavioral Reasons* policy to comport with CMS definitions. Using the interpretive guidelines that accompany the regulations could be very helpful. **Findings:** Policy revisions addressed key areas and prohibit prone restraint.

			Drugs used as restraint merits re-review. **Recommendation 2, September 2008:** Provide competency-based training on the new policies. **Findings:** Nursing procedures for seclusion/restraint have not been completed, therefore this training has not occurred. Because training reports and curriculum were not dated, it cannot be determined if the number of nursing staff trained (76%) were trained on the new hospital policies. **Recommendation 3, September 2008:** Finalize the monitoring tool, monitor implementation, identify and act on improvement opportunities, monitor the effectiveness of actions taken. **Findings:** The audit tool has been revised and is currently in draft form. Audits have been conducted and the new form piloted. **Other findings:** Prone restraint was documented in one chart review. (A W-B, 2/14/09). **Compliance:** Partial. **Current recommendations:** 1. *Using the nursing p/p template, develop the nursing p/p for seclusion, restraint, and involuntary medication.* 2. *See XIII.D.1 regarding training and competencies.* 3. *Provide training to all nursing personnel on the new policy.* 4. *Implement the nursing p/p.* 5. Continue monitoring. Involve clinical staff in analyzing findings,

			determining actions, and evaluating the effectiveness of actions taken.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and chart reviews, I concur. **Recommendation 1, September 2008:** Carefully review scope of work proposals to assure relevant content directed toward preventing circumstances that give rise to seclusion and restraint use. **Findings:** It was reported that the scope of work was reviewed and that training will focus on alternatives to restraint and seclusion as well as nursing documentation. Preventing the circumstances that give rise to seclusion and restraint use is broader than simply focusing on alternatives and needs to be addressed. The CPI modules have not been revised. **Recommendation 2, September 2008:** Provide competency-based training on new policies. **Findings:** See VIII.D.1 and X.A.1. **Other findings:** Record reviews revealed several instances where nursing staff implemented less restrictive alternatives prior to restraint use. **Compliance:** Partial.

			Current recommendation: *See VIII.D.1 and X.A.1*
LDL	X.A.3	the use of side rails on beds, including a plan:	**Current findings on previous recommendations:** SEH reports substantial compliance. Based on document and record review, I believe there is partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Policies have been completed and are generally aligned with CMS definitions. **Recommendation 2, September 2008:** Use the CMS interpretive guidelines as a foundation for revising the policy with special attention to definitions. **Findings:** Hospital policies have been completed and are generally aligned with CMS definitions. **Recommendation 3, September 2008:** Revise Nursing P/P to incorporate recommendations above. **Findings:** The nursing p/p has not been revised to reflect changes in the hospital Medical and Protective Devices Policy and to incorporate previous recommendations. **Recommendation 4, September 2008:** Provide competency-based training on the new policies.

			Findings: This has not been done pending revised nursing p/p. **Recommendation 5, September 2008:** Finalize the monitoring tool, monitor implementation, identify and act on improvement opportunities, monitor the effectiveness of actions taken. **Findings:** No action has been taken. **Other findings:** See X.A.1 and 2 above **Compliance:** Partial. **Current recommendations:** 1. *Using the nursing p/p template, revise the nursing policy that addresses side rails and medical protective devices so that it is aligned with the hospital policy and the terminology is consistent. Assure that assessment factors that influence, and risks associated with, full versus partial side rails are detailed. Clarify accountability for, and intervals of, checking the safety of the equipment.* 2. Eliminate any remaining side rails with winged/tapered ends.
LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, September 2008:**

			Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See X.A.1 and 2 above. **Recommendation 2, September 2008:** See X.A.1 and 2 above. **Findings:** See X.A.1 and 2 above. **Other findings:** It was reported that five patients used side rails between October 2008 and February 2009. Three of these patients used side rails intermittently. This reflects minimal use of side rails. **Compliance:** Partial. **Current recommendation:** Monitor for compliance.
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.	**Current findings on previous recommendations:** SEH reports substantial compliance. Based on record review, I believe there is partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See X.A.1 and 2 above.

			Recommendation 2, September 2008: See X.A.1 and 2 above. **Findings:** See X.A.1 and 2 above. **Other findings:** Medical symptoms that warranted use of side rails were generally documented in the record. Plans to address the underlying causes could not be consistently located in the record and the IRP did not consistently address the use of side rails. **Compliance:** Partial. **Current recommendation:** Monitor to assure compliance.
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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation.

			Findings: CPI content has not been augmented to emphasize alternatives to restrictive measures. SEH is monitoring the use of seclusion and restraint following staff assault (see discussion below). **Recommendation 2, September 2008:** See VIII.D.1 and X.A.2. **Findings:** See VIII.D.1 and X.A.2. **Recommendation 3, September 2008:** Implement the new Nursing Admission Assessment and assure that the findings from the assessment relative to behavioral emergency triggers, and effective strategies to manage surges of emotion, are included in the ITP. Assure integration with the Advanced Directives. **Findings:** The IRPs offered little insight into the behavior of patients who were secluded or restrained. Individualized interventions were not developed and the patient preferences that were described in the personal comfort plan were not integrated. **Recommendation 4, September 2008:** Continue to monitor actions taken with patients following staff assault. **Findings:** There were 21 assaults on staff by patients from October 1, 2008 – January 28, 2009. Seclusion or restraint use followed 14 of these assaults. This suggests that seclusion and restraint are not routinely used after a staff assault.

			Other findings: Overall, SEH reports a decrease in episodes and duration of both restraint and seclusion. This is commendable, especially in light of the fact that reporting has become increasingly accurate. Additional observations include: a small number of individuals have repeated use; the civil side has more use than forensic; RMB-3 accounted for half the episodes reported in the past 13 months; RMB 6 has increased use in the Nov – Jan reporting period; most incidents occur around 4 PM. These trends merit review by clinical leaders. The revised policy on *Restraints and Seclusion for Behavioral Reasons* includes additional examples of alternatives to these measures. In addition, nursing is required to complete the *Advanced Instructions/Personal Comfort Planning* when the patient is admitted. If this plan is consistently used, and incorporated into the IRP, individualized options will be available in order to minimize potential for and/or effectively manage behavioral emergencies without using seclusion or restraint. SEH audit of alternatives before seclusion and restraint use revealed that there was documented evidence of "low level" interventions in 65% of the situations. "Moderate level" interventions were used in 30% of the situations. These findings may be an artifact of the audit tool (discussed below). Chart reviews revealed some individualized interventions prior to restraint use. However, re-direction remains a common intervention. This is not surprising since the IRPs offers little help to understand the underlying issues when a patient's behavior causes imminent danger, there are either no objectives related to the behavior or vague general statements, interventions are not individualized, and information that the patient provides about what would be helpful is not integrated.

			Compliance: Partial. **Current recommendations:** 1. *Implement all new forms and processes as planned.* 2. *Continue IRP training and monitoring.*
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;	**Current findings on previous recommendations:** SEH reports noncompliance in this area. Based on document and record review, I believe there is partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** There appears to be no organized effort to identify unit nursing staff members who can be leaders for the culture change that is needed on the clinical units. This recommendation will be consolidated and revised. Other recommendations have been acted upon. **Recommendation 2, September 2008:** Re-examine "boarding" or otherwise temporarily moving an agitated patient onto another clinical unit. **Findings:** No actions were identified or taken. This recommendation will be revised. **Recommendation 3, September 2008:** Evaluate the RMB 3 program and assure full integration of all disciplines into the daily program activities.

			Findings: No actions were identified or taken. **Recommendation 4, September 2008:** Consider hiring Ward Clerks for each unit to free nursing staff from duties that could be effectively performed by an administrative support professional. **Findings:** Three Ward Clerks were hired. **Other findings:** SEH has made efforts to secure and distribute leisure supplies. They have hired a Volunteer Services Director to assist in this effort. During unit observations, a number of nursing staff were observed playing board games with patients. Unit schedules in both civil and forensic services reflect considerable variance in the number of activities in the evenings and on weekends. Some units should be commended for the initiative and creativity that nursing has shown in developing and implementing unit groups. The RMB3 unit makes heavy use of seclusion and restraint. Patients were also frequently observed being escorted to a screened area when they became agitated, though staff described this as something the patients wanted. Patients also routinely used a "quiet" room, with a closed door. Although the door was unlocked, it was not clear if all the patients using the room were aware that they could leave. The posted schedule was not being followed on this unit despite the fact that the unit serves patients who need consistent structure. The unit does not appear to be operating as intended. Furthermore, the grouping of patients with the most challenging behaviors on one unit limits their access to the peer support that is available on units with patients who

			are at different levels of recovery and/or face different challenges. I agree with the recommendation that this unit be re-organized and have a different mix of patients. The SEH audit of seclusion and restraint episodes found that in 35% of the situations, the record reflected that seclusion or restraint was used as an alternative to active treatment and that it was used as punishment or for staff convenience in 9% of the situations. In the absence of instructions to accompany the audit tool, it is not clear how these conclusions can be reliably determined since the questions are quite subjective. **Compliance:** Partial. **Current recommendations:** 1. Develop instructions to accompany the seclusion and restraint audit. Measure inter-rater reliability on a monthly basis. 2. *Reconfigure RMB 3.*
LDL	X.B.3	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** SEH reports partial compliance in this area. Based on document and record review as well as unit observations, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** A consultant was hired to provide training to psychology staff and targeted ward staff on behavioral support strategies. Trauma informed care has not yet expanded beyond the original two

			units but training is provided as part of new employee orientation. **Recommendation 2, September 2008:** Clarify that certain actions/interventions may constitute seclusion or restraint even if those specific terms are not used. **Findings:** Abuse and neglect training includes information about how the use of a quiet room can become seclusion. **Recommendation 3, September 2008:** Add an explicit statement prohibiting use as a part of a behavioral intervention to the "standards" portion of the restraint/seclusion policy. **Findings:** The revised policy clearly prohibits restraint or seclusion as part of a behavioral intervention. **Other findings:** In the records that were reviewed, there were no instances of using seclusion or restraint as a part of a behavioral intervention. **Compliance:** Partial. **Current recommendation:** Monitor for compliance.
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record reviews, I concur.

