REPORT 7

St. Elizabeths Hospital

May 16-19, 2011

	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 maintained sufficient progress in the process of the IRP reviews (based on observations by three expert consultants who attended seven IRP conferences). Observed IRP conferences were much better organized and appropriately included the individual in care's preferences. 2. Social Workers are attending more IRP conferences. 3. SEH provided formal training on the IRP modules for staff members who missed the initial training (in September 2010) and additional focused training on the update of the case formulation, engagement of the individuals in the process of community integration, and the formulation of objectives and interventions to address the medical needs of the individuals. Overall, the combination of formal training and mentoring as well as informal coaching has had positive outcomes during this review period. 4. In general, the IRP case formulations were much improved compared to the last review. This included both the structure of the formulation and the individualization of clinical information in the precipitating, perpetuating, and predisposing factors sections as well as the review of the present status of the individuals. 5. In general, the IRP focus statements were more focused on the current status and diagnosis and, with few exceptions, did not include a rehash of the individual's psychiatric history. 6. In general, the IRP objectives were measurable and/or behaviorally stated, which is a significant improvement since the last review; 7. Most of the IRP interventions included adequate configuration of group interventions and appeared to be well aligned with the individualized needs of the individuals. 8. SEH has made further progress in revising the IRPs based on the changing needs of the individuals.

			9. SEH has maintained progress in modifying the interventions based on an IRP review of the use of seclusion/restraints. 10. SEH has made significant progress in the substance use education program and adequately addressed previous findings regarding the mismatch between groups and the individual's Stage of Change (SOC). The following is noteworthy: a. The training of the IRP teams regarding the proper alignment (groups and SOC) appeared to be very effective. b. The baseline assessment of individuals with substance use diagnosis using the "readiness ruler" comported with current standards in this area. c. Of 131 individuals with this diagnosis, almost one third had their SOC modified based on this assessment and more than half had their groups assignments modified to better align with the SOC. d. The facility maintained an adequate configuration of groups stratified by SOC and cognitive level that is sufficient to meet the facility's needs in this area. 11. SEH maintained progress in addressing the special needs of individuals with cognitive impairments. The current core groups are sufficient to meet the needs of the individuals. 12. In April 2011, SEH revised its IRP Manual to include more examples to guide the process and content of the IRPs. If properly implemented, the revised Manual is sufficient to meet the needs of the facility. 13. SEH has improved the quality of the medical assessments upon the transfer of the individuals to outside facilities for specialized care. 14. SEH has initiated and implemented an adequate self-auditing system to evaluate admission medical assessments and the medical assessments upon the transfer of individuals to outside medical facilities. 15. SEH has made further progress in the process of self-

			assessment, including gathering, presentation, and analysis of data and comparative data (IRP Observation, Clinical Chart Audit, Comprehensive Psychiatric Assessment, Psychiatric Update and Inter-Unit Transfer Assessments). <u>Areas of Needs:</u> 1. The facility must correct some persistent and significant process deficiencies in the current system that addressed the medical needs of the individuals, primarily in the following areas: a. Responsibilities for review by GMOs/NPs of significant abnormalities in laboratory results and follow up on these results in a timely manner; and b. The assessments of the individuals upon their return from outside hospitalization in a manner that ensures continuity of care, including the need to complete a diagnostic work up. 2. The facility needs to update the IRPs, specifically the present status section of the case formulation regarding precipitating factors and IRP objectives and interventions, for individuals who are determined to be at risk of harm to self or others upon admission (as per CIPA) and/or during hospitalization (as per the psychiatric update). In too many cases, there was evidence of discrepanciesy between results of the risk assessment and the content of the IRPs. This can have negative implications for the management of individuals who are at risk of harm to self or violence towards others. The risk assessment should provide more than just a rating to quantify the risk. This assessment should also provide targets for treatment and rehabilitation to reduce the risk. 3. The review of the present status section needs to clearly address the efficacy and status of behavioral guidelines/PBS plans. 4. In some cases, the focus statements were not specific or aligned

			with the objectives. 5. Some charts contained a number of interventions that were mechanized and amounted to job descriptions of the disciplines without clear rationale as to their significance relative to the identified needs of the individuals.
			Methodology: <u>Interviewed</u>: 1. Bernard Arons, MD, Medical Director 2. Tyler Jones, MD, Director, Psychiatric Services 3. Edger Potter, MD, Supervisor of General Medical Officer 4. Peter Thura, MD, General Medical Officer 5. Richard Smith, MD, General Medical Officer 6. Syed Zaidi, MD, General Medical Officer 7. Elizabeth Olumese, Nurse Practitioner 8. John Stiller, MD, Neurologist 9. Maura Gaswirth, LICSW, Social Work Chief 10. Clotilda Vidoni-Clark, PhD, Director of Treatment Programs 11. Nicole Rafanello, PhD, Deputy Director for Clinical Operations 12. Beth Gouse, PhD, Chief of Staff 13. Paula Palladino Negro, MD, Chair, Medical Records Committee 14. Mark Larkins, Hospital Information Technology Director 15. Eric Strassman, DMH Information Technology Director 16. Motyam Cheruka, AVATAR 17. Janet Maher, DOJ Compliance Officer <u>Reviewed</u>: 1. The charts of the following 51 individuals by Dr. El-Sabaawi: VS, MS, DM, RK, DH, KH, MM, BD, TW, CJ, JAR, RCM, TW, RCM, JAR, EG, FC, TW, JAR, MKS, LCE, BM, JAN, VS, MC, HS, PWC, JM, DLB, HJ, MRP, WNW, VB, JP, JM, HJ, JC, PG, TL, LB, FBH, CB, JR, JC, PH, DN, CH, RD, HH, LP and LHM

			2. The charts of the following 29 individuals by Dr. Boggio: MB, SK, VC, MH, TR, PC, RK, JN, MB1, DH, GL, PN, LS, VG, JD, AH, TJ, SM, SK1, CS, AH1, AA, TD, AB, MC, SC, CL, MP, CD 3. The charts of all individuals currently receiving PBS plans: DJ, CK and MP 4. The charts of three individuals who received Behavioral Guidelines/Initial Behavioral Interventions: GS, AH and SC 5. Saint Elizabeths Hospital (SEH) Compliance (self assessment) Report, April 18, 2011 6. SEH Revised IRP Manual, March 2011 7. SEH IRP training outlines and data 8. SEH PBS Training to Date (March 1, 2010 to February 28, 2011) 9. SEH IRP Training Materials and Training Data 10. SEH Updated IRP Training Data, May 16, 2011 11. SEH Feedback guidelines; IRP meetings, Phase II Icebreakers 12. SEH TLC Schedule 13. SEH Medication Group Capacity Data 14. SEH policy #302.5-10, High-Risk Indicator Tracking and Review 15. SEH Physician's Response to Risk Indicators (report from Performance Improvement department to the Director of Psychiatry) 16. List of All Behavioral Guidelines/Interventions Completed in Past year (March 1, 2010 to February 28, 2011) 17. SEH IRP Observation Monitoring Summary Data (September 2010 to February 2011) 18. SEH Clinical Chart Audit Summary Data (September 2010 to February 2011) 19. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions December 15, 2010 20. Comprehensive Initial Psychiatric Assessment Summary Data (September 2010 to February 2011); 21. Psychiatric Update Template, April 2011 22. Psychiatric Update Audit Summary Data (September 2010 to

			February 2011) 23. Inter-Unit Transfer Audit Summary Data (September 2010 to February 2011) 24. SEH data regarding Cognitive Groups 25. SEH documents regarding the status of Cognitive Remediation and Co-Occurring groups this review period 26. SEH lesson plans for the following substance use education groups per each stage of change: a. Precontemplation: Stress reduction for Co-occurring Disorders; b. Precontemplation: Anger Management for Co-occurring Disorders; c. Precontemplation/Contemplation: Stages of Change; d. Precontemplation/Contemplation (for Nicotine): Learning About healthy Living; e. Preparation: Substance Abuse Education; f. Action/Maintenance: Smart Recovery; g. Action/Maintenance (for Nicotine); and h. Action/Maintenance Relapse Prevention 27. SEH History and Physical Audit form and instructions 28. SEH History and Physical Summary Data (January and February 2011) 29. SEH Medical Transfer Audit Form 30. SEH Medical Transfer Audit Summary Data (December 2010 to January 2011) 31. SEH Policy #209-10, Seizure Management, April 4, 2011 32. SEH Policy #208-10, General Medical Services, April 4, 2011 33. SEH database regarding individuals transferred to outside facilities for medical care during this review period. <u>Observed</u>: 1. Team meeting at unit 1C for IRP review of LM 2. Team meeting at unit 2B for IRP review of MW

			3. Substance Abuse Education Group: "Relapse Prevention" facilitated by Trent Ttucker, PhD. 4. IRP Conference for GL, Unit 1A, 05/16/11 5. IRP Conference for SN, Unit 2A, 05/17/11 <u>Toured</u>: 1. Transitional Mall 2. Intensive Mall

	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.
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;	**Recommendations:** • *Same as in V.A.2 to V.A.5.* • *Same as in V.B, V.C, V.D and V.E.* • *Implement SEH Corrective Action Plan (CAP) of October 7, 2010 relative to Section V.A.* **Findings:** *Same as in V.A.2 to V.A.5., V.B, V.C, V.D and V.E.* In addition, in early March 2011, the facility revised its IRP manual including the addition of more examples to guide the formulation of goals, objectives and interventions, especially around medical issues as well as discharge criteria, barriers to discharge and discharge plans. In order to achieve substantial compliance with this requirement, the facility has to make further progress to ensure that the IRP conference, and the content of the IRPs, address the needs of individuals who are determined to be at risk of harm to self or others upon admission (as per CIPA) and/or during hospitalization (as per the Psychiatric Update). **Compliance:** Partial; improved compared to the last review. **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:	**Findings:** All IRP teams are led either by the treating psychiatrist or by a licensed clinical psychologist. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Findings:** The IRP training program has been substantially revised and utilizes an appropriate curriculum. The IRP manual provides better guidance for clinical staff in how to complete the IRP. Observed teams demonstrated that the team leader had a good grasp of the individual in care's treatment and discharge issues and worked with other team members in a collaborative manner. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
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;	**Findings:** The hospital's data reported that there is a clear trend indicating that community providers are being invited to attend 90% or more of scheduled IRPs. This data indicated, however, less consistency in a similar invitation being extended toward family members, as in two of the last four months, the invitation rate for family members was below the 90% threshold. Maintenance of the 90% rate for community invitations and

			several consistent months achieving a 90% rate for family invitations will be necessary before this provision of the Settlement Agreement will be found to be in substantial compliance. **Compliance:** Partial **Current recommendations:** Continue with identified corrective action plan, but quickly trouble-shoot obstacles if there continues to be lower than 90% compliance for family invitations.
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;	**Findings:** The attendance of social workers at scheduled IRP conferences has increased from 65 to 88% since the last reporting period. It is hoped that with the nearly completed staffing of the Social Work Department, this indicator, which is trending in the right direction, will meet the 90% threshold by the time of the next review. **Compliance:** Partial **Current recommendations:** Continue to analyze social worker attendance rate monthly and develop additional corrective action plans as necessary if data does not show improvement as a result of staffing enhancements.
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Findings:** Both the hospital's data and direct observation of IRP conferences evidenced that treatment teams are functioning in an interdisciplinary fashion.

			Compliance: Substantial **Current recommendations:** Maintain current level of practice.
MES	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Recommendations 1-3, November 2010:** 1. Continue to provide a summary of the aggregated monitoring data regarding the integration of psychiatric and behavioral modalities. The data should include 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. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). 3. Ensure that documentation in the psychiatric updates regarding significant developments during the previous interval reflects integration of behavioral and psychiatric modalities, as clinically appropriate. **Findings:** As described in the previous report, the facility's current process to ensure psychiatric input into the development and review of behavioral interventions is adequate. During this review period, the facility has implemented the following actions to ensure proper implementation of this process: 1. The Psychiatric Update form was modified upon its integration into AVATAR (October 2010) and additional revisions were made in April 2011. To better capture documentation related to this requirement the Avatar

			Psychiatric Update form includes a specific tab that addresses non-pharmacological interventions, requires the psychiatrist to describe the interventions and prompts the psychiatrist to address (and requires explanation of) specific behavioral and/or psychodynamic issues that are affecting the patient's lack of progress." 2. The psychiatrists are periodically reminded at their monthly meetings of the need to ensure integration of behavioral and psychiatric modalities in their monthly updates. 3. The PBS team leader has continued to train psychiatrists on this requirement. Updated PBS training data showed that 100% opf the psychiatrists were trained on PBS as of February 28, 2011 compared to 75% during the previous review period. SEH presented self-assessment data based on the Psychiatric Update (Reassessment) tool (September 2010 to February 2011). The average sample was 11% of the reassessments (target sample was two updates per unit psychiatrist). The mean compliance rate was 99% for the indicator that assessed whetherif the Psychiatric Update contained an appropriate plan that included integration of behavioral and psychiatric interventions. Comparative data showed that the facility has maintained a rate of 90% or higher since the last review. **Other findings:** This expert consultant reviewed the charts of all individuals currently receiving PBS plans at the facility (DJ, CK and MP) as well as three individuals who received Behavioral Guidelines/Initial Behavioral Interventions (GS, AH and SC). There was general evidence that the psychiatric updates (non-

			pharmacological interventions and overall hospital course) included improved review of clinical developments during the interval compared to the last review. Most of the updates (DJ, CK, MP and GS) also addressed this requirement by indicating if the individual had a plan or a guideline. However, the updates did not provide further information (e.g., the individual's response to this modality), which is important to integrate behavioral and psychiatric treatments. In addition, the present status section of the case formulations provided adequate information in this area in some cases (MP, GS and SC) but not others (DJ, AH and CK). **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Ensure that the psychiatric update addresses the individual's response to behavioral treatment. 2. Ensure that the present status section of the case formulation clearly addresses the efficacy and status of behavioral guidelines/PBS plans.
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.	**Findings:** The scheduling of IRP conferences continues to be done by the clinical administrators on each unit. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	V.A.3	provide training on the development and implementation of interdisciplinary treatment	**Findings:** The hospital has instituted a new training program that has an

		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;	appropriate criteria and has developed an IRP manual that provides better guidance to clinicians in how best to complete IRPs. This has been provided to over 90% of the core clinical staff. Additionally, a training module in engagement has been provided to over 90% of the core clinical staff. In both cases, results indicated that 100% of those attending the training had been deemed competent by a post test measure. **Compliance:** Substantial **Current recommendations:** 1. Continue work with new consultant regarding treatment planning 2. Provide re-training where necessary based on audits of written IRPs.
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	**Findings:** This cell essentially duplicates the findings for Cells V.A.2.b and V.A.2.c. **Compliance:** Partial **Current recommendations:** See V.A.2.b and V.A.2.c
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.	**Findings:** The hospital's own data indicated that performance relative to this indicator has fallen off since the time of the last review, from 86% to 81%. While it is clear that this decline was influenced by the fact that only 50% of audited IRP conferences occurred on schedule during September 2010, it is also

			important to note that only 73% occurred as scheduled in January 2011. The variation in this indicator suggests more than one reason that the hospital is having difficulty attaining the 90% threshold, although in two of the last six months, that threshold was reached. **Compliance:** Partial **Current recommendations:** 1. If this indicator does not quickly meet or exceed the 90% threshold, it will be important for the hospital to determine the obstacles to timely completion of scheduled IRP conferences and takes steps to remove those obstacles. 2. Continue to 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.