			Recommendation 1, September 2008: Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Policies for restraint and seclusion use were revised, as was the audit tool. Audits have been conducted. The *Doctor's Order for Restraint and Seclusion* form was revised to expand the number of release criteria and include an option to individualize release criteria. The *Levels of Observation Flowsheet* form was revised and now contains a prompt for nursing to seek the patient's input into how to best support his reintegration into the milieu. The use of routine restrictions following restraint or seclusion use has not been evaluated. **Recommendation 2, September 2008:** Re-evaluate the policy and use of Day Room Restriction and consider alternatives that are informed by a focus on the individual and what will support his/her recovery. **Findings:** No actions have been identified to address this. **Other findings:** SEH audit results report that in 57% of the episodes, patients were released when no longer an imminent danger to self or others; in 52% of the episodes patients were released when they met behavioral criteria for release. Chart reviews revealed similar findings with some individuals remaining in seclusion or restraint up to 45 minutes beyond a

			period when there was imminent danger. The release criteria recorded on the observation form were frequently different from those ordered by the physician. Therefore, it was difficult to know which release criteria were being utilized during assessments and discussions with the patient about release. **Compliance:** Partial. **Current recommendations:** 1. Implement the new doctor's order form with additional options for individualized release criteria. 2. Review and revise the nursing p/p for Physician Order Transcription to assure that the order that contains release criteria is transcribed exactly as written to the *Levels of Observation* Flowsheet form.
	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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** A monitoring tool and process has been implemented. **Recommendation 2, September 2008:**

			Revise the Doctor's Order Form for Restraint and Seclusion. **Findings:** The doctors order form has been revised. There are prompts to specify behaviors requiring seclusion or restraint. **Other findings:** SEH reports that although 70% of the records reviewed included evidence of imminent risk, this was documented on the previous doctor's order form only 43% of the time. Having a prompt on the new order form should facilitate documentation. **Compliance:** Partial. **Current recommendations:** 1. *Implement the new order form.* 2. Continue monitoring.
LDL	X.C.2	the maximum duration of the order;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation, September 2008:** Monitor for sustained compliance. **Findings:** SEH reports that on a pilot review of seclusion and restraint information, using a draft tool, 78% of the doctor's orders included maximum duration. **Other findings:** Chart reviews revealed that doctor's orders specified maximum

			duration. **Compliance:** Partial. **Current recommendation:** Monitor for compliance.
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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** No evidence was provided of joint training for RNs and MDs. No action plan was developed to provide a list of examples of how to write behavior criteria for release. However, the revised *Doctor's Order for Restraint and Seclusion* form contains four examples of release criteria, and provides space for other criteria to be written in. The revised policy includes a provision that the RN contact the physician to review patient behaviors that indicate readiness for release, although may be different from those in the release criteria. **Recommendation 2, September 2008:** Refine administrative monitoring to assure real-time information to interrupt unacceptable seclusion/restraint orders. This recommendation will be revised. **Findings:**

			No actions have been identified. **Recommendation 3, September 2008:** Revise the Doctor's Order Form for Restraint and Seclusion. **Findings:** Completed. **Other findings:** The SEH audit revealed general release criteria; 35% of the records were rated as including individualized behavioral release criteria. Chart reviews continued to reflect standardized criteria e.g. release when calm, release when not at risk for self-injury, when not causing property damage. Although the pre-printed release criteria options contain some behavioral release criteria, they would merit re-review. For example, responding appropriately to questions and requests is vague and requires judgment about what is appropriate. Alternative statements could include: answers staff questions in a moderate voice tone/speech rate; allows staff to perform required assessments such as vital signs. Release criterion that require that the patient "demonstrate the ability to remain calm and cooperative during initial removal of restraints" is not a behavior that would prompt staff to remove the restraints since it requires that the removal be in progress. Lastly, the Medical Director agreed to provide additional space for entering individualized criteria for release on the form. At the time this is done, it would be useful to change the portion of the form that calls for "conditions for release" to "behavioral criteria for release". "Conditions" implies that situations/factors beyond the individual behavior can be taken into account and this is not accurate. **Compliance:**

			Partial. **Current recommendation:** Revise the behavioral release criteria in the *Doctor's Order for Restraint and Seclusion* form (see above discussion).
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Current findings on previous recommendations:** SEH reports substantial compliance in this area. Based on document and record review, I believe there is partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Actions have been taken. **Recommendation 2, September 2008:** Monitor for compliance. **Findings:** Monitoring has been done. **Other findings:** A 25% sample of seclusion and restraint episodes in February 2009 was monitored. SEH reported that the treating physician was either the ordering doctor (74%) or when not the ordering doctor was notified in 44% of the cases. The percentages suggest that there could be duplicative counts. **Compliance:** Partial.

			Current recommendation: Continue monitoring for sustained compliance.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;	**Current findings on previous recommendations:** SEH reports partial compliance in this area. Based on document and record review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** The new audit tool was developed and piloted. **Recommendation 2, September 2008:** The Post Event Analysis Report should include a critical evaluation of behavioral release criteria with recommendations for changes. **Findings:** No action was identified. **Recommendation 3, September 2008:** Evaluate the nursing policy for transcribing MD orders and include the requirement that the flowsheets contain the exact physician order for release criteria. **Findings:** No action was identified. See other findings for additional detail. **Other findings:** SEH monitoring reflected that in 30% of the seclusion or restraint episodes, the patient was notified every 30 minutes of the behavioral release criteria. SEH has the expectation that the new *Levels of*

			Observation Flowsheet (Rev 2-24-09) prompts the nursing staff to inform the patient of the release criteria. However, the new form does not specifically prompt *informing* the patient of the criteria. Rather, it has a code indicating that during 30-minute checks the patient *meets* the release criteria (code N). This merits review and revision. Of greater concern is the fact that chart reviews revealed that the Criteria for Release entered on the *Levels of Observation Flowsheets* form continue to be different from those in the physician order. This means that the patient may be informed about, and release may be based upon, criteria different from those ordered by the physician. This is not acceptable and must be addressed. Lastly, nursing has not completed a nursing policy to provide detailed operational direction for the care of patients who are secluded or restrained. This includes direction for what must be done and documented in the *Levels of Observation Flowsheet.* Forms can be effectively implemented pending policy/procedure revision when a memorandum giving clear instructions for use accompanies the forms. Without this, staff will do the best they can to complete the form, and in the process develop informal patterns that will be difficult to overcome once the policy is promulgated. An example of the kinds of risks that accompany the practice of promulgating forms without clear direction involves the part of the form that requires something to be entered in an area titled "frequency of checks". The SEH seclusion and restraint policy requires continuous monitoring and observation, with specific fifteen-minute assessments, hourly assessments, and the requirement to advise the patient of behavioral release criteria every 30 minutes. The frequency of checks is clearly prescribed. If the intent in the "frequency of checks" part of the form is to increase the frequency, this needs to be made explicit or there is the risk of someone thinking that the continuous monitoring or other assessments can be decreased.

			Compliance: Partial. **Current recommendations:** 1. *See X.A.1.* 2. Revise the Levels of Observation Flowsheet form to make explicit the requirement to notify the patient of release criteria every 30 minutes.
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;	**Current findings on previous recommendation:** SEH reports noncompliance in this area. Based on document and record review I concur. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** Monitoring has been conducted with a revised tool. Actions on trends has not been reported. **Other findings:** SEH reports that the audit revealed debriefing in 5% of the situations. Chart review revealed no documentation of debriefings within 24 hours of seclusion or restraint episodes. **Compliance:** Noncompliance. **Current recommendation:** Explore and resolve barriers to compliance.

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	**Current findings on previous recommendations:** SEH reports substantial compliance in this area. Based on document and record review, I find partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** None. **Recommendation 2, September 2008:** Require an RN to be present when seclusion/restraint is implemented. **Findings:** This has been added to the policy. **Other findings:** SEH reports that there were no instances noted where a patient was secluded or restrained without a physician order. I concur with this finding. However, this requirement addresses physician *assessment*, which goes beyond writing an order. The SEH audit revealed that a face-to-face physician assessment was conducted within 1 hour of the initiation of seclusion or restraint in 57% of the situations. **Compliance:** Partial. **Current recommendation:** Explore and resolve barriers to documenting the assessment.
LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who	**Current findings on previous recommendations:** SEH reports substantial compliance in this area. Based on document

		has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	and record review, I find partial compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.1. The database has not been fully developed, though reportedly is only weeks away. However, compliance cannot be determined. There are still no clear procedures regarding actions taken to limit practice when competence is not achieved. Although SEH indicates that they plan to discuss this matter with a labor management committee, interim measures are needed. One method would be to assure that charge nurses do not assign staff to perform functions during the shift that involve competency that the staff member has not achieved. **Recommendation 2, September 2008:** See VIII.D.1. **Findings:** See VIII.D.1. **Recommendation 3, September 2008:** Develop competency measures for all clinical disciplines based on the responsibilities articulated in the newly developed policy, and the monitoring results. These competencies should have core elements that are required by all disciplines, and discipline specific components related to specified responsibilities. **Findings:** The revised policy describes roles and functions. This recommendation will be revised.

			Recommendation 4, September 2008: Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. **Findings:** This has not been accomplished. **Other findings:** The SEH audit reported that 100% of the staff monitoring individuals in seclusion or restraint had completed or were current in the seclusion/restraint competency training. **Compliance:** Partial. **Current recommendation:** See VIII.D.1.
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.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** SEH reports that the interim measure to improve reporting that involves nursing supervisors has substantially improved data collection. A recent audit revealed 91% of the restraint or seclusion use was accurately recorded in the supervisor log. Phase II of AVATAR, scheduled for implementation this summer, will include seclusion and restraint orders. It is anticipated that this will substantially improve

			data gathering. It appears that little progress has been made in embedding reporting requirements within other documentation requirements in order to limit duplication. For example, a UI form is still required when a person is secluded or restrained. This is in addition to substantial additional documentation that must be in the patient record. **Recommendation 2, September 2008:** Conduct full clinical case reviews on the individuals who have been high users of seclusion/restraint. Focus "upstream" to identify improvement opportunities rather than simply at the circumstances immediately surrounding the restraint/seclusion use. **Findings:** No action steps have been identified. **Other findings:** The SEH December 2008 Trend Analysis reports summary data on seclusion and restraint use. However, the time periods vary, and more importantly averages are used for comparison. Averages are not useful for monitoring and acting on trends in seclusion and restraint use. Furthermore, it is noted that patients frequently involved in seclusion or restraint "skew" the results. Rather than "skew" results, this is a critical indicator that suggests that IRPs are not developed and/or re-evaluated to address issues related to behavioral emergencies. Snapshot volume data for different time periods obscures trend identification. Using run charts to display data would be more useful. Upper and lower control limits for the run charts should be based on SEH data. This will allow analysis that will distinguish common cause variation from special cause variation, supporting more focused analysis and action. Run charts should be developed for episodes, hours, and numbers of patients involved in seclusion use, and the same for

			restraint use. Clinical staff must analyze the data in order to assure relevant actions. Currently, the reports do not describe actions taken and do not reflect an evaluation of the effectiveness of the actions. Parts of the *Seclusion and Restraint Monitoring Tool* (draft 2/25/09) need revision. In Section 2, only the examples of low and moderate level interventions that are suggested in the policy are options for the reviewer. There are many other specific low and moderate level interventions that would meet the requirements for less restrictive interventions. Therefore, provision needs to be made to enter "other" for interventions that are known to be clinically effective and/or that are individualized to the patient. Questions in Section 3 contain very subjective statements. Without instructions to accompany the audit tool, it is not clear how inter-rater reliability will be achieved for some of these questions e.g. the record reflects that S/R was used in the absence of or as an alternative to active treatment. Lastly, the tool continues to contain questions that if answered in the affirmative mean the standard was met, and that if answered in the affirmative mean that the standard was violated. This poses significant potential for audit error and violates conventional approaches to developing audits. Section 3.1 merits review because a number of the criteria start with "ensures" which is difficult to measure. **Compliance:** Partial. **Current recommendations:** 1. *Develop instructions to accompany the seclusion and restraint audit. Measure inter-rater reliability on a monthly basis.* 2. Display data using run charts (see above discussion) where appropriate. 3. *Involve clinical staff in analysis, identification of trends, formulating actions, and evaluating the effectiveness of actions*

			taken. All of this should be clearly documented and tracked.
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.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** The audit tool was revised and auditing is underway. **Recommendation 2, September 2008:** See X.C and X.D. **Findings:** See X.C and X.D. **Other findings:** The SEH policy established this requirement. The SEH audit revealed that the IRP was modified in 0% of the situations. Chart reviews revealed similar findings. It is not clear if there is a mechanism to notify teams if one of their patients meets the established thresholds. **Compliance:** Partial. **Current recommendations:** 1. Explore and resolve barriers to compliance. 2. Establish levels of assistance that teams can access when faced with a patient whose behaviors are challenging and frequently require seclusion or restraint use.

			3. Conduct clinical case reviews on patients who have been high users of seclusion or restraint.
	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;	**Current findings on previous recommendations:** SEH reports noncompliance in this area. Based on document and record review, I find minimal compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** SEH has revised the *Restraint and Seclusion for Behavioral Reasons* policy as well as the *Involuntary Medication Administration* policy (201-05; rev. Feb. 23, 2009). PRN use is referenced as a moderate intervention in the restraint and seclusion policy. PRNs are prohibited under the *Emergency Administration of Involuntary Medication* policy. This policy clear addresses STAT orders. **Recommendation 2, September 2008:** Revise the definitions and "Drugs used as Restraint" part of the *Involuntary Medication Administration* policy to be aligned with the revisions in the restraint/seclusion policy. **Findings:** These two policies now align in this regard. The merits of re-reviewing "Drug use as restraint" were discussed with the Medical Director.

			Other findings: Although SEH tracks use of PRN and STAT medications, they do not have a database that specifically addresses emergency involuntary psychotropic medications. SEH is considering the use of Crystal reports through AVATAR. SEH observes that the seclusion and restraint audit results revealed that 26% of the episodes involved administration of medications on an involuntary basis. They are exploring using this database in the interim. The volume counts in the "List of Patients given PRN/STAT Medications between 8/20/08 and 2/20/09 indicate a total of 389 patients had psychotropic PRN medications; 97 had STAT/Other psychotropic medications. There were 2526 orders for psychotropic PRN medications, and 218 orders for STAT psychotropic medications. The List of Patients (by name) given PRN/STAT Psychotropic Medications between 12-1-08 and 2-25-09 revealed a mix of psychotropic and non-psychotropic medications. A significant number of patients received "emergency" medications several times in one day, several days in one week, or many times in a month (e.g. see CK, GS, JM, JN and MP). This is in marked contrast to the SEH Medication Monitoring and Chart Review Results (February, 2009). Based on monitoring 50 IRPs, this audit found 0% psychotropic PRN orders, and six patients with STAT orders. Of these six patients, five had only one STAT order and one had two STAT orders. No patients had four or more psychotropic PRN or STAT medication orders in the review period. These starkly different findings merit review. **Compliance:** Partial. **Current recommendations:** 1. *Review and evaluate the differences between PRN/STAT reports*

			and audits. 2. *Determine a method to establish a database that will allow monitoring of emergency involuntary psychotropic medication administration.* 3. Involve the P&T Committee in reviewing findings.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Current findings on previous recommendation:** SEH reports noncompliance. Based on record review, I find minimal compliance. **Recommendation, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** In the absence of a database, SEH cannot evaluate this. **Other findings:** Chart reviews revealed that when involuntary medication was administered during the initiation of a seclusion and restraint episode, physician assessment occurred within an hour. The documentation sometimes reflected assessment of both medication use and seclusion and restraint use. **Compliance:** Partial. **Current recommendation:** 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	**Current findings on previous recommendation:** SEH reports noncompliance and I concur.

		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, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** No data are being collected to determine adherence to this requirement. SEH reports that PRN and STAT medication reports are available daily to all staff through AVATAR. However, general availability of reports does not meet the requirement for systematic review, based on established thresholds, with clear accountability. **Other findings:** Record reviews did not reflect treatment team reviews at the established thresholds. The IRP was not changed following frequent administrations of "emergency" medications to patients. **Compliance:** Noncompliance. **Current recommendation:** See X.F.1.
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.	**Current findings on previous recommendations:** SEH reports noncompliance in this area. Based on document review, I find minimal compliance. **Recommendation 1, September 2008:** Take action on previous recommendations that are currently incomplete and monitor implementation. **Findings:** See VIII.D.1 and X.C.8

			Recommendation 2, September 2008: See VIII.D.1 and X.C.8. **Findings:** See VIII.D.1 and X.C.8 **Other findings:** Joint RN MD training was not conducted. This expert did not review physician competencies. Although a nursing course outline for Involuntary Medication Administration was provided, no data relative to attendance at training or competency achievement was provided. **Compliance:** Partial. **Current recommendation:** See VIII.D.1 and X.C.8

	XI. Protection from Harm		
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. During the six months since the last review, the former Risk Manager resigned and the Performance Improvement Department had an interim director who had substantial other duties. Many of the initiatives described in this section of the report were soon to be implemented or had been implemented so recently as to make a fair evaluation of their effectiveness difficult or impossible. This context is important for an accurate understanding of this section of the report. 2. The newly hired Risk Manager has the training and experience to conduct and supervise incident investigations. 3. The hospital has made clear the expectation that all restraint and seclusion episodes are to be documented on an Unusual Incident Report form (UIR). 4. The hospital revised its policies related to incident management and has shown a willingness to make further revisions to ensure that in abuse, neglect and exploitation incidents the victim is an individual in care and the alleged perpetrator is other than an individual in care. 5. The hospital reports incident and other data in the bi-monthly Trend Analysis Report. This includes information (both current and historical) on incident type, location, time of day. Restraint and seclusion data is also reported—frequency, number of individuals using restraint and seclusion, length of the intervention. 6. Trend analysis of unusual incidents indicates that in the period May –December 08, the frequency of incidents each month was either equal to or less than the frequency in 2007.
BJC			**Methodology:** <u>Interviewed</u>: 1. B. Lateef, Nurse Educator

			2. J. Gallo, Human Resources Branch Chief 3. J. Taylor, Policy and Procedures Director 4. L. Mayo, Director of Nursing Education 5. M. Hartley, Director of Performance Improvement 6. M. Pontes, Risk Manager <u>Reviewed</u>: 1. 20 Unusual Incident Reports 2. Bi-monthly Trend Analysis 3. 16 Investigation reports 4. Policies: 302.1-03 Unusual Incident Reporting, Documentation and Investigation, 302.2-04 Sentinel Event/Root Cause Analysis, 302.3-05 Patient Death Review 5. Abuse/Neglect/Exploitation training records for 12 staff members 6. Incident report and performance indicator data on the use of restraint and seclusion for November 08 7. Hospital studies related to RMB-3 and JHP-6 8. Risk Management & Safety Committee meeting minutes for September, November and December 08. 9. Clinical records of seven individuals for follow-up to incidents. <u>Observed</u>: Adverse medication review (April 2, 2009)
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:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Revise the relevant definitions in Policies 301-01 and 305-03 to clarify to whom each applies. **Findings:** Policy 301-01 and 302.1-03 (with policy 305-03 incorporated into it) were revised in February 09. However, further modifications are

			necessary to make them consistent and to ensure that all abuse/neglect/exploitation definitions clearly state that only an individual in care can be the victim, and the alleged perpetrator must be someone other than another individual in care. To this end the following changes are required: • In policy 302.1-03 on page 9 (6a) eliminate the words "any other person." The word "employee" was removed while the monitoring team was on site. • In both policies, limit the definition of sexual abuse to reference the victim as an individual in care and the alleged perpetrator as someone other than another individual in care. • Add "sexual assault" as an incident type to the Unusual Incident form. Provide a definition that clarifies that this term describes incidents of peer-to-peer non-consensual sexual contact in both policies. • Change the heading on p. 9 of policy 305-03 to read "Major Unusual Incident Categories and Definitions." • Modify all training materials to reflect these changes. **Other findings:** Policy 305-03 requires that the PID-approved investigation report be submitted to the Executive Committee. This policy is not being implemented as written. In the Performance Improvement Department plan, the approved investigations will be forwarded to the Performance Improvement Committee for review and approval/modification/additions to the recommendations. This committee will forward a summary of its investigation-related activities to the Executive Committee for its review. Policy 305-03 will need to be modified to reflect this change. **Compliance:** Partial.

			Current recommendations: 1. *Make the changes cited above to policies 301-01 and 302.1-03.* 2. *Ensure consistency between all relevant policies and PID procedures*.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Revise the definitions of incident types in Policies 301-01 and 305-03 to identify clearly who may be a victim and who a perpetrator. **Findings:** See the cell above. **Recommendation 2, September 2008:** Consider revising Policy 305-03 to limit the types of medication errors that the hospital must report to DMH. **Findings:** Policy 305-03 now requires that medication variances that cause the death of an individual in care or which require an individual to be treated in a medical hospital to be reported to DMH. **Recommendation 3, September 2008:** Expedite training for staff members, so that incident data will reflect the use of the revised definitions. **Findings:** Training on the use of the new UI form occurred during the review period. Over time, staff have adopted the new Unusual Incident reporting form (UIR) which eliminates identifying the type of incident using a numeric code and has replaced it with a selection of options,

using a "check all that apply" format.

Other findings:
The Unusual Incident Reporting, Documentation and Investigation policy requires that staff complete a UIR whenever restraint or seclusion is used. A comparison of the list of restraint/seclusion incidents for which a UI form was completed in November 08 with the trigger data identifying individuals who had been in restraint/seclusion two or more times in November reveals that 87% of the multiple user R/S incidents were not reported on UIR as required by hospital policy.

UIRs for R/S— 11/08		Trigger Indicator for 2 or + R/S –11/08	
SJ	1	GS	5
HL	1	SK	2
AF	1	DE*	2
DE*	2	CK	2
DB	1	MP	2
EI	1	YS	2
RB	1		
Total	8	Total	15

* Indicates congruence between the two lists.