<table>
<tr><td></td><td colspan="3">B. Integrated Treatment Plans</td></tr>
<tr><td></td><td></td><td>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:</td><td></td></tr>
<tr><td>MES</td><td>V.B.1</td><td>where possible, individuals have input into their treatment plans;</td><td>Recommendations 1-3 November 2010:
• Provide a summary of all mentoring activities provided to the IRP teams during the review period relative to the engagement of individuals. Specify the participating disciplines in mentoring the teams and the mentoring process (didactic, observation, feedback to teams).
• Ensure that team mentors address the process deficiencies outlined in other findings above.
• Continue to provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.

Findings:
SEH reported the following training and mentoring activities relevant to this requirement:
1. During the period of October 2010 to March 2011, outside consultants provided competency-based training of IRP members who missed the initial training in September 2010 based on the IRP Engagement module. The previous report addressed the initial training in September 2010. The following is a summary of the facility's training data:

<table><tr><td>Discipline (hours of training)</td><td># attendees (% of those required to attend)</td><td># competent (% of attendees)</td></tr></table></td></tr>
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Psychiatry (2)	1 (100%)	1 (100%)
Psychology (1)	2 (100%)	2 (100%)
Nurse Manager (1)	8 (100%)	8 (100%)
Total	11 (100%)	11 (100%)

2. Additional training was provided (February 2011) on the engagement of individuals in the discharge planning process. The following is a summary of the data (no data was provided regarding the competency testing):

Discipline (1 and ½ hours provided for all disciplines)	# attendees (% of those required to attend)
Clinical Administrators	12 (100%)
Psychiatry	21 (96%)
Psychology	14 (100%)
Nurse Manager	8 (50%)
Social Work	13 (100%)

3. Each quarter, the Chief of Staff trained direct care employees hired during the preceding quarter on each of the four modules, including the engagement of individuals.
4. The facility continued the previously described process of internal mentors' observations of at least two IRP conferences each month per unit, and providing feedback and coaching to the IRP treatment teams, including on the engagement of individuals. During the period of

			September 2010 to February 2011, the facility has maintained an adequate number of couching hours (approximately 19 hours per month which is comparable to the hours provided in July and August 2010). 5. IRP observation data and clinical chart audit data were shared with mentors as well as with the management of Clinical Operations, to whom clinical administrators report. The IRP observation data addressed the engagement of individuals. **Recommendations 4-5, November 2010:** • Continue to monitor the individuals' attendance and participation in the IRP conferences using process observation data based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** The facility used its IRP Process Observation Monitoring Audit to assess its compliance with this requirement (September 2010 to February 2011). The average sample was 11% of all IRP meetings in all units (the facility has closed two units at the Annex since the last review). The following is a summary of the data with compliance rates and comparative data (in parenthesis):

			1. Individual attends the IRP Conference (98% compared to 95% during the last review); 2. Individuals have input into their treatment plans (83% compared to 83% during the last review). The facility acknowledged the decrease in compliance regarding the engagement of individuals and reported an adequate plan to continue training and mentoring in this area. **Other findings:** Three expert consultants separately attended seven IRP conferences and found general evidence that the facility has maintained sufficient progress in the process of the IRP conferences in the areas outlined in the previous report. In addition, further progress was made in the following areas: 1. Update of the present status of the individual; 2. Review of discharge criteria and barriers to discharge and discussion of progress towards discharge; 3. Review and revision, as indicated, of foci, objectives and interventions by the team; 4. Review of foci and objectives with input from the individual (instead, team members took turns reviewing with the individual their views of the individual's progress); and 5. Data-based review of the individual's participation in PSR Mall activities. These observations found that further progress is needed in the following areas: 1. Linkages between the IRPs (case formulations, foci, objectives and interventions) and results of the individual's risk assessment, including harm to self and/or others; 2. Interdisciplinary review and discussion of factors that

			underlie the reluctance of some individuals to participate in discharge planning. **Compliance:** Substantial. **Current recommendations:** 1. Provide a summary of any significant modifications in the current training, mentoring and coaching activities regarding the process of the IRP conferences, including the engagement of the individuals. 2. Continue to monitor the individuals' attendance and participation in the IRP conferences using process observation data based on an adequate sample. Present a summary of the aggregated monitoring data, including comparative data and analysis of low compliance with plans of correction.
	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;	**Recommendations 1-2, November 2010:** • Continue to monitor the timeliness of the initial disciplinary assessments during this review period. 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. • Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:
The following summarizes the facility's data regarding the timeliness of all disciplinary initial assessments.

Audit	Timeframe	%S*	%C (p)	%C (c)
Comprehensive Initial Psychiatric Assessment	24 hours	21%	100%	100%
Comprehensive Initial Nursing Assessment	8 hours	19%	72%	85%
Initial Psychosocial Assessment Part A	5 days	15%	50%	52%
Initial Psychosocial Assessment Part B	12 days	15%	64%	45%
Social Work Assessment	5 days	21%	60%	78%

*%S: mean sample size
*%C (p): mean compliance rate, previous period
*%C (c): mean compliance rate, current period

The data demonstrated the timely completion of the initial psychiatric assessments and relative improvement in the timeliness of nursing and social work assessments. The facility attributed the lack of compliance with the timeliness of the psychology assessments to the staffing shortage due to budget limitations and reported a variety of corrective actions to reach/maintain compliance will this requirement.

Other findings:
This expert consultant reviewed the Comprehensive Psychiatric Assessments in the charts of nine individuals (VB, VS, MS, DM,

			RK, DH, KH, MM and BD). The review found that the assessments were completed within the required timeframe in all cases. Findings regarding other disciplinary assessments are addressed in corresponding sections of this report. **Recommendation 3, November 2010:** Same as in VI.A.1 to VI.A.5. **Findings:** Same as in VI.A.1 to VI.A.5. **Compliance:** Partial **Current recommendations:** 1. Continue to monitor the timeliness of the initial disciplinary assessments during this review period. Present a summary of the aggregated monitoring data in the progress report, including comparative data and by analysis of low compliance with plans of correction, as indicated. 2. Same as in VI.A.1 to VI.A.5.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Recommendations 1-2, November 2010:** • Continue to monitor the timeliness of the comprehensive IRPs based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average mean. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in

			current review period vs. last review period). **Findings:** SEH reported self-assessment data using the Clinical Chart Audit (September 2010 to February 2011). Based on an average sample of 12%, the facility assessed the timeliness of the initial comprehensive treatment plan (by 7th day +/- 3 days since admission). Using this indicator, the mean compliance rate was 83% with this requirement, which is the same rate reported for the last review period. **Other findings:** This expert consultant reviewed the charts of nine individuals (VB, VS, MS, DM, RK, DH, KH, MM and BD) who were admitted during this review period. The review found that the initial IRPs were completed as required in all cases. **Compliance:** Substantial **Current recommendations:** Continue to monitor the timeliness of the comprehensive IRPs based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and by analysis of low compliance with plans of correction, as indicated.
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Recommendations 1-2, November 2010:** • Continue to monitor the treatment plan reviews based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population

			audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** SEH used the self-assessment method described in V.B.2.b above to assess the timeliness of the IRP reviews (by 30 days, 60 days and every 60 days thereafter). The facility reported a mean compliance rate of 81% compared to 86% during the last review period. Data analysis by the facility attributed this decrease in compliance to low performance in September 2010 when IRP teams received a week- long training **Compliance:** Partial **Current recommendations:** Continue to monitor the treatment plan reviews based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	V.B.3	individuals are informed of the purposes and major side effects of medication;	**Recommendation 1, November 2010:** Continue the process of Consumer Satisfaction Surveys and provide a summary of results. **Findings:** SEH continued the process of annual Consumer Satisfaction

Surveys, which addressed this requirement during the previous review period.

During this review period, the psychiatric update audit began tracking whether individuals are informed about the purposes and major side effects of medication in October 2010. The facility presented self-assessment data based on a mean sample of 11% (December 2010 to February 2011) showing 100% compliance with the following indicator:
Does the update reflect that medication benefits, risks and side effects were explained to the individual?

Recommendation 2, November 2010:
Provide information regarding medication education groups provided during the interval, including number of groups scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education.

Findings:
The facility provided information to address this recommendation (September 2010 to February 2011). The following outlines medication education groups, disciplines providing service, group capacity and individuals' attendance as of February 28, 2011:

Group	Discipline (provider)	Group Capacity	#individuals enrolled
"Understanding Your Illness and Treatment"	Psychiatry	94	64
"What's Up Doc?"	Psychiatry	16	13

			"Mental Health Teaching/Illness Recovery"	Psychiatry	88	59
			"Understanding Your Illness and Treatment"	Nursing	20	13
			"Medication Education"	Nursing	158	131
			"Understanding Treatment"	Nursing	10	10
			Total		386	290

More recent data (February 2011 to present) showed that groups had a total capacity of 376 with 293 individuals attending.

The above data showed that the medication education groups at SEH are sufficient to meet the facility's needs.

Compliance:
Substantial.

Current recommendations:
1. Continue the process of Consumer Satisfaction Surveys and provide a summary of results.
2. Provide self-assessment data based on the psychiatric update audit.
3. Provide information regarding medication education groups provided during the interval, including number of groups scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education.

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;	**Recommendations 1-2, November 2010:** 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). **Recommendations 3-4, November 2010:** 1. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** SEH presented self-assessment data using the Clinical Chart Audit (September 2010 to February 2011). The facility acknowledged the need for further progress in this area. Corrective actions included training (by outside consultants) provided in February 2011 targeting the formulation of focus statements, objectives and interventions in the IRP and completion of present status and discharge related sections of the clinical formulation. In addition, each treatment team had at least three clinical formulations (and IRPs) reviewed by the consultant who provided corrective feedback.

			Other findings: Same as in V.D.1 to V.D.5. This expert consultant found general evidence that the facility has made adequate progress in the formulation of foci, objectives and interventions. However, the facility has yet to make progress in ensuring that the foci, objectives and interventions are modified to address results of risk assessments (in the comprehensive psychiatric assessments and psychiatric updates) regarding the risk of harm to self and/or others. At this stage, the facility needs to prioritize this area while maintaining current progress in other aspects of the process and content of the IRPs. **Compliance:** Partial; improved compared to the last review (substantial compliance is contingent on progress in updating the IRPs to address the risk of harm to self and/or others). **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. 3. Prioritize efforts to ensure that the IRPs adequately address the risk of harm to self and/or others. 4. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Recommendation 1, November 2010** Continue to provide data regarding documentation of the review and assessment by the Director of Psychiatric Services of

			individuals who reach high risk triggers/thresholds. **Findings:** With the implementation of the facility's new High Risk Indicator Tracking and Review Policy, SEH has improved the process of reviews by the Director of Psychiatric Services. The new procedure integrates these reviews within progressive levels of reviews and interventions that correspond to the level of risk. Based on the revised process, beginning in March 2011, the Psychiatric Services Director provides a second level review when the high level thresholds (two or more episodes of restraint/seclusion in 24 hour period, three or more episodes of restraint/seclusion in a rolling 30 day period, any restraint/seclusion episode lasting more than 12 hours, three or more Unusual Incidents in 30 day period or three or more emergency involuntary medication administrations in a 24 hour period) are reached despite first level interventions by the IRP team/psychiatrist. This second level review is to be tracked by the Performance Improvement department and a database is being developed as a tracking mechanism. **Recommendation 2, November 2010:** *Same as in XII.E.2.* **Findings:** *Same as in XII.E.2.* **Other findings:** This expert consultant reviewed progress notes by the Director of Psychiatric Services documenting second level reviews of six individuals (JP, JM, HJ, JC, PG and TL) who reached a variety of risk triggers/thresholds. In general, the reviews were adequate,

			including specific recommendations for corrective actions. **Compliance:** Substantial. **Current recommendations:** 1. *Continue to provide data regarding documentation of the review and assessment by the Director of Psychiatric Services of individuals who reach high risk triggers/thresholds.* 2. *Same as in XII.E.2.*
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;	**Findings:** A review of the 10 most recent Forensic Review Board (FRB) submissions found over 90% compliance. This corresponds with the hospital's data indicating compliance rates between 90 and 100% since 12/09. Additional data indicates that the hospital is on track to have reviewed about 90% of these cases before the calendar year ends. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
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;	**Recommendation 1, November 2010:** • Same as in V.E.3, V.E.4 and V.E.5. • Same as in VIII. **Findings:** Same as in V.E.3, V.E.4 and V.E.5.

			Same as in VIII. **Recommendation 3, November 2010:** Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by comparative data to the last review and analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH reported that its previously used indicator in the Clinical Chart Audit (July and August 2010) was clarified to improve auditor reliability and that data collection on the revised indicator began in March 2011. The facility presented self-assessment data based on the Psychiatric Update Audit (September 2010 to February 2011). The following summarizes the data (with compliance rates listed for each indicator). Some of the indicators were added since the previous review and others deleted during this review period. However, the current configuration of indicators is appropriate to this requirement. The mean sample size was 11%: 1. The Psychiatric Update accurately reflects the individual's progress/response to treatment (99%). 2. The diagnosis reflects current clinical data or changed/updated data (99%). 3. The pharmacological plan of care reflects diagnosis, mental status assessment and response to treatment (99%).

			Other findings: As mentioned earlier, the facility has yet to make progress in ensuring that the foci, objectives and interventions are modified to address results of risk assessments (in the comprehensive psychiatric assessments and psychiatric updates) regarding the risk of harm to self and/or others. **Compliance:** Partial, improved compared to the last review (substantial compliance is contingent on progress in addressing results of the risk assessments). **Current recommendations:** 1. Same as in V.B.4, V.E.3, V.E.4 and V.E.5. 2. Same as in section VIII. 3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	V.B.8	an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and	**Recommendations 1-2, November 2010:** • Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data, 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. • Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:

SEH presented self-assessment data based on the Inter-Unit Transfer Audit (March to August 2010). The average sample was 35% of the transfers during each month. The following is an outline of the relevant indicators and corresponding mean compliance rates (items 1-2 and 9-16 apply to the psychiatric transfer assessment):

#	Indicator	%C (p)	%C (c)
1	Psychiatric transfer note present	42%	78%
2	Psychiatric acceptance note present	71%	78%
3	Social Work transfer note present	19%	83%
4	Social Work acceptance note present	19%	39%
5	Nursing transfer note present	65%	67%
6	Nursing acceptance note present	77%	83%
7	General Medical Officer transfer note present	58%	72%
8	General Medical Officer acceptance note present	52%	89%
9	Rationale for transfer	66%	94%
10	Current behavior, treatment and response	65%	82%
11	Anticipated benefits of transfer	71%	82%
12	Brief course of treatment	65%	82%
13	Risk factors	68%	88%
14	Current diagnosis	74%	94%
15	Discharge barriers	71%	76%
16	Recommended plan of care	61%	88%
17	IRP completed within 7 days of	58%	72%

	transfer		

During this review period, the facility experienced a relatively large number of transfers during the period of January and February 2011 due to the closure of all units in the Annex. The data showed overall improvement in compliance since the last review.

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

Initials	Dates of inter-unit transfer
JM	1/20/11
DLB	2/28/11
HJ	3/21/11
MRP	1/20/11
JM	2/3/11
WNW	3/21/11

The review found substantial compliance in charts of JM, BLB, HJ, MRP and JM and partial compliance in the chart of WNW (due to lack of clinical information regarding the reason for transfer).

Compliance:
Substantial.

Current recommendations:
Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data, including comparative data and analysis of low compliance with

			plans of correction, as indicated.
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.	**Recommendations 1-2, November 2010:** • Present an outline of all current self-assessment tools, including sample sizes, status of implementation during the review period, and any modifications made during the review period or planned for next review period. • Consolidate and simplify some of the auditing tools that address overlapping areas and that contain redundant indicators (e.g., the Medication Monitoring Audit can be discontinued in favor of a more complete Psychiatric Update Audit and the Therapeutic Progress Notes tool can be simplified). **Findings:** The following is a summary outline of the current auditing tools at SEH, including sample size (in parenthesis) and changes made in the auditing indicators since last review: 1. IRP Process Observations (two observations per unit per month): the tool was not changed during this review period. 2. Clinical Chart Audit (two IRPs per unit per month): the tool was modified in January 2011 to combine questions related to timeliness and clarify some instructions to improve inter-rater reliability. 3. Comprehensive Initial Psychiatric Assessment (20% of admissions per month): the tool was modified to add an indicator regarding laboratory testing and consultations and rearrange some indicators to improve clinical flow. 4. Psychiatric Update (two updates per psychiatrist per month): the tool was modified to address high risk medication uses (as the medication monitoring tool was discontinued as recommended in the previous report). 5. Inter-Unit Transfer (20% of transfers per month): the tool

			was not changed during this review period. 6. Tardive Dyskinesia (100% of individuals with diagnosis every six months): an indicator was added related to the psychiatric update addressing TD. 7. Initial Psychological Assessments (20% of assessments per month): the tool was not changed during this review period. 8. Psychological Risk Assessments (one per practitioner per month): the tool was modified by adding some indicators and deleting others. 9. PBS plans/guidelines (target changed to 50% sample per month, no other changes were made). 10. Neuropsychology Assessments (one assessment per practitioner per month) the tool was initiated as a modification of the previous tool regarding "Other Psychological Assessments." 11. Initial Rehabilitation Services Assessment (20% of assessments per month): no significant change was made during this review period. 12. Nursing Initial Assessments (20% of admissions per month): no change was made during this review period. 13. Nursing Update (four per unit per month): A new tool was introduced in November 2010 due to change in Progress Update form. 14. Social Work Initial Assessment (20% of admissions per month): the tool was modified to better reflect the IRP process and family participation in this process. 15. Social Work Update (one per practitioner per month): the tool was modified similar to better reflect the IRP process and family participation in this process. 16. Seclusion/Restraints (50% sample per month): significant changes were made to correspond to the requirements of the Agreement. 17. Nursing Side Rail Audit: this tool was not initiated as it was

			deemed unnecessary (per discussion with the nursing expert consultant). 18. Discharge Record Audit (10% of discharges): two indicators were added regarding the individual receiving and reviewing a copy of discharge plan of care. 19. Emergency Involuntary Medication audit (20% of individuals given involuntary medications per month): no changes were made. 20. Therapeutic Progress notes (one note per group leader/individual therapist per month): the tool was modified by removing few indicators and breaking others into more discrete indicators (as recommended in the previous report). 21. Group Facilitator Observation Audit (one per group leader every four months): tool was implemented during this review period. 22. DMH Post Discharge audits (monthly): the tool was modified beginning in September 2010 to include whether DMH received the discharge plan of care. For further information regarding each type of audit, please refer to the corresponding section of the Agreement. **Compliance:** Substantial. **Current recommendations:** 1. Present information regarding any significant modifications in current self-assessment tools, including changes in the monitoring indicators and sample sizes as well as the status of implementation during the review period. 2. Streamline the indicators within some of the auditing tools to simplify the auditing process without reducing its value (provisional tools that streamline auditing of the

			Comprehensive Psychiatric Assessment and the Psychiatric Updates were discussed with this expert consultant on-site).

<table>
<tr><td></td><td colspan="3">C. Case Formulation</td></tr>
<tr><td></td><td></td><td>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:</td><td>Please see sub-cells for findings and compliance.</td></tr>
<tr><td>MES</td><td>V.C.1</td><td>be derived from analyses of the information gathered including diagnosis and differential diagnosis;</td><td>Recommendation 1, November 2010:
Continue to provide aggregated data regarding competency-based training of IRP team core members regarding the Interdisciplinary Case Formulation.

Findings:
The following summarizes the facility's actions during this review period:
1. Outside consultants trained staff members who missed the initial training in September 2010 on the case formulation module (this training was addressed in the previous report). The following summarizes the training data:

<table>
<tr><th>Discipline (hours of training)</th><th># attendees (% of those required to attend)</th><th># competent (% of attendees)</th></tr>
<tr><td>Psychiatry (12)</td><td>1 (100%)</td><td>1 (100%)</td></tr>
<tr><td>Psychology (12)</td><td>2 (100%)</td><td>2 (100%)</td></tr>
<tr><td>Nurse Manager (12)</td><td>8 (100%)</td><td>8 (100%)</td></tr>
<tr><td>Total</td><td>11 (100%)</td><td>11 (100%)</td></tr>
</table>
2. Refresher training was provided (in February 2011) to</td></tr>
</table>

			the clinical administrators on developing the present status section of the clinical formulation and presenting present status at the IRP conference. This training was provided in part as a result of reviewing the data from the clinical chart audit. The training (1.5 hours) was attended by 10 staff members (83% of those required to attend). 3. Outside consultants observed IRP conferences on each unit and provided IRP teams with feedback around the writing of IRPs, including the case formulation. The facility reported that, since December 2010, the consultants have reviewed at least three clinical formulations per IRP team with feedback provided. Internal mentors observed least two IRP conferences each month per unit, and provided feedback and coaching to the IRP treatment teams to reinforce formal training/mentoring by outside consultants. 4. A form was developed through which the mentors/auditors can provide written comments and suggestions to the IRP teams about specifics from the audit results (Clinical Chart Audit Feedback Form). 5. As mentioned earlier, each quarter, the Chief of Staff trained direct care employees hired during the preceding quarter on each of the four modules, including the Case Formulation. **Recommendations 2-3, November 2010:** • Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the

			review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** SEH used the Clinical Chart audit (September 2010 to February 2011) to assess all the requirements in V.C based on a mean sample of 12%. The mean compliance rates are presented in each corresponding cell. The facility reported a mean compliance rate of 74% for the requirement in this cell (compared to 71% for July and August 2010 during the last review period). The data for December 2010 to February 2011 showed relatively higher rates of compliance. The facility reported that it will continue to review data from the monthly clinical chart audit to identify IRP teams in need of additional training/coaching. **Other findings:** This expert consultant reviewed the charts of 12 individuals (VB, VS, MS, DM, RK, DH, KH, MM, BD, JM, LB and FBH). This review found substantial compliance in seven charts (VB, VS, DM, RK, MM, JM, DH and BD) and partial compliance in four. The review found general evidence of inadequate modifications of the case formulation to address threatening behavior (MS) and/or IRP objectives and/or interventions to address results of violence (LB and FBH) and suicide (MM) risk assessments (as identified in the comprehensive psychiatric assessments and psychiatric updates). The case formulation was not found in the chart of KH.

			Overall, there was general evidence that SEH has made sufficient progress with this requirement, but has yet to make progress in updating the case formulation and/or the IRP objectives and interventions to address results of the risk assessments. At this stage, the facility needs to prioritize this area while maintaining current progress in other aspects of the process and content of the case formulation. **Compliance:** Partial, improved compared to the last review (substantial compliance is contingent on progress in updating the case formulation and/or objectives/interventions to address the results of risk assessments). **Current recommendations:** 1. Prioritize efforts to ensure adequate update of the case formulation (and linkage with the IRP objectives and interventions) in response to results of risk assessments and linkage with the IRP objectives and interventions. 2. Provide a summary of any modification in the current training, mentoring and coaching activities regarding the process and content of the case formulation. 3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Findings:** The mean compliance rate for this requirement was 75% compared to 49% during the last review period (July and August 2010). The data for December 2010 to February 2011 showed

			relatively higher rates of compliance. **Compliance:** Partial, improved compared to last review (substantial compliance is contingent on progress in updating the case formulation and/or objectives/interventions to address results of risk assessments). **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;	**Findings:** The facility reported a mean compliance rate of 99% for this requirement, the same rate reported for the period of July and August 2010. **Compliance:** Substantial. **Current recommendations:** 1. Same as above. 2. Same as in VI.A.5
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Findings:** The self-assessment audit showed a mean compliance rate of 92% (compared to 85% for July and August 2010). **Compliance:** Substantial. **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;	**Findings:** The facility reported a mean compliance rate of 94% (compared to 74% during July and August 2010). **Compliance:** Substantial. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Findings:** The facility reported a mean compliance rate of 45% (compared to 37% for July and August 2010). **Compliance:** Partial, improved compared to last review (substantial compliance is contingent on progress in updating the case formulation and/or objectives/interventions to address results of risk assessments). **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.	**Findings:** The facility reported a mean compliance rate of 57% compared to 52% during the last review (July and August 2010). **Compliance:** Partial, improved compared to last review (substantial compliance is contingent on progress in updating the case formulation and/or objectives/interventions to address results of risk assessments).

			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;	**Recommendation 1, November 2010:** Develop and implement corrective actions to address the process deficiencies in medical and nursing care outlined above. Include an update regarding the status of implementation of the facility's policies and procedures regarding provision of medical care and seizure management. **Findings:** The following summarizes the facility's actions to address this recommendation: 1. The general medical services policy was modified (April 2011) regarding the following areas: a. Updates of Axis III diagnosis and medical problem lists; b. Timeframes for documentation of medical assessment and communication with outside facility following the individual's return from outside hospitalization; c. Documentation (medical) of discharge assessments; d. Medical collaboration with social work to improve continuity of care upon discharge of the individuals; e. Entry of laboratory results into AVATAR; f. Completion and transmittal of medical consultation.