The Risk Manager reported that she reviews every R/S episode and has also found that not all R/S episodes are reported on UI reporting form. This is consistent with the disparity between the December Trend Analysis report and the Risk Management Unusual Incident Tracking form, as shown below:

Month	#R&S UIRs per 12/08 Trend Analysis	#R&S episodes reviewed by RM
October 08	7	19
November 08	12	34

December 08	2	20

[There is also a discrepancy between the number of R&S events reported in the December Trend Analysis and in the Risk Management Incident Tracking form for the months cited above. The Trend Analysis documents a total of 58 episodes for the three months while the tracking form cites 73.]

The findings of a review of 20 Unusual Incident Reports indicated a unacceptably high error rate (60%, with two UIRs having more than one error) as shown below. Since the information on the UIRs is used to populate the incident database which will be used to identify individuals in care at high risk for behavioral and some medical issues and staff members' incident histories, inaccuracies on these forms will jeopardize the accuracy of these lists and of tracking and trending data. [Assigning a discrete UI number to each form would have made identification of the specific incidents in the table below more precise, but not all UIRs reviewed had such a number.]

Error	# of UIRs	Identifying info—incident date
One or more codes missing	3	1/2/09, 11/21/08, 10/26/08
A/N/E alleg. with victim coded as "involved"	4	12/2/08, 1/2/09, 1/8/09, 10/26/08
Incomplete name of staff witness	1	2/9/09
Old form—inaccurate coding	1	10/13/08
Staff member not identified as staff	2	11/17/08, 12/3/08,
A/N/E no staff coded as aggressor, but identified elsewhere	2	11/6/08, 2/3/09
A/N/E no staff member(s) named	1	2/3/09

			Wrong incident time recorded | 1 | 11/27/08 **Compliance:** Partial. **Current recommendations:** 1. Continue monitoring each use of restraint and seclusion and take measures to ensure that each is recorded on a UI reporting form. 2. Determine and correct the cause of the discrepancy in the R&S data between the Trend Analysis and the Risk Management Incident tracking form. 3. Review and make corrections to UI reports. *4. Correct errors in the incident database.* *5. Provide training or take any other measures the hospital believes will improve the accuracy of the UI reports.*
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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Provide guidance in Policy 305-03 for designating the severity of an incident. **Findings:** Policy 305-03 includes a Key for Severity Rating that is to be used by the hospital's Risk Manager only. Review of 18 UIRs (revised form) found one-third did not include a severity code designation. These included five A/N/E incidents and one physical assault incident. **Recommendation 2, September 2008:** Ensure the A/N training being developed specifically addresses timely reporting, including also the possibility of disciplinary action for failure to report an incident as required by hospital policy.

			Findings: The Risk Manager, who provided much of the A/N/E training during February and March 09, explained that failure to report was extensively discussed. **Recommendation 3, September 2008:** Provide the necessary staff training to expedite on-line incident reporting. **Findings:** Online reporting is presently available. Reporting through AVATAR is expected to be available in the fall of 09. **Other findings:** The hospital HR Branch Chief replied in response to a direct question that he had never been asked to proceed with disciplinary action against a staff member for failure to report A/N/E. This is consistent with the Risk Manager's explanation that the importance of reporting and the possible consequences for not reporting were emphasized for the first time in training completed in the last two months. See also XII.B.1 and XII.E.I.a for rationale for this monitor's observation that there is underreporting of A/N/E. **Compliance:** Partial. **Current recommendations:** 1. *Develop written guidelines on disciplinary actions for failure to report allegations of staff misconduct in the manner prescribed in policy.* 2. Ensure that the portion of the UIR reserved for the Risk Manager is completed.

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>BJC</td><td>XII.A.3</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Document specifically in every investigation if and when the alleged perpetrator was removed from contact with the victim or, if the alleged perpetrator was a staff member, if and when he/she was removed from all contact with individuals in treatment.

Findings:
In the investigation reports reviewed, the decision regarding whether the named staff member was removed from contact with the alleged victim was inconsistently documented as demonstrated below.

<table>
<tr><td>Incident identification</td><td>Relevant documentation</td></tr>
<tr><td>2/9/09 A/N/E alleg. involving AB</td><td>Yes, staff removed</td></tr>
<tr><td>1/2/09 A/N/E alleg. involving PM</td><td>No relevant documentation</td></tr>
<tr><td>10/10/08 A/N/E alleg. involving OZ</td><td>Yes, staff removed</td></tr>
<tr><td>2/3/09 A/N/E alleg. involving ST</td><td>No relevant documentation</td></tr>
<tr><td>9/18/08 A/N/E alleg. involving BP</td><td>Yes, staff removed</td></tr>
<tr><td>11/21/08 Medication variances involving SS</td><td>No relevant documentation</td></tr>
<tr><td>1/8/09 A/N/E alleg. involving SK</td><td>Yes, staff removed</td></tr>
<tr><td>10/14/08 A/N/E alleg. involving CC</td><td>No relevant documentation</td></tr>
<tr><td>10/6/08 A/N/E alleg. involving AB</td><td>Yes, staff removed</td></tr>
<tr><td>11/27/08 A/N/E alleg. involving CL</td><td>Yes, staff removed</td></tr>
<tr><td>10/24/08 A/N/E alleg. involving DT</td><td>No relevant documentation</td></tr>
</table>

Hospital policy 302.1-03 states that whenever any incident occurs that involves, or may involve, an allegation of abuse, neglect and/or injury, hospital staff shall take immediate and appropriate action to protect the patients involved, including removing the alleged perpetrators from direct contact with the patient pending the outcome of any</td></tr>
</table>

			investigation. **Other findings:** The Risk Manager explained that when an allegation of A/N/E is reported, the named staff member is immediately removed for 72 hours, during which time the Associate Director of Nursing makes a determination whether the staff member can return to work on a different unit while the investigation proceeds or whether the staff member should be placed on administrative leave until the investigation is completed. I found no instances in the investigations reviewed where the immediate health/medical needs of the individual did not receive timely attention. **Compliance:** Partial. **Current recommendation:** *Document decisions and rationales for removing and returning staff members who allegedly engaged in misconduct while the investigation is in process*.
BJC	XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue with plans for hiring a Training Director who will institute an Abuse/Neglect Identification and Reporting curriculum (by whatever name the hospital chooses) for orientation and annual training. **Findings:** During February and March 09, the hospital reports that nearly 98% of the staff received competency-based training on A/N/E identification

and reporting. Annual retraining will occur.

Recommendation 2, September 2008:
Begin competency-based orientation and annual A/N prevention, identification, and reporting training.

Findings:
This recommendation has been successfully implemented per the hospital's report and my review of the records of 12 staff members.

Other findings:
The training records of 12 staff member selected to represent staff members in various positions indicated that all had recently received A/N/E training with post-test scores between 90 –100%.

Staff Member	A/N/E training date
LT	2/4/09
CL	3/19/09
GN	2/12/09
JI	2/11/09
UP	2/4/09
RG	2/11/09
KT	3/18/09
RD	2/5/09
OW	2/12/09
SR	3/18/09
BF	2/13/09
AH	2/13/09

Compliance:
Substantial.

Current recommendation:

			Continue current practice.
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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** See recommendations in XII.A.4. **Findings:** The hospital's training adequately addresses the responsibility to report incidents. **Recommendation 2, September 2008:** Ensure that disciplinary measures are taken when employees fail to report suspected abuse or neglect. **Findings:** See XII.A.2. **Other findings:** JJ, an individual in care, made an allegation of physical abuse to a staff member who wrote a note in the clinical record on 8/26/08 but did not report the allegation on a UIR. The allegation was discovered by a Clinical Administrator reviewing the record on 9/9/08. No determination was made in the investigation of the abuse allegation regarding the failure to report the allegation in a manner required by policy. HR stated that the contract of the staff member was not renewed. **Compliance:** Partial. **Current recommendation:** Write specific guidelines for disciplining staff members who fail to

			report allegations of staff misconduct as required in policy.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** A poster enumerating the rights of individuals in care was present in a common area on each of the units visited. The name and telephone number of the Risk Manager was prominently displayed in several areas of the hospitals visited. Staff were able to produce forms for individuals in care to complete when they wished to present a grievance. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Document in the investigation when an individual in care or staff member has been arrested. **Findings:** None of the investigations reviewed resulted in referral of an individual in care or staff member to law enforcement. **Other findings:** Policy 302.1-03 does not clearly set forth the obligation to contact the

			Metropolitan Police Department in all instances where it appears criminal action has occurred. The policy ties notification of the MPD to the request by a manager to hospital Security. **Compliance:** Partial. **Current recommendation:** Clarify policy 302.1-03 to direct that in "all cases involving potential criminal action," Security shall notify MPD.
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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Remind staff members who report abuse/neglect of their right to be free of retaliation and their recourse should they be threatened or retaliated against. **Findings:** Hospital policy 302.1-03 addresses the right of any staff person, individual in care, family member or visitor to be free from retaliatory action by SEH, DMH, and/or the Government of DC. The Power Point training material does not address the right of staff members and others to be free of retaliation and what to do should they be threatened for reporting staff misconduct. **Other findings:** In the 11/24/08 incident in which WW, an individual in care, alleged that he witnessed staff members "roughing up" another individual on multiple occasions, the informant said that he feared retaliation by the accused staff members. The hospital was unable to produce a copy of the investigation of this allegation.

			The hospital is planning A/N/E training for the individuals in care. This should include a discussion of the right to be free of retaliation and how to report threats or acts of retaliation. **Compliance:** Partial. **Current recommendations:** 1. *Include the right of staff members and individuals in care to be free of retaliation for reporting A/N/E and how to report threats or retaliatory actions in all training provided on the subject.* 2. Address in investigations the reason for delays in reporting, as the delay may be related to fear of retaliation.
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:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Expand the investigational responsibilities of the Risk Manager to meet the requirements of the Enhancement Plan and provide any additional supports necessary to enable the completion of investigations in a timely manner. **Findings:** The Risk Manager (hired in January 09) is presently investigating all allegations of A/N/E and deaths. She is also reviewing all reported incidents of restraint and seclusion using an auditing tool. **Other findings:** There has been a misunderstanding regarding the level of evidence to be used in reaching determinations in investigations of A/N/E. In the investigation of the 2/9/09 allegation of physical abuse by AB, the rationale for the determination reads as follows:

			Please note that up to the point of [named staff member's] return to work, while the Risk Manager did not find that the available evidence provided clear and convincing proof that AB's allegation of physical abuse by [named staff member] was substantiated, the plausibility of actual confrontation does exist. During the tour, the Director of Performance Improvement and the Risk Manager conferred with DMH. DMH confirmed that the standard to be used in reaching determinations is preponderance of the evidence and not clear and convincing evidence. **Compliance:** Noncompliance. **Current recommendations:** 1. *Include the use of the preponderance of the evidence standard in the policies and procedures being written for the Performance Improvement Department.* 2. *Reference the standard in making determinations (substantiated or not substantiated).*
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;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Expedite the work of the Serious Incident Follow-up Work Group and expand its composition, if necessary, to address this systemic issue. **Findings:** This Work Group is no longer meeting. **Other findings:** The former Risk Manager, who investigated all allegations of A/N/E, left employment at the hospital in October 08. A new Risk Manager

			was hired in January 09. In the interim period, investigations were done by staff members "filling in." In some instances, the former Risk Manager had begun, but not completed, investigations and made determinations (substantiated or not substantiated) based on an incomplete investigation. These determinations were allowed to stand. Other problems in specific investigations are described below and include, but are not limited to, not interviewing witnesses, determinations not supported by the facts, failure to apply the preponderance of evidence standard, failure to recognize neglect and investigate the incident as such, and not seeking expert opinion when necessary. • In the investigation of the 10/10/08 allegation of physical abuse of OA, the rationale for the unsubstantiated determination does not flow from the findings of fact. Three individuals in care said they saw or heard the push. Two staff members said they heard OA immediately complain he was pushed. [OA has chronic back pain and was sent to the ER the morning following the incident for evaluation of what was later reported as an acute lumbar sprain.] The named staff member said he did not push OA and, in fact, never left his chair in the office, but another staff member said the named staff member "jumped up in a teasing manner." The investigation offers two concluding statements: 1) The named staff member "did not have physical contact with or handle OA with more force than was reasonably necessary to ensure the safety of the consumer or others." 2) The named staff member "used proper force to remove OA and another consumer out of the nurses station." The preponderance of the evidence, as presented, indicates that OA was pushed out of the nurses' station by the named staff member. This investigation was reviewed and approved. • DT alleged on 10/24/08 that his arms were held behind his back too tightly when staff moved him out of the quiet room. He said this caused him considerable pain. The investigator had the named

			staff member demonstrate the hold he used on DT while still photos were taken. The investigator determined that the allegation of physical abuse was not substantiated because the pressure placed on DT's damaged wrist (old injury) was not intentional. I took the photos to the hospital trainers who confirmed that the hold used was not an approved technique and was an unsafe hold. This allegation should have been substantiated. This investigation was not reviewed and approved. • The alleged physical abuse of AWB on 10/13/08 occurred in an activity room where "other patients were watching a movie." No individuals were interviewed as to the events of the afternoon that resulted in the allegations. This investigation was reviewed and approved. • CL suffered "chest wall contusion; bilateral" on 11/27/08, per the hospital ER discharge report. He alleged he was punched by the named staff member in his lower ribs. The investigator • determined the allegation was not substantiated and noted "there is general suspicion and assumption on the part of unit staff that the redness and bruising in the photos was self-inflicted." The investigator provided no findings to support this—no history of prior SIB, no witness to SIB, no witness to CL bragging he had put a staff member out by hurting himself, etc. The investigator made no attempt to get a medical determination that the bruising was consistent with SIB. • The nurse on duty did not examine CL when he complained of pain because she did not want him "to become mad at me too." This allegation of neglect was not picked up by the investigator and pursued, other than to recommend a nursing protocol that would mandate a nursing assessment when an individual claims he/she has been injured. This investigation was not reviewed and approved. • A hand-written note on the UIR describing DR's 12/21/08 allegation of physical abuse states that an investigation is needed. No investigation was conducted.

			• On 1/2/09, PM was left behind on a locked unit alone when everyone was moved to another unit because of heating problems. The "investigation" consists of a written statement from one staff member stating PM was determined missing during a security check. There was no determination as to the allegation of neglect. • SE alleged that on 2/3/09 she was denied her request to speak with a physician prior to being given an IM injection. The UIR is coded as an allegation of A/N/E. The investigation consists solely of an exchange of e-mails with the physician assuring him that his statements that he took measures to calm SE before prescribing the injection were not being challenged, although there was insufficient supporting documentation in the clinical record. No interviews were conducted and no determination made. • SS's wound dressing was not changed for four days because staff forgot. This was not recognized as neglect and was not investigated as such. The staff members received a written note describing their breach of duty. If there were a recurrence, the note would be placed in their personnel file. • The investigation of the allegation of physical abuse made by AB on 10/6/08 was begun by the former Risk Manager, but she did not complete her investigation report prior to leaving. It is impossible to tell from the short summary available if AB is alleging that his 1:1 staff member hit him or that he was hit by someone else when his 1:1 was not attending to him. • Similarly, the investigation of the allegation by BP that she was physically and verbally abused when she refused to get out of bed was begun by the former Risk Manager, but the investigation was not completed prior to her leaving. There is no investigation report to clarify how BP injured her eye (she allegedly reported it occurred prior to this incident) and no information on which, if any, staff members were interviewed. The former Risk Manager determined in an e-mail that the allegation should be determined unsubstantiated.

			• Written statements from six staff members constitute the entirety of the investigation of physical abuse (being pushed in the shower) made by YL on 10/26/08. Five of the six statements state that the employee either was not present during the shift in question or did not see the incident. The named staff member denied pushing YL. YL was not interviewed. The "investigation" was completed by the Assistant Director of Nursing and determined to be unsubstantiated. The December 08 Trend Analysis report indicates that UIRs did not reach the Risk Manager within two days in 38% of the cases in the period October 1—December 31. **Compliance:** Noncompliance. **Current recommendations:** 1. *Adopt a standard face sheet for A/N/E investigations that states the type of incident, date of the incident, date received in Risk Management, synopsis of the allegation, names of the alleged victim, named staff member and witnesses, and the determination.* 2. *Follow standard investigation procedures, including the dating of all interviews and a summary of the contents. Do not accept only written statements from persons critical to an investigation unless there is no alternative.* 3. Make determinations based on preponderance of the evidence. 4. Take measures to ensure that reports of incidents reach the Risk Manager in the timeframes required by policy through training and feedback to units submitting late reports.
BJC	XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and	**Current findings on previous recommendation:** **Recommendation, September 2008:**

		programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	Expand the investigatory responsibilities of the Risk Manager to include all serious injuries. Provide necessary supports to enable the timely completion of this work. **Findings:** The Risk Manager, hired in January 09, who is completing all A/N/E investigations presently, is qualified by training and experience to conduct investigations in the hospital setting. **Other findings:** In the three-month interval between the departure of the former Risk Manager and the hiring of the current Risk Manager investigations did not consistently meet current practice standards. Examples are provided in the cell above. See the last bullet in the cell above describing an investigation completed by the Assistant Director of Nursing that did not meet professional standards. **Compliance:** Presently in partial compliance with the hiring of the current Risk Manager. **Current recommendations:** 1. Continue to implement current procedures wherein the Risk Manager investigates or supervises the investigation of incidents specified in the Settlement Agreement. 2. Continue the procedure of having the PID Director review and approve <u>all</u> investigation reports.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide	**Current findings on previous recommendations:** **Recommendation 1, September 2008:**

		technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	Provide the date and time of all interviews in the investigation report. When an investigation is completed and then when it is approved, sign and date it. **Findings:** Beginning in August 08, most investigations included the date of interviews. The investigation of the physical abuse of CL (11/27/08) and the allegation of sexual assault by MH (10/16/08) are exceptions. **Recommendation 2, September 2008:** Initiate the use of a face sheet with the identifying information discussed above. **Findings:** Some more recent investigations have a face sheet that provides some essential information. No investigations include a face sheet that includes all essential information. **Other findings:** As indicated in cell XII.B.1, some of the investigations reviewed did not contain the signature of the approving supervisor. Under the present PID procedures, the investigations completed by the Risk Manager will be approved by the Performance Improvement Department Director. The more current investigations reviewed contain a face sheet which indicates that the investigation summary was completed by the Risk Manager and sent to the PID Director. There was no approval signature by the Director. **Compliance:** Partial **Current recommendations:**

			1. *Implement plan to have all investigations reviewed and signed by the PID Director. Any investigations that do not meet practice standards should be returned for additional work.* 2. *Implement plans to hire another investigator so that investigations are completed in a timely manner and other Risk Management monitoring can proceed.*
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 a result of investigations.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Expedite the work of the Serious Incident Follow-up Work Group and expand its composition, if necessary. **Findings:** The Serious Incident Follow-up Work Group is no longer meeting. Problems continue in identifying and monitoring the implementation of recommendations for corrective and preventative actions identified in investigations. PID has drafted procedures for approving and monitoring implementation of corrective actions stemming from incidents; however, these newly drafted procedures have yet to be implemented. **Other findings:** The Performance Improvement Department plan for Investigation and Review of Incidents assigns responsibility for the approval of recommendations to the appropriate committee (e.g., Performance Improvement Committee, Sentinel Event Review Committee). These are then forwarded to the Executive Director/Executive Committee. Once approved by the Executive Director/Executive Committee, recommendations will be monitored for effective implementation by the Performance Improvement Department. PID will also assist in ensuring that any required training is provided to the relevant staff members.

			PID plans to begin implementing these procedures by May 1, 2009. Following the substantiated determination in the investigation of the 10/14/08 allegation of verbal abuse and exploitation, the named staff member was terminated. **Compliance:** Noncompliance. **Current recommendation:** *Implement the PID procedures for the Investigation and Review of Incidents as planned. Document the monitoring of implementation of the approved recommendations.*
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Expedite the work of the Serious Incident Follow-up Work Group to determine the source of the hospital's inability to act on its own recommendations in a timely fashion and offer solutions. **Findings:** This work group is no longer meeting. **Recommendation 2, September 2008:** The Executive Director should actively monitor and/or participate in the work group. **Findings:** This work group is no longer meeting. **Recommendation 3, September 2008:** Revise the review of deaths and the operations of the Mortality Review

			Committee to meet current practice standards. **Findings:** The hospital revised the Patient Death Review policy (302.3-05) effective March 2, 2009. The policy states that unexpected deaths will be investigated by the DMH Office of Accountability. All deaths will be reviewed internally following a defined process by the Sentinel Event Committee. Its chief responsibilities are to review the recommendations developed by the Mortality and Morbidity Review Committee, the SEH Risk Manager, any external reviewers and post-mortem examination findings. Recommendations for performance improvement made by the Sentinel Event Committee are forwarded to the Executive Staff Committee and, if approved, implementation will be monitored by and any necessary training provided by the Performance Improvement Department. This policy has not yet been implemented, as the most recent death at the hospital occurred in November 08. **Other findings:** See the cell above for a description of the PID policies and procedures which, when fully implemented, should meet the requirements of this section of the Settlement Agreement. **Compliance:** Noncompliance. **Current recommendations:** 1. *Ensure that the Sentinel Event Committee includes a senior psychiatrist when the case under review raises issues in his/her domain.* 2. Implement the policies and procedures of the PID for identifying and monitoring recommendations from investigations.
BJC	XII.D	By 24 months from the Effective Date hereof,	**Current findings on previous recommendation:**

		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, September 2008:** Continue with plans to institute the on-line reporting of incidents using the revised reporting form. **Findings:** Electronic reporting is now available. Incident reporting through AVATAR should be available in the fall of 09. **Other findings:** As reported earlier, not all incident reports carried a discrete number. The hospital produced a listing of all incidents that occurred in RMB-3 for the time period October 1—December 31, 2008 that included the date, narrative summary of the incident, the individuals and staff members involved and the immediate clinical and administrative response. The hospital has the capacity to access incidents by type, location, staff named as aggressors or victims and individuals named as aggressors or victims. **Compliance:** Partial. **Current recommendation:** Assign a discrete number to each UIR.
BJC	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:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Identify procedures for sharing significant incident trending and pattern data with treatment teams with the expectation that the team will consider the information in directing treatment. See the recommendation in XII.E.1.c for a suggestion on how to begin.