			2. The seizure management policy was updated (April 2011). In this regard, Nursing revised the Seizure Observation Form and process to include two parts: one part completed by the staff witnessing the seizure and the other part completed by the RN. This revision is to be completed no later than May 2011. 3. Audit tools were developed for reviewing the quality and timeliness of the History and Physicals as well as documentation around medical transfers, and audits were begun in January 2011. Audit results for the history and physical audits showed high performance on all indicators. Audit results for the medical transfer audits showed high compliance on most indicators. The facility acknowledged that improvement was needed on indicators relating to completion of all subsections of basic information, accuracy/completeness of diagnoses and inclusion of a brief description of current behavior and response to treatment. **Recommendation 2, November 2010:** Continue to provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/ Interventions. **Findings:** The following summarizes the facility's actions to address this recommendation: 1. During the period of October 2010 to March 2011, outside consultants provided competency-based training to IRP members who missed the initial training in September 2010 based on the IRP module regarding foci, objectives and interventions. The previous report

addressed the initial training in September 2010. The following is a summary of the facility's training data:

Discipline (hours of training)	# attendees (% of those required to attend)	# competent (% of attendees)
Psychiatry (12)	1 (100%)	1 (100%)
Psychology (2)	2 (100%)	2 (100%)
Nurse Manager (1)	8 (100%)	8 (100%)
Total	11 (100%)	11 (100%)

2. Additional training was provided on developing foci, objectives and interventions, with a specific focus on medical needs. This training was held with clinical administrators and nurse managers. Staff members were provided with examples of possible objectives and interventions for those with medical needs and were asked to develop their own. These additional examples have been incorporated into the revised IRP manual. The following summarizes the facility's training data (2 hours for all disciplines):

Discipline (hours of training)	# attendees (% of those required to attend)	# competent (% of attendees)
Clinical Administrators	11 (92)	11 (100%)
Nurse Managers	13 (81%)	13 (100%)
Total	24 (86%)	24 (100%)

			3. Other training and coaching activities provided by outside consultants and internal mentors (as described in V.B) were also applicable to this requirement. **Recommendations 3-4, November 2010:** • Continue to monitor each requirement in V.D.1 to V.D.6 based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates and weighted average compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** SEH used the Clinical Chart audit (September 2010 to February 2011) to assess all the requirements in V.C based on a mean sample of 12%. The mean compliance rates are presented in each corresponding cell. Regarding the requirement in this cell, the facility reported mean compliance rate of 76% compared to 68% for the last review period (July and August 2010). **Recommendation 5, November 2010:** Ensure that the self-report contains a summary outline of the following: o Number and types of Cognitive remediation interventions that are currently provided and plans to increase these

interventions; and

- Specific information regarding the assignment of TLC groups to individuals based on initial cognitive screening of the individuals.

Findings:

SEH reported that the TLC has continued to offer cognitive programming, including the same core groups that were described in the previous report (an online cognitive skill building program for those with mild cognitive impairments; a "pen and pencil" cognitive skill building program for those with moderate impairments, and a sensory enhancement/reminiscence/remotivation program for individuals with severe impairments (e.g., mental retardation or dementia). The following table summarizes the facility's data for this review period compared to the last period:

Indicator	September 20, 2011	February 28, 2011
Number of cognitive groups per week	130	127
Number of distinct group curricula per week	51	51
Number of group sessions per week	254	252
Total capacity of groups per week	1004	1024
Number of individuals enrolled in groups	No data	857
Hospital census	312	276

			Since the last review period, some groups were reorganized. This resulted in a decrease of three different groups per week and a decrease of two different groups sessions per week. However, the total group capacity has increased. **Other findings:** This expert consultant reviewed the charts of 12 individuals (VB, VS, MS, DM, RK, DH, KH, MM, BD, JM, LB and FBH) to assess the formulation of foci of hospitalization. The reviews found substantial compliance in five charts (VS, BD, KH, JM, and DM) and partial compliance in seven (VB, RK, MS, LB, FBH, DH and MM). There was evidence of inadequate linkage between the psychiatric focus and corresponding objectives and interventions (VB), over-inclusive and/or vague focus statements (MS, DH and RK) and inadequate modifications in the IRP foci, objectives and/or interventions to address results of violence (LB and FBH) and suicide (MM) risk assessments (as identified in the comprehensive psychiatric assessments and psychiatric updates). The chart of KH did not include a comprehensive IRP. Overall, there was general evidence that SEH has made sufficient progress in the development of a focus of hospitalization, but has yet to make progress in modifying the IRP foci (and corresponding objectives/ interventions) to address results of the risk assessments. At this stage, the facility needs to prioritize this area while maintaining current progress. This expert consultant reviewed the charts of 19 individuals diagnosed with seizure (TW, CJ, JAR and RCM), cognitive (TW, RCM, JAR, EG and FC), and substance use (TW, JAR, MKS, LCE,

			BM, JAN, VS, MC, HS and PWC) disorders. The purpose of the review was to assess whether the IRP included appropriate diagnosis, foci, objectives and interventions to address the special needs of these subpopulations of individuals. The review found that the facility has strengthened progress in some areas as follows: 1. The present status section of the case formulation reviewed the status of individuals diagnosed with seizure disorders (RCM and JAR) and dementing illnesses (RCM and EG). 2. The IRPs included foci, objectives and interventions related to seizure disorders in most charts reviewed. 3. The objectives related to seizure disorder were based on learning outcomes in some cases (JAR). 4. The IRPs included foci, objectives and interventions related to dementias in most charts of individuals diagnosed with these disorders (RCM). 5. The IRPs included foci, objectives and interventions relevant to the needs of individuals with Mental Retardation in all the charts of individuals diagnosed with this condition. 6. There was evidence of caution in the choice of anticonvulsant medications regarding the risk of further cognitive decline in individuals suffering from cognitive impairments and seizure disorders (TW). 7. In general, neuropsychological testing and neurology consultations were obtained when indicated. 8. Group interventions were tailored to the individual's level of cognitive functioning, including formal cognitive remediation, for individuals diagnosed with dementing illnesses. The following are examples: a. Reminescence Group (RCM); b. Sensory Enhancement Group (RCM and LS); c. Cognitive Stimulation Group (EG) d. Cognitive Skills Building (LS and MKS) and

			e. Restorative Care Group (JSA) 9. Group interventions adequately addressed the needs of individuals diagnosed with Mental Retardation (CLG and MKS). 10. Group interventions for individuals suffering from substance use disorders adequately addressed (and aligned with) the needs (and stage of change) of these individuals (JAR, LE, JAN, MKS, VS, MC, and PWC). This review found the following deficiencies: 1. Individuals diagnosed with seizure disorders: a. The present status section did not include a review of seizure activity during the interval (TW and CJ). b. The IRP objectives related to seizure disorders were not based on adequate learning outcomes (RCM, TW and CJ). 2. Individuals diagnosed with cognitive disorders: a. The present status section of the case formulation did not include an adequate review of the cognitive status of an individual diagnosed with a dementing illness (TW). b. The IRP did not include focus, objectives or interventions to address the cognitive dysfunction of individuals diagnosed with a Dementing illnesses (TW). c. TW: both neuropsychological testing and neurological consultation suggested a possible diagnosis of Vascular Dementia but the IRP included generic diagnosis of "Dementia Due to Trauma, HIV disease or Huntington's disease". 3. Individuals diagnosed with substance use disorders: The IRP did not include objectives or interventions to address the needs of two individuals in the precontemplative stage of change (TW and BM).

This expert consultant reviewed the charts of six individuals who were transferred to an outside facility for medical care on eight occasions during this reporting period. The review focused on the provision of timely and appropriate assessments and interventions to address the medical needs of the individuals. The following outlines these reviews:

Initials	Date of transfer	Reason for transfer
[redacted]	1/23/11	Unresponsive
[redacted]	11/22/10	Hyponatremia
[redacted]	9/21/10	Left-sided pleuritic pain
[redacted]	1/20/11	R/O lithium toxicity vs. vascular event
[redacted]	1/29/11	Generalized Seizure
[redacted]	2/5/11	R/O CVA R/O Seizure
[redacted]	2/16/11	Fall with possible head injury
[redacted]	4/12/11	Possible seizure and prolonged confusion

This review found general evidence of improved practice regarding the documentation of the individual's status upon outside transfer. However, the following deficiencies were identified:

1. There was evidence of a significant delay in medical attention to sub-therapeutic levels of an anticonvul t medication (12/30/10 and 1/12/11) in an individual ([redacted] who developed recurrent seizure activity (1/29/11). During the outside hospitalization, the anticonvulsant regimen was adjusted but an additional finding of critically low serum sodium level was made. Upon the return transfer of this individual, there was no further evaluation at SEH of factors contributing to the critical

			drop in serum sodium level until the individual had another episode of loss of consciousness requiring another hospitalization at the outside facility. 2. There was evidence of a delay in recognizing the manifestations of possible delirium in the context of physical complaints suggesting significant change in the medical condition of an individual ( ). The psychiatric reassessment for this individual did not occur in a timely manner. 3. An individual experienced a serious change in neurological status suggesting a vascular event but the transfer assessment that was sent to the outside hospital included inadequate information regarding findings from the physical examination ( ). However, the outside transfer was timely. 4. The nursing follow up of an individual who complained of recurrent chest pain did not assess the individual's status in a timely and adequate manner (. 5. The nursing assessment of an individual ( ) who developed recurrent seizure activity included only a partial description of the seizure type. **Compliance:** Partial, improved compared to the last review (substantial compliance is contingent on progress in the provision of timely and adequate assessments and interventions to address the medical needs of the individuals while maintaining current progress in other areas relevant to this requirement). **Current recommendations:** 1. Develop and implement corrective actions to address the process deficiencies in medical and nursing care outlined above. Include an update regarding the status of

			implementation of the facility's policies and procedures regarding provision of medical care and seizure management. 2. Provide a summary of any significant modifications in current training, mentoring and coaching regarding the formulation of Foci/Objectives/ Interventions. 3. Continue to monitor each requirement in V.D.1 to V.D.6 based on an adequate sample. Present a summary of the aggregated monitoring data, including comparative data and analysis of low compliance with plans of correction, as indicated. 4. Provide a summary outline of any significant changes in the number and types of groups offering cognitive remediation and substance use education.
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);	**Findings:** The facility presented a mean compliance rate of 74% for this review period compared to 80% during the last review (July and August 2010). **Compliance:** Partial, improved compared to the last review (substantial compliance is contingent on progress in the provision of timely and adequate assessments and interventions to address the medical needs of the individuals while maintaining current progress in other areas relevant to this requirement). **Current recommendations:** Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Findings:** SEH reported a mean compliance rate of 67% compared to 61% during the last review (July and August 2010).

			Other findings: This expert consultant reviewed the charts of 12 individuals (VB, VS, MS, DM, RK, DH, KH, MM, BD, JM, LB and FBH) to assess the formulation of IRP objectives. This review found substantial compliance in nine charts (VB, VS, MS, DM, RK, DH, BD, JM, and FBH) and partial compliance in three (LB, MM and KH). There was evidence of inadequate modification of the IRP objectives to address results of violence risk assessment (LB). The chart of MM included an inappropriate objective for the individual. The comprehensive IRP was not found in the chart of KH. Overall, there was general evidence that SEH has made sufficient progress with this requirement, but has yet to make progress in updating the IRP objectives (and interventions) to address results of the risk assessments. At this stage, the facility needs to prioritize this area while maintaining current progress in other aspects of the process and content of the IRP objectives. **Compliance:** Partial, improved compared to the last review (substantial compliance is contingent on appropriate modification of the IRP objectives to address results of the risk assessments). **Current recommendations:** Same as above.
MES and RB (PSR/	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Recommendations 1-3, November 2010:** • Same as above. • Continue to monitor this requirement using the Clinical Chart Audit and the Therapeutic Progress Notes Audit.

Mall)

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

- Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:

SEH Data from the Clinical Chart audit showed a mean compliance rate of 75% compared to 84% during the last review (July and August 2010).

In addition, SEH used the Therapeutic Progress Notes Audit to assess the individuals' participation in group activities relative to established objectives and interventions. The average sample was 19% of therapeutic progress notes each month (January and February 2011). The data addressed the notes completed by group leaders from the core disciplines (Psychiatry, Psychology, Rehabilitation, Social Work and Nursing). The facility has modified the configuration of indicators to better address this requirement and improve inter-rater reliability. The following is a summary of the relevant indicators, corresponding mean compliance rates and comparative data as available:

#	Indicator	%C (p)	%C(c)
1	Notes completed in a timely manner	67%	90%
2	Number of sessions scheduled indicated	No data	100%
3	Number of sessions attended indicated	No data	100%

4	Number of sessions scheduled equaled number attended	No data	69%
5	If applicable, there is a specific reason why numbers are not identical	94%	76%
6	The intervention (group or individual therapy) is noted and individual's participation noted and informative)	95%	96%

Other findings:
This expert consultant reviewed the charts of 12 individuals (VB, VS, MS, DM, RK, DH, KH, MM, BD, JM, LB and FBH) to assess the formulation of IRP interventions. The review found substantial compliance in seven charts (VB, VS, MS, DM, MM, BD and LB) and partial compliance in five (RK, DH, JM, FBH and KH).

There was evidence of interventions that included (RK and FBH) or were limited to (JM) job descriptions of various disciplines without relevance to the identified IRP needs of the individuals. The IRP of FBH did not include interventions to address results of the violence risk assessment. The interventions for DH were focused on medication adherence but the case formulation did not identify this to be an area of need. The chart of KH did not include a comprehensive IRP.

Overall, there was general evidence that SEH has made sufficient progress in the development of IRP interventions, including groups that were tailored to the special needs of individuals. However, the facility has yet to make progress in modifying the IRP interventions to address results of the risk assessments. At this stage, the facility needs to prioritize this area while maintaining current progress.

Additionally, the revised IRP Manual gives clear direction for the

			appropriate completion of interventions as required by the Settlement Agreement. The revised Therapeutic Progress Note Self-Audit Tool (footer date: 02/08/11) is a superior tool to the one previously used by the hospital. While data in the self-assessment report was only available for a couple of months, trends across disciplines with the exception of nursing were clearly at or above 90% for most sub-indicators. It will be important for the facility to determine what systemic issues are impeding better Therapeutic Progress Notes by nursing staff, but an inadequate number of RNs may certainly be part of the problem. A review of 10 randomly chosen medical records from individuals in care admitted on or after February 1, 2011 found that there were interventions in each of these IRPs that related to each objective, and that specified who will do what and within what time frame to assist the individual to meet his/her goals as specified in the objective. **Recommendation 4, November 2011:** Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. Present auditing data for this instrument according to instructions in Cell V.B.9. **Findings:** The facility reported that it has initiated a Group Facilitator audit tool to address the alignment of active treatment at the Mall and IRP objectives and that data will be available during the next review.

			Compliance: Partial, improved compared to last review (substantial compliance is contingent on adequate modification of treatment interventions to address results of violence risk assessments and the proper individualization of treatment interventions). **Current recommendations:** 1. Same as above. 2. Maintain current level of performance in the proper documentation of IRP interventions. 3. Determine the barriers to the completion of better Therapeutic Progress Notes by nursing staff and develop appropriate corrective action plan. Maintain the gains in proper Therapeutic Progress Note completion by the other disciplines. 4. Continue to monitor this requirement and present aggregated monitoring data including comparative data and analysis of low compliance with plans of correction, as indicated. Supporting documents should be provided.
RB	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	**Findings:** The hospital introduced a new catalogue of groups for the TLCs in September 2010, and made further refinements to programming for a number of individuals in care who have been difficult to engage in treatment. While the overall consensus of the DOJ consultant was that group treatment offerings have improved, the hospital's data indicated that only about 60% of individuals in care with LOS over 14 days are being routinely assigned 20 hours of active treatment per week, and that less than one-fourth of these individuals who are assigned to any number of group treatment hours are attending as scheduled. The hospital is also planning to breakdown their analysis of both assigned and attended treatment hours based on cohorts with different lengths of stay, based on the sound reasoning that

			individuals only may be able to attend fewer hours of prescribed treatment groups in the earlier part of their hospitalization. **Compliance:** Partial **Current recommendations:** 1. Continue to track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. 2. Continue with current plan to analyze group assignment and attendance based on cohorts defined by length of stay. 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.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.	**Recommendations, November 2010:** Same as in V.D.1 through V.D.5. **Findings:** Same as in V.D.1 through V.D.5. **Compliance:** Partial, improved compared to the last review. **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;	**Recommendations 1-2, November 2010:** • Continue to monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** The facility conducted a self-assessment based on the Clinical Chart Audit (September 2010 to February 2011). The mean sample was 12% and the compliance rate was 48% (compared to 59% during the period of July and August 2010). In addition, the facility used the Observation Monitoring Audit (September 2010 to February 2011) to assess the IRP team's process of revising the objectives during the IRP conference. The monitoring indicator was focused on the use of clinical observations and data in the process of reviews/revisions of the IRP. The mean compliance rate during this review period was

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<td>79% compared to 86% during the last review period (July and August 2010).

Other findings:
This expert consultant reviewed the charts of six individuals to assess the process of revising the IRPs as clinically indicated. The following outlines the reviews:

<table>
<tr><td>Initials</td><td>IRP reviews</td></tr>
<tr><td>JAN</td><td>2/8/11 and 4/20/11</td></tr>
<tr><td>RD</td><td>1/19/11 and 3/4/11</td></tr>
<tr><td>HH</td><td>1/20/11 and 3/15/11</td></tr>
<tr><td>JM</td><td>1/19/11 and 4/6/11</td></tr>
<tr><td>AP</td><td>2/9/11 and 4/11/11</td></tr>
<tr><td>LHM</td><td>3/16/11 and 5/12/11</td></tr>
</table>

This review found substantial compliance in four charts (JN, DR, HH and LM) and partial compliance in two (JM and AP).

Compliance:
Substantial (in order to maintain this rating, the facility must address findings in V.D.1 to V.D.IV regarding the modification of IRP foci, objectives and interventions in response to results of the risk assessments).

Current recommendations:
Continue to monitor each requirement (V.E.1 through V.E.3 based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.</td>
</tr>
<tr>
<td>MES</td>
<td>V.E.2</td>
<td>monitor, at least monthly, the goals, objectives, and</td>
<td>Recommendation 1, November 2010:</td>
</tr>
</table>

		interventions identified in the plan for effectiveness in producing the desired outcomes;	Same as in V.E.1. **Findings:** Same as in V.E.1 **Recommendations 2-3, November 2010:** • Continue to monitor this requirement using the Psychiatric Update Audit based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by an analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** SEH used the Psychiatric Update Audit (September 2010 to February 2011) to assess if the Psychiatric Update accurately reflected the individual's response to treatment/progress. Based on a mean sample of 11%, the facility reported a mean compliance rate of 100% compared to 99% during the last review (July and August 2010). **Other findings:** Based on chart reviews (see VI.A) this expert consultant found that SEH has maintained progress regarding this requirement. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td></td><td>Current recommendations:
1. Same as in V.E.1.
2. Continue to monitor this requirement using the Psychiatric Update Audit based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.</td></tr>
<tr><td>MES</td><td>V.E.3</td><td>review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;</td><td>Recommendations November 2010:
Same as in V.E.1.

Findings:
The facility used the Clinical Chart Audit (September 2010 to February 2011) and reviewed a sample of 12% to assess this requirement. The mean compliance rate was 86% which is the same rate reported for the last review period (July and August 2010). Other reviews relevant to this requirement were addressed in V.B.5.

Other findings:
This expert consultant reviewed the charts of five individuals who experienced the use of seclusion/restraints during this review period. The review focused on the documentation (in the Present Status section of IRP/Clinical Formulation) of the circumstances leading to the use of restrictive interventions and modifications of treatment interventions to decrease the risk of future occurrences.

The following table outlines the initials of the individuals and the dates of the seclusion/restraints (S/R) and subsequent reviews of the IRPs:

<table>
<tr><th>Initials</th><th>Date of S/R</th><th>IRP reviews</th></tr>
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			<table><tr><td>AWB</td><td>1/2/11</td><td>1/11/11</td></tr><tr><td>MC</td><td>1/8/11</td><td>1/18/11</td></tr><tr><td>JN</td><td>3/8/11 and 3/10/11</td><td>3/9/11</td></tr><tr><td>JD</td><td>3/10/11</td><td>4/4/11</td></tr><tr><td>VS</td><td>2/26/11</td><td>4/4/11</td></tr></table> The review found substantial compliance in four charts (AWB, MC, JAN and VS) and partial compliance in one (JD). In the chart of JD, there was no evidence that an IRP review occurred to address the use of restraints on March 10, 2011 prior to the individual's discharge on March 15, 2011. **Compliance:** Substantial. **Current recommendations:** Same as in V.E.1.
MES	V.E.4	provide that the review process includes an assessment of progress related to discharge; and	**Recommendation 1, November 2010:** Continue to provide aggregated data regarding competency-based training of all core members of the IRP teams relevant to this requirement. **Findings:** As mentioned in the previous report, outside consultants at SEH provided training (in September 2010) on the IRP training module dedicated to discharge planning. The facility provided additional training during this review period for staff members who missed the initial training. The following summarizes the training data: <table><tr><td>Discipline (15 hours of</td><td># attendees (% of those required</td><td># competent (% of attendees)</td></tr></table>

training to all disciplines)	to attend)	
Psychiatry	1 (100%)	1 (100%)
Psychology	2 (100%)	2 (100%)
Nurse Manager	8 (100%)	8 (100%)
Total	11 (100%)	11 (100%)

In addition, training was provided on the engagement of the individuals in the process of community integration. The data regarding this training were presented in V.B.1.

Recommendations 2-3, November 2010:

- Monitor this requirement using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data, 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.
- Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:
SEH used the IRP Observation Monitoring Audit and reviewed a sample of 11% (September 2010 to February 2011). The mean compliance rate was 86% compared to 79% during the last review (July and August 2010).

Other findings:
This expert consultant reviewed the charts of four individuals

			(RK, DH, MM and BD) to assess documentation of the teams' review of the individuals' progress towards discharge. This review found substantial compliance in three charts (DH, MM and BD) and partial compliance in one (RK). In the chart of RK, the discharge plan review by the IRP team indicated discussion of progress towards discharge criteria but the criteria were not properly linked to the IRP foci, objectives and interventions. **Compliance:** Substantial. **Current recommendations:** 1. Provide a summary of any significant modification to the current training, including mentoring and coaching of IRP team members regarding the process of discharge planning. 2. Monitor this requirement and present a summary of the aggregated monitoring data, including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Recommendations 1-3, November 2010:** • Same as in Section V.A.1 to V.A.1.5. • Same as in V.B.1. • Same as V.E.4. **Findings:** Same as in Section V.A.1 to V.A.1.5. Same as in V.B.1. Same as V.E.4. **Recommendations 4-5, 2010:** • Monitor this requirement using both process observation and clinical chart audit tools based on an adequate

			sample. Present a summary of the aggregated monitoring data, 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 an analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** The facility presented process observation data as reported in V.E.1. The corrective actions to improve compliance included the previously described training and mentoring activities. In addition, the facility updated the format for the Psychiatric Update, effective January 2011. The new format included prompts for the psychiatrist to provide an overall narrative of the current assessment and changes in symptoms and functional condition since the most recent update, indicate whether the individual is progressing toward treatment goals, and describe the progress in a narrative. If properly implemented, these prompts can provide information to facilitate implementation of this requirement. **Compliance:** Substantial. **Current recommendations:** 1. Same as in Section V.A.1 to V.A.1.5. 2. Same as in V.B.1. 3. Same as V.E.4. 4. Monitor this requirement and present a summary of the aggregated monitoring data, including comparative data and

			analysis of low compliance with plans of correction, as indicated.

	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 Status:** **Progress:** 1. The Medical Director and the Chief of Psychiatry continue to provide effective leadership in their respective roles. 2. SEH has maintained progress in diagnostic accuracy and the finalization of provisional diagnoses in a timely manner as clinically appropriate. 3. In general, SEH has corrected previously noted deficiencies in the medical and psychosocial history sections of the Comprehensive Initial Psychiatric Assessment (CIPA). 4. In general, SEH has maintained progress in the psychiatric updates in the areas where improvements were noted during the previous review. In addition, the facility made further modifications in the format for the psychiatric reassessments. The most significant modifications addressed the course of hospitalization, the rationale for medication changes and the mental status examination. These modifications had a positive impact on the quality of the updates. 5. SEH has improved the clinical monitoring of individuals suffering from tardive dyskinesia. 6. In general, SEH has improved the previously noted deficiencies in the inter-unit transfer assessments regarding the course of hospitalization and the plan of care to ensure continuity of care. 7. SEH has made further progress in the organization and presentation of self-assessment data based on the CIPA, Psychiatric Update and Inter-Unit Transfer audit tools. 8. Rehabilitation Services is now in substantial compliance with all provisions of the Settlement Agreement. **Areas of Need:**

			1. The CIPAs did not include an adequate mental status examination of current dangerousness to self and/or others. This is a significant deficiency at this stage and must be corrected ASAP. 2. The inter-unit transfer assessments must specify the clinical reason for the transfer. 3. The facility needs to streamline the auditing indicators within its CIPA and Psychiatric Update auditing tools to simplify the auditing process without reducing its value. 4. Initial assessments completed by psychologists, social workers, and rehabilitation services are not supposed to recommend specific groups from the TLC catalogues. 5. Psychology continues to have problems in the timely completion of psychological assessments and evaluations, as well as in the completion and auditing of all psychological services. 6. Psychology is at significant risk of not being able to satisfy the Settlement Agreement without an increase in staffing levels to fill the five empty positions.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Tyler Jones, MD, Director, Psychiatric Services Reviewed: 1. Charts of the following 27 individuals by Dr. El-Sabaawi: KTH, TL, FBH, PLH, MS, LB, TH, JR, YCS, RWS, VB, VS, MS, DM, RK, DH, MM, BD, FKC, PSS, DN, LHM, JTT, CD, NH, VH and MC 2. SEH Compliance (Self-Assessment Report), April 18, 2011 3. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians 4. SEH database regarding individuals receiving diagnoses listed as NOS, R/O and/or deferred 5. SEH Policy #602.1-08: Assessments, revised April 4, 2011 6. Comprehensive Initial Psychiatric Assessment Summary Data September 2010 to February 2011 7. Most recent template of the Psychiatric Update (April 2011) 8. Psychiatric Update Audit Summary Data, September 2010 to February 2011 9. Inter-Unit Transfer Audit Summary Data, September 2010 to February 2011 10. SEH database: Dementia NOS Review 11. SEH Initial Psychological Assessment Audit summary data September 2010 to February 2011 12. SEH outline of CME activities since during this review period
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	**Recommendation 1 November 2010:** Same as in VI.A.2 through VI.A.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.

		reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Findings:** Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. **Recommendations 2 and 3, November 2010:** • Continue to monitor the timeliness and content of psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** During this review period, the Hospital modified the template for the Comprehensive Initial Psychiatric Assessment (CIPA) to improve the clinical flow of the sections without substantive change in the items. Upon the integration of the Psychiatric Update template into AVATAR (in October 2011), the facility made a series of substantive modifications in this template to address the findings of deficiency in the previous report. The most recent change occurred in April 2011. The modified template included requirements for the following: 1. A narrative description in the sections regarding the overall hospital course since the last update (addressing an individual's progress and response to medication and other types of interventions);

2. Review of whether the IRP supports the individual's goals and objectives given the individual's current condition;
3. Description and rationale for medication changes; and
4. Prompts to identify behavioral interventions.