			Findings: The Risk Manager has begun sharing graphed incident data with units and discussing the findings with unit leadership. The bi-monthly reports produced by the Performance Improvement Department, the most recent dated 3/2/09, contain some information on incidents. For example, the report tracks through 2008 the use of restraint and seclusion. The use of seclusion has not exceeded 10 episodes in any one month since April 08. Episodes of restraint have been maintained at or below 21 per month since June 08. Average duration of restraint in 08 was 1 hour 27 minutes, down 27 minutes from 07. The average duration of seclusion in 08 was 4 hours 51 minutes, an increase of 34 minutes over 07. In no month in the 13-month review period (January 08—January 09) did more than three individuals require restraint or seclusion more than three times. Other tracking and trending presented by the hospital is discussed in succeeding cells. **Other findings:** See also XII.A.1, as there are discrepancies in the R & S data. The hospital is not yet able to track actions taken in response to incidents beyond disciplinary actions related to particular staff members. **Compliance:** Partial. **Current recommendation:** *Implement PID policies and procedures that direct the approval, implementation, and monitoring of recommendations emerging from incident investigations.*

BJC	XII.E.1	Track trends by at least the following categories:	Please see sub-cells for findings and compliance:
BJC	XII.E.1.a	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Identify expectations on how the data will be used to improve the quality of care at the hospital. Write guidelines/policies around these expectations. **Findings:** The Performance Improvement Department in its policies and procedures has outlined a process that when fully implemented will provide for the careful review of serious incidents, the identification of remedial measures and the monitoring of their implementation. PID will also ensure that necessary training is provided to the relevant staff. Central to this process is the sharing of data with the unit/discipline involved. All critical incidents will be reviewed by the Sentinel Event Committee and a Root Cause Analysis completed. The Sentinel Event Committee (under the present PID leadership) met for the first time to review the February suicide attempt. The summary of the findings and recommendations was being written, but was not yet ready for review by the monitoring team. I observed an interdisciplinary meeting which reviewed the factors that contributed to the medication variance that presumably led to an individual having a seizure. This was described by the PID Director as an example of the type of review he intends to hold when critical issues emerge. **Recommendation 2, September 2008:** Clean the incident management database at regular intervals.

			Findings: The finding described in XII.A.1 related to errors in UIRs indicates that further work is needed to ensure the accuracy of the incident management database. **Other findings:** The December 08 Trend Analysis presents graphed data on the number of UIRs from January 08 through the end of the year. The graph shows wide variability in monthly frequency from a low of 95 incidents in September to a high of 158 in October. The report concludes that the average number of incidents per month was slightly lower in 2008 compared with 2007. Incidents were identified by type for each month in the last quarter of 2008 in the December 08 Trend Analysis. Not surprisingly, the greatest percentage (35%) were assaults/altercations, followed by physical injury (19%) and medical emergencies (14%). Allegations of A/N/E total 20 in the three-month period or 5% of the total incidents. This represents an increase in reporting over 2008, according to the analysis provided. Nonetheless, as suggested by two examples in XII.B.1 and the small number of A/N/E allegations (only 2 in December), there is reason to believe that there is a problem in the identification and reporting of these types of incidents. **Compliance:** Partial. **Current recommendation:** Take measures to bring the problem of under-reporting to the attention of unit and discipline leadership. PID should undertake a review of communication and transportation logs to identify events that should have been reported on UIRs and were not. Social workers and others reviewing clinical records should be alerted to the need to

			identify events that should have been reported as incidents and ensure a UIR is completed.
BJC	XII.E.1.b	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue training for staff on the use of the on-line incident reporting system. **Findings:** Electronic incident reporting is available. **Recommendation 2, September 2008:** Ensure that a monitoring system is in place to review the completeness and accuracy of the information in incident reports. **Findings:** See XII.A.1. Additional work is needed to improve the accuracy of UIRs. **Other findings:** The December 08 Trend Analysis report cites statistics showing that in the period October 1—December 31, on average each month 118 staff members were identified in UIRs, 44% as witnesses and 21% as involved or not identified. In the same time period 168 individuals in care were identified in UIRs, 32% as aggressors and 26% as victims. Only 1% of the individuals in the UIRs were identified as witnesses. This figure underscores the need to identify individuals in care who saw or heard an incident on the UIR, so that they can be interviewed during an investigation. **Compliance:**

			Partial. **Current recommendations:** 1. Monitor UIR forms for accuracy and provide any necessary training. Make the necessary changes in the database to improve its accuracy. 2. Train staff completing UIRs to list individuals who saw or heard the incident on the reporting form.
BJC	XII.E.1.c	individuals involved and witnesses identified;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Take measures to ensure that every incident report is complete, accurate and legible as required by Policy 305-03. Do not enter incomplete information into the incident database. **Findings:** Inaccurate incident reports remain a problem. See XII.A.1. **Recommendation 2, September 2008:** As a first step, in using incident data for the benefit of the individuals in care, produce reports on a periodic basis of individuals who are repeat victims and repeat aggressors and forward this information to the respective treatment teams for a treatment response. **Findings:** The hospital produced a list of individuals in care on RMB-3 who were victims and aggressors in the last quarter of 2008. The number of incidents in which each individual figures as an aggressor or as a victim was identified. Six individuals were identified as repeat aggressors and nine as repeat victims. One individual was identified as both a repeat aggressor and repeat victim.

			Other findings: See also XII.E.1.b. The hospital has not yet developed a protocol whereby individuals repeatedly involved in incidents are identified, the IRP team is notified, and a response is received and monitored (on at least a sample basis). **Compliance:** Partial. **Current recommendations:** 1. *Setting inclusion criteria, expand the list of repeat victims and repeat aggressors to cover all units of the hospital. Alert units/teams when an individual is added to the list.* 2. *Establish a protocol whereby the IRP team will respond by identifying interventions it has/will undertake in response to the alert.* 3. Monitor the implementation of the interventions on at least a sample basis.
BJC	XII.E.1.d	location of incident;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Document in the appropriate forum, the review of this data, recommendations for addressing patterns and trends and follow-up implementation strategies. **Findings:** Pattern and Trend data will be reviewed by the Performance Improvement Committee and other relevant committees, according to the new Performance Improvement Department procedures. **Other findings:** A focused review of the number of incidents occurring on JHP-6 during

			the period 10/1/08—3/19/08 revealed that JHP-6 accounted for 28 of the total of 215 incidents for the entire building. The percentage of the total ranged from a low of 3.1% in February 09 to 35.5% in March 09. The December 08 Trend Analysis report provides data on the location of incidents in 2008. In nine of the 12 months, RMB units accounted for one-half or more of the incidents. There was a sizeable increase in the percentage of incidents occurring in JHP units later in the year. Specifically, in the first five months of 08, JHP incidents represented 13.4% of the total. In the months June—December 08, this figure rose to 36.8%. The December report graphed incidents by unit location for the period October 1—December 31. RMB-3 and RMB- 6 were the sites of more incidents than any other units: RMB-3=62, RMB-6=52. RMB-3 incident frequency was more than twice that of any other unit in the hospital with the exception of RMB-6. **Compliance:** Partial. **Current recommendation:** *Take appropriate measures to reduce the incidents on RMB-3 and RMB-6.*
BJC	XII.E.1.e	date and time of incident;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Attach all reports referenced in the minutes of the Risk Management and Safety Committee to the minutes. **Findings:**

			The Risk Management & Safety Committee minutes reviewed did not include a copy of the documents the committee was reviewing. **Recommendation 2, September 2008:** Document in the minutes the important points of discussion and recommendations for actions. **Findings:** The September and November minutes are in narrative form and make following any discussion or recommendations that bridge more than one meeting very difficult. The committee adopted a new style for keeping minutes in December which identifies the topic under discussion, work that needs to be done, the staff member responsible, and whether the issue has been closed or will continue at subsequent minutes. All agenda items in the December minutes (except the approval of the November minutes) are identified as continuing. No subsequent minutes were provided. **Other findings:** The Performance Improvement Department completed a focused study on unit JHP-6 for the period 10/1/08—3/19/09 identifying the time that incidents occurred. With one exception, no incidents occurred between 11PM and 6AM and no time period (shown in hourly intervals) had more than two incidents. In total, 28 incidents were reported in the study period from that unit. An earlier study completed on RMB-3, covering the period 10/1/08—12/31/08 found that the greatest number of incidents occurred on Wednesdays (24) and the smallest number on Saturdays (4). The greatest number of incidents occurred in the early morning (6:00AM) and 6:00 PM, and at least one incident occurred during every one-hour interval except between 4:00—5:00AM.

			The December Trend Analysis report provided data on the times of day that episodes of restraint and seclusion occurred in the period January 08—January 09. Fifty-two percent of the episodes occurred between 7:00AM and 3:00PM, but the highest single hour was between 4:00—5:00 PM. It further provided data on the time of day of incidents during the last quarter of 08 which showed that 87% of all incidents occurred during the day and evening shifts. Numbers on the frequency of UIs by day of the week was not presented. The Performance Improvement Department intends to discuss graphed incident data specific to the unit with the unit leadership. PID staff expect to have presented and discussed incident data with all units once by the end of May 2009. **Compliance:** Partial. **Current recommendations:** 1. *Implement plans to discuss the unit-specific incident data with the unit staff and leadership. Briefly document the outcomes of these discussions.* 2. *Identify in writing the purpose and responsibilities of the Risk Management & Safety Committee meetings.*
BJC	XII.E.1.f	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** If not already in place, write a policy or guideline explicitly directing the work responsibilities of the Risk Management and Safety Committee to include discussion of factors contributing to incidents. **Findings:** This recommendation has not yet been implemented as evidenced by

			review of the minutes for the last quarter of 2008. **Recommendation 2, September 2008:** Identify in investigation any environmental, staffing or other factors that may have caused or contributed to an incident. **Findings:** The investigation of the unauthorized restraint of SK in a chair (1/8/09) clearly identified short-staffing and/or conflicting job duties as contributing factors and made recommendations directed at these issues. The other investigations reviewed did not identify contributing factors. **Compliance:** Noncompliance. **Current recommendations:** 1. Focus the work of the Risk Management & Safety Committee by writing guidelines describing its function, composition, responsibilities, etc. 2. Identify contributing factors when investigating incidents. Bring these to the attention of the Risk Management & Safety Committee or other relevant committees when incidents are reviewed.
BJC	XII.E.1.g	actions taken.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Expedite the work of the Serious Incident Follow-up Work Group and expand its membership, if necessary, in order to develop a functioning system for the collection, review, approval, implementation, and monitoring of recommendations.