In addition, the facility reported that technical problems that initially led to incomplete population of items regarding the mental status assessment (thought content) have been resolved.

The audits for CIPA and the Psychiatric Update were updated to reflect the changes in the template. The current audits include adequate indicators and operational instructions. At this stage, both audits could be simplified to reduce any unnecessary auditing burden. This expert consultant discussed this matter with the Medical Director and the Director of Psychiatry during the tour.

Using the CIPA Audit, the facility reviewed an average sample of 21% of admissions during each month (September 2010 to February 2011). The following is an outline of the indicators and corresponding mean compliance rates for this review period: %C (c), compared to rates during the previous review: %C (p).

#	Indicator	%C (p)	%C (c)
1.	Completed within 24 hours of admission	100%	100%
2	Past psychiatric history including information from other previous indicators (December 2010 to February 2011)	No data	100%
3.	History of present illness	100%	100%
4.	Medical history	91%	98%
5.	Information about current medications	56%	76%

			6.	Substance abuse history	98%	98%
			7.	Family history	79%	95%
			8.	Social and developmental history	79%	100%
			9.	Mental status examination (all components included)	88%-100%	83%-100%
			10.	Consistency between diagnosis and clinical presentation	91%	100%
			11.	Strengths	86%	98%
			12.	Risk associated with medication regimen	86%	97%
			13.	AIMS test	77%	83%
			14.	Labs/consultations ordered as clinically indicated	No data	95%

In general, the data showed improved performance compared to the last review.

During this review period, some new indicators were used and others were consolidated (no data were available during the previous review for these indicators). The indicator regarding substance use assessment was moved to another tool that assessed Co-Occurring Disorders.

Data from the Psychiatric Update Audit (September 2010 to February 2011) were based on a mean sample of 11%. The following is a summary of all relevant indicators, including data presented in the previous report in section VI.A.7.

#	Indicator	%C (p)	%C (c)
1.	Completed every 30 days	97%	99%
2.	Risk Assessment sections completed	95%	100%

			3.	Address significant developments since last update (December 2010 to February	No data	100%
			4.	All sections of the subjective findings are completed and consistent with relevant progress notes	100%	99%
			5.	Response to treatment/progress completed	99%	100%
			6.	Mental status examination (all components included but no data presented for the individual's affect and no explanation provided)	94% to 100%	98% to 100%
			7.	Use of Stat medications is addressed specifically including if and how the benefits outweigh the risks (January and February 2011)	No data	100%
			8.	Medication side effects, risks/benefits are explained (December 2010 to February 2011)	No data	100%
			9.	Update adequately analyzes risks and benefits of chosen treatment (December 2010 to February 2011)	No data	99%
			10.	Adverse reactions noted, as appropriate	88%	91%
			11.	Rationale for use of benzodiazepines for individuals with substance use disorders	88%	100%
			12.	Rationale for use of two or more antipsychotics	89%	94%
			13.	Rationale for use of anticholinergics for individuals with cognitive disorder	84%	97%
			14.	Laboratory levels obtained at appropriate intervals	92%	99%

			15.	Abnormal laboratory levels are addressed	95%	99%
			16.	Documented justification for R/O or NOS diagnosis	82%	86%
			17.	Diagnosis reflects current clinical data or is updated based on current data	98%	99%
			18.	Pharmacological plan of care reflects diagnosis, mental status examination and response to treatment	99%	99%
			19.	Pharmacological plan of care reflects monitoring of antispychotics for side effects	90%	100%
			20.	Pharmacological plan of care adequately addresses use of benzodiazepines in high risk populations	88%	100%
			21.	Noted by attending physician if update completed by a trainee	83%	98%

In general, the data showed improved performance compared to the last review.

During this review period, some new indicators were used and the indicator regarding the use of Stat medications was separated from the indicator regarding the use of seclusion/restraints (no data were available during the previous review for these indicators). The indicator regarding the accurate description of current medications was discontinued because it lacked monitoring value after SEH implemented improvements to AVATAR. The indicator that required an explanation for the involuntary administration of medication was consolidated within the indicator regarding the use of Stat

			medications. **Other findings:** This expert consultant reviewed the charts of nine individuals who were admitted during this review period (VB, VS, MS, DM, RK, DH, KTH, MM and BD) to assess the timeliness and content of the Comprehensive Initial Psychiatric Assessments. In addition, the charts of 10 individuals (KTH, TL, FBH, PLH, MS, LB, TH, JR, YCS and RWS) whose psychiatric updates were completed following the most recent revisions in the template were reviewed to assess the timeliness and content of the Psychiatric Updates. The reviews found that the assessments and reassessments were, in general, timely. The content of the assessments was improved compared to the last review in some sections. However, a new and significant deficiency was noted regarding the lack of a mental status examination of current suicidal/homicidal ideations, intent or plan. In general, the content of the reassessments (updates) was adequate. See findings in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. **Compliance:** Partial, improved compared to the last review. **Current recommendations:** 1. Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. 2. Continue to monitor the timeliness and content of psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.

<table>
<tr><td></td><td></td><td></td><td>3. Streamline the auditing indicators within the CIPA and Psychiatric Update auditing tools to simplify the auditing process without reducing its value.</td></tr>
<tr><td>MES</td><td>VI.A.2</td><td>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;</td><td>Recommendation 1, November 2010:
Same as VI.A.1.

Findings:
Same as VI.A.1.

Recommendations 2 and 3, November 2010:
• Continue to monitor risk assessment as part of the Comprehensive Initial Psychiatric Assessment and the initial psychological assessment, based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
• Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:
SEH presented data from the CIPA audit based on a mean sample of 21% (September 2010 to February 2011). The following is a summary of data as compared to the previous review period (March to August 2010).

<table>
<tr><td>#</td><td>Indicator</td><td>%C (p)</td><td>%C (c)</td></tr>
<tr><td>1.</td><td>Self-injury</td><td>98%</td><td>100%</td></tr>
<tr><td>2.</td><td>Completed suicide</td><td>98%</td><td>98%</td></tr>
</table>
</td></tr>
</table>

3.	Physical aggression	100%	98%
4.	Sexual aggression	100%	98%
5.	Elopement	100%	98%
6.	Appropriate precautions for each type of risk	95%	100%

Data from the Initial Psychological Assessment (IPA) Audits (September 2010 to February 2011) were based on a mean sample of 15%. The following is a summary of data as compared to the previous review period (March to August 2010).

#	Indicator	%C (p)	%C (c)
1.	Assessment of Violence risk	100%	97%
2.	Findings of violence risk	86%	100%
3.	Assessment of suicide risk	96%	90%
4.	Findings of suicide risk	89%	97%

Other findings:
This expert consultant reviewed the Comprehensive Initial Psychiatric Assessments in the charts of nine individuals (VB, VS, MS, DM, RK, DH, KH, MM and BD). In general, the admission risk assessments were completed in a timely and adequate manner. The indicators of the risk assessment adequately addressed this requirement.

Compliance:
Substantial.

Current recommendations:
1. Same as VI.A.1.
2. Continue to monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on an adequate sample.

<table>
<tr><td></td><td></td><td></td><td>Present a summary of the aggregated monitoring data including the comparative data and analysis of low compliance with plans of correction, as indicated.</td></tr>
<tr><td>MES</td><td>VI.A.3</td><td>By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;</td><td>Recommendation 1, November 2010:
Same as in VI.A.1 and VI.A.6.

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

Recommendations 2, 3 and 5, November 2010:
• Continue to monitor diagnostic accuracy in psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
• Present comparative data (mean %C for each indicator in current review period vs. last review period).
• Ensure timely updates of diagnoses on AVATAR.

Findings:
The following is a summary of the facility's data from the CIPA Audit (September 2010 to February 2011, mean sample of 21%). The data includes comparisons to the previous period (March to August 2010).

<table>
<tr><td>#</td><td>Indicator</td><td>%C (p)</td><td>%C (c)</td></tr>
<tr><td>1.</td><td>All (diagnosis) Axes completed</td><td>93%</td><td>98%</td></tr>
<tr><td>2.</td><td>Diagnosis reflects the clinical</td><td>91%</td><td>100%</td></tr>
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	presentation		

Data from the Psychiatric Update Audit (September 2010 to February 2011, mean sample of 21%) are summarized as follows, including comparisons to the previous period (March to August 2010).

#	Indicator	%C (p)	%C (c)
1.	Diagnosis reflects current clinical data or changes/updates based upon change in current data	98%	99%
2.	All (diagnosis) Axes completed	97%	99%
3.	Adequate justification for R/O or NOS diagnosis (Axis I)	82%	86%

The above data demonstrate that the facility has maintained progress noted during the last review.

Recommendation 4, November 2010:

- Provide an outline of the average number of individuals in each of the following categories (during the review period as compared with the previous period):
    - All individuals in care;
    - Individuals with "no diagnosis" on Axis I;
    - Individuals receiving Axis I diagnosis listed as Deferred for 90 or more days;
    - Individuals receiving Axis I diagnosis listed as R/O for 90 or more days; and
    - Individuals receiving Axis I diagnosis listed as NOS for 90 or more days.

Findings:

The facility presented data showing a continued downward trend

in the number of individuals receiving Axis I diagnosis listed as R/O, NOS or Deferred for 90 or more days during this review period compared to the last review period. The following is a summary:

Indicator	September 23, 2010	April 5, 2011
Total # of individuals in care	314	276
Total # with Axis I diagnosis	313	2
R/O diagnosis >90 days	4	0
NOS diagnosis >90 days	34	21
Deferred diagnosis >90 days	0	0

This expert consultant reviewed the charts of nine individuals who have received diagnoses listed as NOS or R/O during this reporting period. The following is an outline of the reviews:

Initials	**Diagnosis**
FKC	Dementia NOS
PSS	Dementia NOS
DN	Dementia NOS finalized to Moderate Mental Retardation and Dementia Due to Head Trauma
LHM	Cognitive Disorder NOS
JTT	Cognitive Disorder NOS
CD	Impulse Control Disorder NOS
NH	Psychotic Disorder NOS
VH	Psychotic Disorder NOS finalized Schizophrenia, Paranoid Type
MC	Psychotic Disorder NOS

The review found substantial compliance in seven charts and partial compliance in two (LHM and JTT). There was evidence of

			inadequate psychiatric monitoring of the cognitive status (e.g., using Mini Mental Status Examination) despite current diagnosis of cognitive impairment in the charts of LHM and JTT. **Compliance:** Substantial. **Current recommendations:** 1. Same as in VI.A.1 and VI.A.6. 2. Continue to monitor diagnostic accuracy in psychiatric assessments and reassessments based on adequate samples and streamlined indicators. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated. 3. Continue to provide an outline of the average number of individuals in each of the following categories (during the review period compared with the previous period): a) All individuals in care; b) Individuals with "no diagnosis" on Axis I; c) Individuals receiving Axis I diagnosis listed as Deferred for 90 or more days; d) Individuals receiving Axis I diagnosis listed as R/O for 90 or more days; and e) Individuals receiving Axis I diagnosis listed as NOS for 90 or more days.
MES	VI.A.4	By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;	**Recommendations November 2010:** Same as in V.A.3. **Findings:** Same as in V.A.3

			Compliance: Substantial. **Current recommendations:** Same as in V.A.3.
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;	**Recommendations November 2010:** Same as in VI.A.1 to VI.A.3. **Findings:** Same as in VI.A.1 to VI.A.3. **Other findings:** This expert consultant reviewed the charts of nine individuals (VB, VS, MS, DM, RK, DH, KTH, MM, and BD) who were admitted during this review period. In general, there was evidence of adequate corrective action to address the previously mentioned deficiencies in the sections regarding medical and psychosocial histories. However, the mental status examination did not include comment on current suicidal/ homicidal ideations, and intent of plan in too many individuals (VB, DM, RK, KTH and MM), including those who were rated as being at "moderate" risk for suicide (DM and MM) and/or violence to others (MM). The charts of DH, VS, and BD did not include this comment as part of the mental status examination but the information was provided as part of the history of present illness. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.1 to VI.A.3. 2. Develop and implement immediate corrective actions to

			address the lack of documentation of mental status examination of current dangerousness to self and/or others.
	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;	**Recommendations November 2010:** Same as in VI.A.1 and VI.A.3. **Findings:** Same as in VI.A.1 and VI.A.3. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1 and VI.A.3). **Current recommendations:** Same as in VI.A.1 and VI.A.3.
MES	VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments;	**Recommendations 1 and 2, November 2010:** • Continue to monitor implementation of this requirement in psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C), and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:
The following summarizes the facility's data (September 2010 to February 2011) including comparisons to the last review period (March to August 2010):

CIPA audit (mean sample: 21%):

#	Indicator	%C (p)	%C (c)
1.	CIPA is signed by the attending Psychiatrist.	100%	98%
2.	If CIPA is completed by a resident, there is a note from the attending Psychiatrist	72%	98%

Psychiatric Update Audit (mean sample: 11%):

#	Indicator	%C (p)	%C (c)
1.	If completed by a resident, there is documented evidence that the update was reviewed by the attending Psychiatrist.	83%	98%
2.	If completed by a resident, there is a note by the attending Psychiatrist.	85%	97%

The data showed a continued positive trend since the last review.