			Findings: With implementation of the Performance Improvement Department policies and procedures, investigation recommendations will be reviewed, approved, and monitored for implementation. PID expects to have these procedures operating by May 1, 2009. **Compliance:** Noncompliance. **Current recommendation:** Implement plans for the review, approval, and monitoring of recommendations resulting from incident investigations. Document monitoring findings.
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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents. **Findings:** The hospital reports that the Medical Executive Committee will identify medical high-risk indicators within the next 30-60 days. (Completion is expected by May 15.) In addition, the PID will present other high-risk indicators to the Performance Improvement Committee within essentially the same time frame. The hospital expects to begin collecting data on the indicators within 30 days of their identification. **Other findings:** A review of the follow-up by IRP teams of individuals involved in

			incidents yielded variable results. • See XIII.C for examples of individuals whose IRP teams did not address multiple incidents of R &S. • While walking on grounds on 10/24/08, DB fell when her walker got caught on the grass. She was sent to the hospital and was diagnosed with a sprain and a contusion on her knee. Her IRP dated 12/15/08 made no mention of the fall. • In contrast, the IRP (11/10/08) for GR who suffered a fall on 11/1/08 mentions the fall as Problem 6, with interventions calling for close observation and an updated fall risk assessment. **Compliance:** Noncompliance. **Current recommendations:** 1. *Implement plans to identify medical and behavioral high-risk indicators*. 2. See also recommendation in XII.E.1.C.
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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Begin identifying behavioral and medical triggers and expectations for responses from treatment teams when they are advised that an individual has reached a trigger. These expectations should have a hierarchical structure that reflects increased scrutiny as individuals are involved in more incidents or more serious incidents. **Findings:** See findings in the cell above. **Other findings:**

			The hospital has not yet developed and implemented a policy establishing a hierarchical review structure that moves the review of a high-risk individual's treatment to senior, interdisciplinary staff as the individual continues to engage in high risk behaviors or whose medical condition merits a higher level of review. **Compliance:** Noncompliance. **Current recommendations:** 1. *Identify a number of behavioral and medical high-risk indicators and begin to identify those individuals who meet the criteria.* 2. Alert the IRP teams as individuals meet an indicator and request a response from the team indicating the interventions in place or planned to address the risk. 3. Identify criteria for when a review of an individual treatment should move beyond the team to receive attention from senior clinicians.

	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. On a systemic level, the hospital has demonstrated the capacity to gather, present, and analyze data. The newly-drafted procedures of the PID provide an organized way to ensure that the hospital reviews the data and takes action to improve the issue under review. They provide for the tracking of quality indicators and the implementation of corrective actions related to incidents and trending and pattern data. The final selection of quality indicators is expected to occur by mid-May. Within 30 days of the final selection, specific committees and departments will begin collecting data. PID will monitor specific indicators. 2. As reported in the Incident Management section of this report, the hospital has demonstrated the ability to produce trending and pattern data related to specific issues. 3. The hospital is tracking several triggers and High Risk Indicators. These include: individual with two or more medical emergencies in 30 days, individuals in restraint/seclusion two or more times in 30 days, and individuals involved in three or more incidents in 30 days.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Taylor, Director, Policy and Procedures 2. M. Hartley, Performance Improvement Department Director 3. M. Pontes, Risk Manager <u>Reviewed</u>: 1. Performance Improvement Department Procedures: #1 Risk Management Trigger and Intervention Tracking, #2 Implementation of Corrective Action to Improve Performance 2. Risk Management & Safety Committee minutes for last quarter of 08.

			3. Performance Improvement Committee minutes for March 09. 4. Trigger and High Risk Indicator data (9/1/08—2/19/09). 5. Clinical records of four individuals involved in incidents of R&S.
BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure the operation of the Performance Improvement Committee to include making specific recommendations for improving care based on studies completed, incident, and other data presented. **Findings:** Review of the minutes of the March 6 and March 25 meetings of the Performance Improvement Committee revealed that the hospital has developed a list of 22 possible performance indicators. Following a voting process and approval by the Executive Staff Committee, the hospital will begin data collection on the selected indicators. **Recommendation 2, September 2008:** Track recommendations faithfully through the approval and implementation phases. **Findings:** The Performance Improvement Department has put in place an internal department procedure, effective March 23, 2009, titled, Implementation of Corrective Action to Improve Performance. It requires that data and events monitored by PID to be forwarded to the relevant hospital committee for review and recommendations for addressing the issue. A written summary of the committee's work will be submitted to the CEO and Executive Staff Committee for approval and/or additions/modifications to the recommendations. The results of the Executive Staff Committee review will be shared with the sending committee, which will be responsible for monitoring

			implementation for six months. Implementation of this process will be reviewed during the next tour. Some of the tracking and trending data presented in the bi-monthly Trend Analysis report is discussed in the Incident Management section of the report. **Compliance:** Partial. **Current recommendation:** Identify additional high-risk indicators, continue tracking and trending. Develop policies around expectations for the response of IRP teams and other clinicians/disciplines to individuals who reach triggers. See cell below.
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:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue implementation of plans to identify additional quality indicators and monitor performance. Consider both behavioral and clinical indicators. **Findings:** As reported, the hospital expects to have both behavioral and medical quality indicators identified by mid-May 09 and data collection to begin within 30 days of the identification. See also XIII.C for a listing of indicators that will be reviewed specifically by PID. **Other findings:** The hospital has demonstrated the capacity to gather, present, and analyze data. The newly-drafted procedures of the PID provide an

			organized way to ensure that the hospital reviews the data and takes action to improve the issue under review. Its incident recommendation follow-up procedures, when implemented, will ensure that recommendations made at the close of incident investigations will be implemented and monitored. There is a need additionally for the hospital to develop and implement a quality improvement process that specifically addresses the responsibilities of the IRP teams and senior clinicians in meeting the treatment needs of individuals who reach high-risk behavioral and medical indicators. The process should address at least the following elements: • Identifies individuals who reach high-risk indicators; • Notifies the IRP team that the individual has reached the trigger; • Receives back from the team a response identifying the interventions taken or planned to address the trigger; • Sets expectations that teams will review incidents that have occurred since they last met and triggers which the individual has reached; • Sets expectations that teams will evaluate the effectiveness of interventions; • Establishes a hierarchical structure for the review of individuals who continue to reach triggers or reach new triggers that includes review by senior clinicians who act as consultants to the IRP team; • Provides for the monitoring of the implementation of interventions and feedback to the team or senior clinicians on at least a sample basis. Compliance with the provisions of this portion of the Settlement Agreement will depend on the successful implementation of these procedures.

			Compliance: Noncompliance. **Current recommendations:** 1. Implement the PID procedures as planned. 2. *Develop policies necessary for the implementation of a quality management system for addressing the treatment needs of high risk individuals*.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Expedite plans to identify quality indicators through the use of consultant services and the review of indicators recommended by accrediting bodies. **Findings:** See XIII.B. The hospital expects to identify additional quality indicators by mid-May with data collection beginning shortly thereafter. **Compliance:** Noncompliance. **Current recommendation:** Implement the procedures prescribed by the PID policies and begin work on drafting policies/procedures addressing the treatment needs of individuals reaching high-risk indicators.
BJC	XIII.B.2	the anticipated outcome of each step; and	[The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.] The hospital will not be able to meet this requirement of the

			Settlement Agreement until it has identified additional high-risk indicators, has identified individuals reaching these indicators and has policies and procedures for responding to the treatment needs of individuals who reach the indicator criteria. It will likewise be essential to implement the PID policies and procedures for approving, implementing, and monitoring recommendations emerging from incident investigations.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	[The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.] See cell above.
BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Expedite plans to identify quality indicators. **Findings:** The process for identifying additional quality indictors (also called high risk indicators) is expected to be concluded by mid-May. **Recommendation 2, September 2008:** Expedite the work of the Serious Incident Follow-up Work Group. **Findings:** As noted previously, the Serious Incident Follow-up Work Group is no longer functioning. The Performance Improvement Department wrote department procedures, effective 3/23/09, entitled Risk Management and Intervention Tracking. This document establishes procedures to facilitate corrective actions of individual events and the correction of systems to decrease the likelihood of the recurrence of high priority events. Specifically, the following events will be tracked:

			• Individuals with 3 or more UIRs in 30 days • Individuals with 3 or more episodes of restraint/seclusion in 30 rolling calendar days • Individuals kept in restraint or seclusion more than 12 consecutive hours • Sentinel events • All A/N/E allegations • Any elopement **Other findings:** Review of the clinical records of four individuals who reached the indicator "2 or more R/S in 30 days" found that the IRP following the events did not mention the events. Attention to high-risk individuals needs to begin with the recovery team. • JD in restraint on 1/22/09 and in seclusion on 1/31/09. IRP dated 3/13/09 makes no mention of these events. • YS in seclusion on 11/24 and 11/25. IRP dated 2/16/09 makes no mention of these events. • SK in restraints on 1/7/09. IRP dated 1/14/09 makes no mention of the events. • GS in seclusion on 11/1,2,3,4. IRP dated 1/23/09 makes no mention of the events. **Compliance:** Noncompliance. **Current recommendations:** 1. *Ensure that recovery teams are aware of their responsibility to review incidents and high-risk indicators, including restraint and seclusion episodes, when they convene.* 2. See also XIII.B

BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	The hospital is not yet able to meet this Settlement Agreement requirement. See other findings and recommendations.
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	The hospital is not yet able to meet this Settlement Agreement requirement. See other findings and recommendations.
BJC	XIII.C.3	modifying corrective action plans, as necessary.	The hospital is not yet able to meet this requirement of the Settlement Agreement. See other findings and recommendations.
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Identify performance indicators and set performance goals. **Findings:** The hospital anticipates that it will have identified additional medical and behavioral high-risk indicators by mid-May and will begin data collection shortly thereafter. **Recommendation 2, September 2008:** Promulgate these indicators and performance goals hospital-wide. **Findings:** See above. **Recommendation 3, September 2008:** Trend performance. **Findings:** The hospital will track trend performance on the additional high-risk indicators, as it does on the indicators it presently tracks: individual with two or more medical emergencies in 30 days, individuals in

			restraint/seclusion two or more times in 30 days, and individuals involved in three or more incidents in 30 days. **Compliance:** Noncompliance. **Current recommendations:** 1. Identify, as planned, additional medical and behavioral indicators. 2. Adopt procedures to ensure that IRP teams address the treatment needs of individuals involved in incidents and who have reached triggers. See XIII.B.