Chart reviews by this expert consultant confirmed the facility's findings regarding the documentation of a review by the attending physicians of the content of documentation by trainees.

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<td>Compliance:
Substantial.

Current recommendations:
Continue to monitor implementation of this requirement in psychiatric assessments and reassessments based on adequate samples and streamlined indicators. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated.</td>
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<tr>
<td>MES</td>
<td>VI.A.6.c</td>
<td>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</td>
<td>Recommendation 1 November 2010:
Same as in VI.A.3.

Findings:
The facility's self-assessment data regarding this requirement were presented in VI.A.3.

Recommendation 2, November 2010:
Continue to provide documentation of CME training during the review period, including dates and titles of courses and names of instructors and their affiliation.

Findings:
The following is an outline of relevant CME education that was provided at SEH during this review period:

<table>
<tr><td>Title</td><td>Speaker and Affiliation</td><td>Date</td></tr>
<tr><td>Genetic Neuropathology in Human brain Development</td><td>Joel Kleinman, MD, PhD, George Washington University</td><td>11/3/10</td></tr>
<tr><td>Integrating Behavioral</td><td>Andrew Kolbnasovsky,</td><td>12/10/1</td></tr>
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<tr><td>Health and Medical Care</td><td>PsyD, MBA, Emblem Health</td><td>0</td></tr>
<tr><td>Meeting the Needs of Families</td><td>Lisa Beth Dixon, MD. MPH, University of Maryland</td><td>1/5/11</td></tr>
<tr><td>Psycho-educational Groups for Psychiatric Inpatients</td><td>Nina W. Brown, EdD, Old Dominion University</td><td>2/2/11</td></tr>
<tr><td>Chronic Mental Illness and Metabolic Syndrome</td><td>Gloria Reeves, MD, University of Maryland</td><td>3/2/11</td></tr>
</table>

Other findings:
Same as in VI.A.3.

Compliance:
Substantial.

Current recommendations:
1. Same as in VI.A.3.
2. Continue to provide documentation of CME training during the review period, including dates and titles of courses and names of instructors and their affiliation.
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<tr>
<td>MES</td>
<td>VI.A.6.d</td>
<td>each individual's psychiatric assessments, diagnoses, and medications are clinically justified.</td>
<td>Recommendations November 2010:
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, improved compared to the last review (this rating considered findings in VI.A.1 through VI.A.6.a and VI.6.c).</td>
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			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.	**Recommendations 1, 3 and 4, November, 2010:** • Implement corrective actions to improve the review of clinical developments during the interval and the clinical flow of data in the Psychiatric Update. • Continue to monitor this requirement using the Psychiatric Update and Medication Monitoring Audits based on an adequate sample. Present a summary of the aggregated monitoring data 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. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** As mentioned in VI.A.1, SEH made further modifications in the format for the Psychiatric Update (Reassessment). The facility used the Psychiatric Update Audit to assess compliance with this audit. The data provided in VI.A.1 and VI.A.3 were sufficient to address this requirement. The Psychiatric Update data showed a trend of further improvement in compliance since the last review. At the recommendation of this expert consultant, the facility discontinued the use of the Medication Monitoring Audit and consolidated the items in this audit within the Psychiatric Update audit.

			Other findings: This consultant reviewed the charts of ten individuals (KTH, MS, LB, TL, TH, JR, YCS, RWS, FBH, and PLH), whose updates were completed following the most recent revision of the template by the facility (in April 2011). The review found substantial compliance in eight charts (TL, FBH, KTH, MS, LB, TH, JR, and RWS) and partial compliance in the charts of YCS (non-psychopharmacological plan was inadequate) and PLH (hospital course and plan of care were generic). The integration of behavioral and psychiatric modalities was addressed in V.A.2.e. The risk benefit analysis regarding continued treatment of new generation antipsychotic medications for individuals suffering from a variety of metabolic disorders is addressed in section VIII. In general, there was evidence that the facility has maintained progress in the areas that were outlined in the previous report. In addition, there was general evidence of adequate corrective actions to address the previously mentioned deficiencies regarding the documentation of significant events during the interval and the psychiatrists' overall assessment of the individual's condition. The recent modifications of the template, as described in VI.A.1, appeared to have facilitated these corrections. **Compliance:** Substantial. **Current recommendations:** 1. Same as in V.A.2.e and VI.A.1. 2. Continue to monitor this requirement based on an adequate

			sample and streamlined indicators. Present a summary of the aggregated monitoring data including comparative data and analysis of low compliance with plans of correction, as indicated.

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Richard Gontang, Ph.D., Chief of Psychology Maura Gaswirth, LICSW, Chief of Social Work Crystal Robinson, MT-BC, Chief of Rehabilitation Services Reviewed: 1. Medical Records: TL, HA-S, AB, JH, DJ, HM, CA, IB, MB, LH, RB, JD, JD2, LE, RE, FF, DH, RN, KP, TR, LC, JF, RG, WJ, LM, RM, PN, CP, AS, DT 2. Initial Psychology Assessment Audit Tool and Results 3. Psychology Evaluation Audit Tool and Results 4. Neuropsychological Evaluation Audit Tool and Results 5. Risk Assessment Audit Tool and Results 6. Social Work Initial Assessment Audit Tool and Results
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.	**Findings:** The hospital's data indicated that all psychological assessments (IPAs, Risk Assessments, Neuropsychological Evaluations, other Psychological Evaluations) are not being completed in accord with Psychology Department established timeframes. In fact, for both Risk Assessments and other Psychological Evaluations, the timely completion rate showed a considerable decline from the last reporting period, whereas IPA completion rates remained at about 50%. In contrast, the timely completion of Neuropsychological Evaluations increased from 33% to 70%. Discussions with Psychology leadership revealed that these problems in timely completion of assessments continued to occur despite some increases in overall psychology staffing. However, it is important to point out that Psychology currently has a total of five actual vacancies between the fact that three positions had been subject to a hiring freeze and two additional positions were not

			available to be filled due to labor disputes. The net effect of these vacancies is that psychology staff are responsible for very high patient to staff ratios, especially on admission units, and it is, therefore, not surprising that psychology staff experience an overload in clinical duties and responsibilities. Psychology Department leadership believes that filling the five vacant positions is necessary to ensure that compliance rates regarding the timeliness of psychological assessments show a marked improvement, and the DOJ consultant strongly agrees with that opinion. Failure to provide appropriate staffing ratios may well lead to practitioner burnout, which research has shown to be predictive of staff turnover and/or reductions in appropriate clinical care. **Compliance:** Partial **Current recommendations:** 1. Fill the five vacancies in the Psychology Department. 2. Continue to 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.
	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;	**Findings:** The hospital's data demonstrated that, for all categories psychological evaluation, this indicator has been at or trending toward 100% for several months. A random sample of psychological evaluations reviewed

			by the DOJ consultant also found that the purpose for which the psychological evaluation was being performed was clearly indicated in all cases. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Continue to 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.
RB	VI.B.2.b	be based on current and accurate data;	**Findings:** In all reviewed psychological assessments, it was independently found that they were based on current and accurate data. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Continue to 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.
RB	VI.B.2.c	provide current assessment of risk for harm	**Findings:**

		factors, if requested;	This requirement was met in all reviewed risk assessments. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Continue to 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.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Findings:** As of 03/10/11, clear instructions to psychologists completing IPAs that they are to recommend specific TLC treatment groups as part of the IPA process are now included in the auditing instructions for this instrument. The hospital's data indicated that for Part A of the IPA, this criterion was only being met 76% of the time on average over the current review period; however, the indicator reached 100% for the final two months of the review period, demonstrating the effectiveness of the new instructions. The DOJ consultant also found that this criterion was being met 100% of the time when individuals in care had also been assessed with Part B of the IPA, but only 60% of the time when based on Part A alone. Additionally, the data for Neuropsychological Evaluations indicated that they were making recommendations appropriate to the purpose of the evaluation 100% of the time since November 2010. For other Psychological Evaluations, however, this criterion was only being met 77% of the time, which indicates no real change since the last review period (75%). A random sample of other Psychological Evaluations completed during this review period was audited by the DOJ consultant, and 80% of them met this criterion, which is quite similar to the hospital's data. While the

			hospital's self-assessment report did not articulate a strategy for addressing this issue as it pertains to other Psychological Evaluations, it will be necessary for the hospital to address this issue in order to be in substantial compliance with this element of the Settlement Agreement. **Compliance:** Partial **Current recommendations:** 1. Identify barriers to providing recommendations that directly address the referral question in focused psychological assessments and institute a corrective action plan. 2. Continue to 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.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Findings:** All reviewed assessments continued to include a summary of the empirical basis for conclusions. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Continue to 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.
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.	**Findings:** Completed **Compliance:** Substantial **Current recommendations:** 1. None needed
RB	VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Findings:** Based on data provided by the Psychology Department, 96% of those individuals in care identified as needing a psychological assessment now have an up-to-date psychological assessment in their medical record. **Compliance:** Substantial **Current recommendations:** None needed
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.	**Findings:** The audit tool for neuropsychological assessments continues not to contain this item, which was pointed out in our last report. The hospital has been using a special form on which treatment team members acknowledge receipt of the psychological evaluation. With respect to Risk Assessments and other Psychological Evaluations, the hospital's data indicated that there was evidence of the communication of the results of these evaluations 73% of the time for Risk Assessments and 85% of the time for other Psychological Evaluations. In the case of Risk Assessments, this marks a slight decline from the last review period (80%), while in the case of other

			Psychological Evaluations, this marks a significant increase from the last review period (35%). The hospital's self-assessment report indicated that > Treatment team members seem reluctant to sign the acknowledgment before reading the results, even though it is clear it is just a receipt acknowledgment. The Hospital is considering eliminating this form, as the increased participation of psychologists in the IRPs is improving communication, and as psychological evaluations will now be scanned into the record through FILENET, and thus their availability to teams will be ensured…. Upon completion of each psychological assessment, the psychologist usually meets with the clinical administrator to review the results, and the clinical administrator should be signing the acknowledgement of receipt of the report and recommendations. In addition, each treatment team is supported by a psychologist who is available on an ongoing basis to provide further guidance to teams about the results of various assessments. The above comments may represent solutions to the problem being addressed by this aspect of the Settlement Agreement, but to date the hospital has not determined how to better audit for this issue. In a discussion with psychology leadership, it was learned that the treatment team psychologist is required to write a progress note in the medical record indicating that that he/she has seen the psychological evaluation and communicated its results to the treatment team, although this progress note is not currently being audited. If the requirements of the progress note are refined to include a discussion of the team's acceptance or rejection of the recommendations from the psychological evaluation and the clinical rationale for its decision, then auditing this progress note may represent the best way for the

			hospital to ensure that this provision of the Settlement Agreement is able to reach substantial compliance. It is surely a poor use of resources to invest psychologist time in the completion of complex and comprehensive evaluations – deemed important enough by the treatment team that they are routinely requested – and then not take appropriate steps to ensure that those results are discussed and acted upon in a clinically meaningful manner. **Compliance:** Partial **Current recommendations:** 1. Quickly determine a method to ensure that the results of psychological evaluations are both communicated to the treatment team and meaningfully responded to by that team, perhaps in the team psychologist's progress note. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: Crystal Robinson, MT-BC, Director of Rehabilitation Services Reviewed: 1. Charts: MB, SK, VC, MH, TR, PC, RK, JN, MB1, DH 2. Rehabilitation Services Audit Tool and Results
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.	**Findings:** Both hospital data and data provided by an independent chart review completed by the DOJ content expert found that completion of the RSA within the timelines indicated in policy are now occurring over 90% of the time. **Compliance:** Substantial **Current recommendations:** 1. Maintain current practice. 2. Continue to present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
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:** Both the hospital's data and an independent review found that all RSAs

			achieved this standard. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Findings:** Both the hospital's data and an independent review found that all RSAs achieved this standard. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Findings:** Both the hospital's data and an independent review found that all RSAs achieved this standard. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
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:** Both the hospital's data and an independent review by the DOJ content expert found that that this standard is being met 90% of the time. **Compliance:**

			Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Continue to present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.C.3	By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment.	**Findings:** This has been accomplished. **Compliance:** Substantial **Current recommendations:** None needed.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: Maura Gaswirth, LICSW, Social Work Supervisor Reviewed: 1. Medical Records: MB, SK, VC, MH, TR, PC, RK, JN, MB1, DH 2. Social Work Initial Assessment Audit Tool and Results
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	**Findings:** The hospital's data found that results for all of the SWIA indicators with the exception of timeliness have declined over the course of the current review period. Timeliness, in contrast, has been maintained at 100%, and this was verified by an independent review conducted by the DOJ content expert. Additionally, the SW department made modifications to the SWIA audit tool and instructions, which appear to have removed some sources of confusion that may have been impeding more adequate SWIAs, and it is hoped that data presented for the next review period will bear this out. To that end, it is imperative that the SWIA report format in AVATAR be updated so that the prompts clearly indicate the information needed in each section of the assessment. Although social workers have been trained on a work-around process, the proper alignment of prompts is a better overall solution. Finally, the soon to be anticipated full staffing of the SW Department will be an asset in approving the functioning of all social workers, ensuring that caseloads are manageable. **Compliance:** Partial **Current recommendations:** 1. Continue with current corrective action plan.