	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 has maintained progress in ensuring that individuals have sufficient clothing and personal hygiene supplies. Bed linens were clean on the units toured. 2. The hospital has revised policies to address contraband and searches of individuals in care as measures to enhance the safety of individuals and staff members. 3. The common areas of all units visited were clean. Common areas had adequate furniture. 4. The hospital's Patient Safety Assessment has identified suicide hazards and other safety issues. This monthly assessment assigns responsibility to staff members for correction of those conditions under their control.
BJC			**Methodology:** <u>Interviewed</u>: 1. D. Moran, Director of Logistics and Materials Management 2. R. Morin, Maintenance Department 3. R. Winfrey, Acting Security Supervisor 4. W. Trimmier, Housekeeping Foreman <u>Reviewed</u>: 1. Nursing staffing information 2. Quarterly Environmental Survey findings 3. Hospital Patient Safety Assessment (January 2009) 4. Policy 108-09: Control of Contraband 5. Policy 107-02: Patient Searches 6. Approval Certificate for the hospital's Fire and Safety Evacuation Plan 7. Trouble Desk Quarterly Report for October, November and December 08

			Toured: Five units: RMB-2, RMB-4, JHP-9, JHP-12, JHP-10
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement the use of the Safety Inspection Checklist and advise units of the findings. **Findings:** Each month the residential units of the hospital are reviewed using the Patient Safety Assessment form. This form specifically identifies multiple types of suicide hazards to look for, such as door knobs, hinges, closet bars and all bathroom fixtures that support body weight over 40 pounds, security of medications and chemical cleaners, accessible curtain/window blind cords, call bell cords, and electric bed cords. Review of the results of the January 09 Safety Assessment reveals that many structural suicide hazards were identified. Correction of these would require major environmental modifications requiring significant resource allocation. These would include changing many bathroom fixtures and all bedroom doorknobs, flush-mounting sprinkler heads, and making modifications to the seclusion rooms. The January 09 report identifies the problems found in each unit and the staff member responsible for correcting it or providing a response. A number of problems related to cleanliness and supplies are noted as corrected. **Recommendation 2, September 2008:** Develop a plan for addressing the safety/suicide hazards found considering the level of risk associated with each.

			Findings: The hospital recently undertook a Suicide Awareness campaign, linking it to TJC 2009 National Patient Safety Goals. A "Warning Signs" poster and power-point presentation were part of the campaign. **Other findings:** The quarterly environmental survey conducted by the hospital (discussed in XIV.F) does not look at suicide hazards. The monthly safety assessments review suicide hazards as reported above. In several units toured, air vents are positioned directly above toilets and a recent suicide attempt involving the use of an air vent in a bedroom clearly indicates the need to assess the replacement/modification of the air vents. The shower and control panel fixtures in the bathrooms in JHP are a suicide hazard. **Compliance:** Partial. **Current recommendations:** 1. *Assess the environment to determine areas where individuals are likely to have privacy and where the air vents can present a suicide hazard.* 2. *If not already done, alert all units to the hazard presented by the air vents.* 3. *Identify ways to minimize the hazard presented by the vents. This might include bolting furniture to wall/floor away from vents, replacing the vents with a finer screen that still permits adequate airflow.*

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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Add contraband issues to the Safety Inspection checklist. **Findings:** This recommendation has been implemented. During the monthly Patient Safety Assessment, the Security Supervisor asks the units to identify for him any contraband items that have been confiscated in the last month. He records this information on the form. **Recommendation 2, September 2008:** Revise the Patient Search policy as planned. **Findings:** The Patient Search Policy was revised in February 09. It identifies the circumstances under which various types of searches will be conducted, emphasizes the desirability of obtaining the individual's consent, and the requirement that the search be conducted under circumstances "that assure maximum dignity and privacy for patients." This policy provides a definition and examples of contraband and weapons. **Other findings:** The Control of Contraband policy was revised in February 09. It prohibits any person from knowingly giving, selling, or otherwise providing drugs, alcohol or other contraband to an individual in care unless prescribed by a physician as part of the individual's treatment. It further prohibits employees from carrying contraband or weapons onto the hospital grounds. Procedures for confiscating contraband and weapons and for barring persons from the hospital are also covered by this policy. **Compliance:**

			Partial. **Current recommendation:** Provide information in the next progress report on incidents involving contraband.
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue efforts to reduce elopements. **Findings:** SEH data indicates that elopements have been decreasing. [Elopements are defined as the failure of an individual to return to an assigned unit or location within 24 hours of the assigned time.] Dividing the eight-month report period July 08—February 09 into two four-month time frames, on average 10.25 elopements occurred during the first period and 5.25 occurred during the second. **Recommendation 2, September 2008:** Comment in the investigation reports on staffing levels at the time an incident occurred in order to identify staffing issues that may be contributing factors. **Findings:** The investigation of the restraint of SK on 1/8/09 (tied seated in a chair with a sheet) determined that the named staff member was assigned Security checks (observe each of the individuals in the unit and identify the location of any individuals off the unit at the same time he had 1:1 observation responsibilities. In his statement, the named staff member said that at one point in the morning he was the only day shift staff member present. The short-staffing and conflicting work assignments were acknowledged in the investigation

report as factors contributing to the incident.

Other findings:
Review of staffing data for the period January 5-14, 2009 (randomly chosen only to avoid holidays) indicates that on some units during some shifts there was wide variability in the number of staff on duty during this 10-day period. While acknowledging that staffing levels must be adjusted to reflect the acuity of the individuals served, some of the variations cited below cannot be explained solely by this consideration and suggest instances of understaffing and overstaffing.

Unit	Shift	Range of number of staff present
RMB-3	Day	5—9
RMB-4	Eve	3—7
RMB-5	Day	4—8
RMB-6	Night	3—7
RMB-8	Day	5—9
RMB-8	Night	3—7
CT3	Eve	3—7
JHP-1	Eve	2—8
JHP-2	Night	3—9
JHP-3	Day	3—8
JHP-4	Day	2—6
JHP-4	Night	3—8
JHP-9	Day	3—10
JHP-10	Day	3—7

In addition, there were 16 instances in the 10-day review period when night staffing was higher than evening staffing on the same day and unit in JHP. In RMB, night staffing exceeded evening staffing on the same day and unit on 23 occasions. The hospital's own data shows that

			41% of all UIs for the last quarter of 08 occurred during the evening shift as compared with 12% on the night shift. Staffing should reflect the level of activity on the unit. During my tour of five units, each had adequate staff as judged by the unit escort in answer to the direct question. The number of staff on duty at the time appeared reasonable. **Compliance:** Partial. **Current recommendations:** 1. *Determine if there is a problem staffing the evening shift and take appropriate measures to address the issue.* 2. *Take any other steps necessary to staff units commensurate with the needs of the individuals*.
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 local authorities.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement an elevator service log that includes the date of the dysfunction and the date of the repair. **Findings:** This recommendation has been implemented. The Trouble Desk report now includes the date of the problem and the date of the repair, as well as the location of the problem. See below for data. **Recommendation 2, September 2008:** Inventory the residential units of individuals using wheelchairs to ensure that whenever possible, these individuals are housed on the first floor.

			Findings: The hospital reports that JHP layout does not permit all individuals who use wheelchairs to be housed on the first floor. Unit 2 for frail, elderly individuals and medically compromised post-trial patients are on the second floor with access to a courtyard by one flight of stairs. **Other findings:** The hospital acknowledges that the elevators continue to require attention. The Trouble Desk Quarterly Report (October-December 08) cites nine (unduplicated) calls for repairs in the three-month period. Each repair was reportedly completed on the same day the call was received. **Compliance:** Substantial—with recognition that some individuals using wheelchairs are not housed on the first floor. **Current recommendation:** Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure the Fire Prevention and Emergency Life Safety Evacuation Management Plan is approved as often as required by local ordinances. **Findings:** Review of this plan indicates that it is has been approved by the local fire authority and is current until September 09. **Compliance:** Substantial.

			Current recommendation: Continue current practice.
BJC	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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Initiate the planned nursing reviews of unit safety and cleanliness with particular emphasis on clothing storage and bathroom cleanliness and supplies. **Findings:** This recommendation has not yet been implemented. **Other findings:** The hospital conducted a quarterly environmental self-assessment. Surveyors do not review the areas of the hospital for which they are responsible. Teams of 2-3 surveyors used a 119- item tool to review the hospital. Perfect score =4.0. General cleanliness, maintenance, food handling, infectious waste and sharps disposal, and several safety issues are among the issue areas addressed. Results from the final third quarter of 2008 were compared with those of the final quarter. With the exception of laundry rooms and storage rooms, all areas of the hospital in both quarters scored at 3.5 or higher. The report compiled following the survey ranks each unit/treatment area on each of the standards and provides a unit- by- unit identification of any problems found. Findings are shared with all directors, the CEO, and nursing. The responsible parties must respond, and the responses are shared with the Risk Management Safety Committee. Several positive findings from the most recent survey were consistent with my five unit tour findings. Specifically, the common areas of the units were clean and odor-free and the furnishings adequate. Bedding was clean. Temperature in the common rooms was comfortable.

			Findings related to the condition of clothing, the condition of bathrooms and the stocking of bathrooms with supplies, and the temperature in bedrooms were scored far more positively in the hospital survey than the conditions I observed. Specifically I found: • Bathrooms in RMB 4 are not stocked with toilet tissue or paper towels. Individuals must ask for these at the nurses' station. One bathroom and shower room had rusty and disintegrating trap doors used to access the plumbing and/or rusty stalls. • Bathroom in JHP-9 and JHP-10 are not stocked with paper products. Individuals must ask for these at the nurses' station. In JHP-9, a stall door does not secure and was rusted. Two showers and the water control panel were leaking. This resulted in standing water on the floor. These same conditions (leaking plumbing resulting in standing water) were present in JHP-12. • The metal lockers in JHP discourage the proper storage of clothing. The narrow space with no shelving makes it difficult to keep clothing neat. It often appeared that clean clothing was mixed with clothing that needed to be laundered. • Several bedrooms visited were very warm. Windows opened only an inch or two or could not be opened at all because the crank did not work or there was Plexiglas between the window and the screen. [These conditions reportedly improve when the air conditioning is on.] • The wardrobe of one man on RMB-4 had a very strong urine odor. **Compliance:** Partial. **Current recommendations:** 1. *Consider revising the protocol for the quarterly surveys from a blitz style to avoid alerting the units that the inspections are underway.*

			2. *During the hospital quarterly surveys, ask a sample of individuals to show how they store their clothing and personal hygiene supplies.* 3. *Address the standing water issue in the showers with expertise from the maintenance department and infection control, if necessary.* 4. *Adopt a weekly review of the environment by unit leadership that includes a review of personal clothing care and storage.*