			2. Quickly align the prompts in AVATAR for the SWIA so that they are congruent with the actual information being documented in each section of the assessment. 3. Continue to present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	VII. Discharge Planning and Community Integration		
MLS		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 hospital has made significant progress to reduce its inpatient census. Since October 2010, the census has decreased from 308 to 283 in April 2011. The census has consistently been under 300 since December 2010. As a result, the hospital closed its Annex. 2. The Social Work Department has been strengthened with the appointment of a Director and all but two vacancies have been filled. The two vacancies are on the approved to be filled list. 3. There has been increased attention and focus on discharge planning and community integration. Additional training was provided to all treatment team members and for new hires. There was additional training for social workers and clinical administrators. 4. The "Community Integration Meetings" where personnel from DMH, SEH and Community agencies review "discharge ready individuals" with regard to roles, responsibility, and communication continue to be refined. 5. The hospital has identified areas in need of improvement by the treatment team with regard to the clinical formulation and identification of a preliminary discharge setting. 6. Social Work modified its instructions and processes on how to complete the Social Work Initial Assessment and Assessment Update forms and its internal audit forms (April 2011). 7. Since the last review, there has been progress in addressing the needs of individuals with housing and/or nursing home barriers and the number of individuals considered "resistive to discharge."
MLS			**Methodology:** <u>Interviewed</u>: 1. Jana Berhow, Director of Integrated Care, DMH 2. Jermaine Wyatt, New Directions (by telephone) 3. Clo Vidoni-Clark, Director of Treatment Programs, SEH

			4. Maura Gaswirth, Social Work Director, SEH 5. Christine Litwa, Social Worker, SEH 6. Denise Brown, Social Worker, SEH 7. Susan Bergmann, Director of Performance Improvement, SEH 8. Won-Ok Kim, Director of Statistics and Reporting, SEH <u>Reviewed</u>: 1. The charts of current and discharged individuals: CH, JN, BA, TJ, EH, YS, DB, WM, JJ, EC, JR, JM, JH, BW, AH, HH, MJ, JR, JS, OA, KB, DC, KJ, KJ, JN, and CJ. 2. SEH Compliance Report Tab # 001e, IRP Training Outline and Data – Engagement 3. SEH Compliance Report Tab #001g, IRP Training Module I Outline 4. SEH Compliance Report Tab #001h, IRP Training Module II Outline 5. SEH Compliance Report Tab #001j, IRP Training Module IV Outline 6. SEH Compliance Report Tab #001k, Training Materials 7. SEH Compliance Report Tab #001l, Discharge Planning Documentation 8. SEH Compliance Report Tab #001m, IRP Meeting Icebreakers 9. SEH Compliance Report Tab #003, Clinical Chart Audit Results 10. SEH Compliance Report Tab #007, Clinical Chart Auditors Feedback 11. SEH Compliance Report Tab #008, IRP Observation Audit Tool 12. SEH Compliance Report Tab #009, IRP Observation Audit Results 13. SEH Compliance Report Tab #010a, Clinical Chart Audit Form and Instructions 14. SEH Compliance Report Tab #010b, Clinical Chart Audit Form and Instructions 15. SEH Compliance Report Tab #010c, Clinical Chart Audit 16. SEH Compliance Report Tab #031b, Social Work Initial Assessment 17. SEH Compliance Report Tab #031c, Social Work Initial Assessment 18. SEH Compliance Report Tab #031d, Social Work Initial Assessment Avatar

			19. SEH Compliance Report Tab #031e, Social Work Initial Assessment 20. SEH Compliance Report Tab #032a, Social Work Initial Assessment 21. SEH Compliance Report Tab #032b, Social Work Initial Assessment 22. SEH Compliance Report Tab #033, Social Work Audit Data Analysis – Initial 23. SEH Compliance Report Tab #033, Social Work Audit Data Analysis – Update 24. SEH Compliance Report Tab #034b, Social Work Update Guidelines 25. SEH Compliance Report Tab #034c, Social Work Update Light Bulb Instructions 26. SEH Compliance Report Tab #034d, Social Work Update Operational Instructions 27. SEH Compliance Report Tab #035a, Social Work Update Audit Tool 28. SEH Compliance Report Tab #035b, Social work Update Guidelines 29. SEH Compliance Report Tab #035c, Social Work Update New Chart 30. SEH Compliance Report Tab #042, Vacancies Approved to be Filled 31. SEH Compliance Report Tab #043, Treatment Team Assignments 32. SEH Compliance Report Tab #047, Wellness and Recovery Guide 33. SEH Compliance Report Tab #067, Discharge Plan of Care Audit 34. SEH Compliance Report Tab #068, Discharge Audit Results 35. SEH Compliance Report Tab #072, Discharge List Planning Log 36. SEH Compliance Report Tab #073a, DMH SEH Discharge Tracking 37. SEH Compliance Report Tab #073b, DMH SEH Outcomes October 38. SEH Compliance Report Tab #073c, DMH SEH Outcomes November 39. SEH Compliance Report Tab #073d, DMH SEH Outcomes December 40. SEH Compliance Report Tab #073e, DMH SEH Outcomes January 41. SEH Compliance Report Tab #073f, DMH Outcomes Committee 42. SEH Compliance Report Tab #079, List of Individuals in Care Attending Commmunity Day Treatment Programs

			43. SEH Compliance Report Tab #081, Discharge Plan of Care Avatar 44. SEH Compliance Report Tab #083, DMH Discharge Protocol and Practice 45. SEH Compliance Report Tab #085, Evening Weekend Activities 46. SEH Compliance Report Tab #096, List of Hiring 47. SEH Compliance Report Tab #164a, SEH Workshop 48. SEH Compliance Report Tab #164b, Working Together 49. SEH CAP 3-4-11 50. PRISM, April, 2011 Report date May 11, 2011 51. June 6, 2011 Memo from Maura Gaswirth <u>Observed</u>: 1. DMH-SEH Community Integration Meeting 2. Team Meeting of Unit 1E for IRP comprehensive of OA 3. Team Meeting of Unit 1E for IRP review of JM 4. Team Meeting of Unit 2B for IRP comprehensive of BW
MLS	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:** 1. There have been improvements to the IRP training regarding discharge planning. SEH has revised its employee orientation to include discharge planning and modified its IRP training for new hires. 2. In February 2011, treatment teams received additional training on discharge planning; social workers and clinical administrators received further training. 3. Based upon the hospital's own data and this expert's review, attention should focus on the clinical formulation that leads to a preliminary discharge setting and development of attainable goals. (JR, DC) **Compliance:** Partial

			Current Recommendations: 1. The hospital should continue to monitor the IRP process utilizing existing audit tools and identify staff in need of coaching. 2. The hospital should continue to focus training on identifying factors at point of admission that bear on discharge planning.
MLS	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Current Findings:** 1. The IRP includes a section that documents the identification of an individual's strengths, preferences, and personal goals. 2. The audit tools for the social work initial assessment and social work assessment update were modified in April 2011. Based on two months of data, there is significant progress. Maintaining progress should result in substantial compliance at the next review. 3. The three IRP meetings and a majority of records reviewed included the consumer's preferences and personal goals. **Compliance:** Partial **Current Recommendations:** 1. See VII.A 2. IRP training and coaching should focus on identifying an individual's strengths and how to incorporate them into specific objectives and attainable goals that will lead to discharge. 3. Implement Corrective Action Plan.
MLS	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Current Findings:** 1. SEH focuses on individual symptoms of mental illness; it is a strong component of the IRP team process. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor

MLS	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:** 1. The hospital and DMH have improved their processes for identifying barriers to discharge including revisions to the Community Integration Meeting, hiring additional social workers and implementing specific training around discharge planning. 2. A second DMH and SEH seminar "Working Together" was held; and a third is planned for June, 2011. 3. There appears to be no formal internal process for identifying and reviewing the clinical histories of individuals with multiple hospitalizations or readmissions within 30 days. 4. Although the combined (forensic and civil) 30 day readmission rate for one year (2 months of exception) is under the national benchmark, the civil readmits for February and March 2011 were trending negatively (9.1% and 11.1% vs. 7.8% benchmark). 5. Records reviewed did not reflect an understanding of what precipitants (other than medication compliance) led to re-hospitalization. (CH, KJ) **Compliance:** Partial **Current Recommendations:** 1. The hospital should continue providing opportunities for the hospital and community to collaborate including the hospital/community seminars. These forums increase understanding of community resources and the skills necessary for an individual to be successful. 2. The hospital should consider implementing a formal and routine process to review the clinical and discharge needs of individuals with multiple admissions or readmissions within 30 days. 3. SEH Corrective Action Plan, Action Steps should be implemented and monitored.

MLS	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Current Findings:** 1. According to the hospital's own data (Social Work Initial Assessment and Clinical Chart Audits) and based upon this consultant's observations and record reviews, IRPs do not reflect the identification of skills needed for discharge and the positive changes needed for successful discharge. Hospital data indicate a decline of skills needed for discharge. 2. SEH has increased the array of transitional and community groups within its transitional TLC. DMH has established a community based apartment program to help in skill development and to facilitate discharge planning. 3. The discharge planning curricula needs significant attention and revision. 4. Hospital data and this expert's attendance at 3 IRP meetings indicate a positive trend in including the community and/or family in the treatment team process. **Compliance:** Partial **Current Recommendations:** 1. SEH should continue to refine matching individuals' functional skills with the revised TLC curricula. 2. Consider incorporating peer specialists and/or community agency staff into a revised discharge planning curricula. 3. Continue to implement and monitor the SEH Corrective Action Plan.
MLS	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:** 1. The hospital has made progress in incorporating the individual into the IRP process with regard to their personal goals and treating the individual with respect and dignity. **Compliance:**

			Substantial **Current Recommendations:** 1. Continue to maintain this progress through ongoing monitoring.
MLS	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:	**Current Findings:** 1. The IRP contains a section (Focus 6) entitled Community Integration. SEH has implemented additional trainings and coaching around discharge planning and community integration for all treatment teams, and further trainings for clinical administrators and social work staff. 2. SEH monitoring reports document improved attendance and participation by social work staff in the IRP process. 3. According to the hospital's own data (Social Work Initial Assessment and Clinical Chart Audits) and based upon this consultant's observations and record reviews, areas of improvement in the IRP include: the identification of skills needed for discharge and the positive changes needed for successful discharge; a descriptive identification of discharge needs; and the clinical formulation necessary to establish the setting and changes necessary for discharge. 4. There has been improvement in developing measureable interventions. **Compliance:** Partial **Current Recommendations:** 1. Continue to implement and monitor the Corrective Action Plan. 2. Focus social work staff and individual social work supervision meetings on IRP participation and process. 3. Identify staff and/or treatment teams in need of coaching.
MLS	VII.C.1	measurable interventions regarding his or her	**Current Findings and Recommendations:**

		particular discharge considerations;	1. See VII.C **Compliance:** Partial
MLS	VII.C.2	the persons responsible for accomplishing the interventions; and	**Current Findings:** 1. Records and data reviewed and IRP meetings observed indicate that specific staff are identified. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor to ensure compliance.
MLS	VII.C.3	the time frames for completion of the interventions.	**Current Findings:** 1. Avatar includes timeframes of 30 and 60 days for completion of IRP planning. Specific interventions are open ended with an assumption that that they will occur sometime between the last team meeting and the next. This does not create momentum by the team or individual members to meet specific interventions sooner. IRP meetings and a review of documents do not include an anticipated date of discharge. (OA, MJ). The Community Integration meeting does not establish a projected discharge date. 2. The social work department received training specific to completing the social work initial assessments. 3. There has been improvement in developing measureable interventions as observed at two of the three IRP meetings this consultant attended. **Compliance:** Partial **Current Recommendations:** 1. SEH should establish a projected discharge date for individuals

			who are on the discharge ready list. 2. SEH should continue training and coaching specific to establishing specific timeframes for interventions that are measureable. 3. Implement and monitor the Corrective Action Plan and the revised audit tools.
MLS	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:** 1. SEH has reduced it census significantly since the last visit and has not seen a significant overall readmission rate. The civil readmits for February and March 2011 were trending negatively against the national benchmark. 2. There have been significant revisions to the transitional TLC curricula including the addition of community groups and cognitive/skill building groups. 3. There is a revised discharge monitoring tool. The audit indicates significant improvement in the evidence of transition assistance (from 22% to 74%). Continued improvement should result in substantial compliance at the next review. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the Corrective Action Plan. 2. Continue to monitor readmission rates by legal category.
MLS	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 acceptance of the individual for the services, and the discharge of the individual.	**Current Findings:** 1. The AVATAR system does not document whether a copy of the discharge plan was provided to the consumer upon discharge. 2. The hospital's discharge audit results indicate a mixed performance improvement/trend with regard to post-hospital services arranged. **Compliance:** Partial

			Current Recommendations: 1. Implement and monitor the Corrective Action Plan. 2. Consider adding a note in the clinical record that the individual was provided a copy of the discharge plan.
MLS	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:** 1. DMH has developed and implemented a system of monitoring of individuals 30, 60 and 90 days post discharge. This process commenced in January, 2010 and continues. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor progress.
MLS	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	**Current Findings:** 1. A monitoring system has been developed by DMH to follow individuals 30, 60 and 90 days post discharge. This monitoring is triggered based on DMH receiving a completed discharge plan of care. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor progress.
MLS	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Current Findings:** 1. There is a sufficient number of staff to implement monitoring/quality assurance activities within SEH. **Compliance:** Substantial **Current Recommendations:**

			1. Continue to monitor progress.

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Status:** **Progress:** 1. SEH has maintained adequate psychiatric staffing levels to meet its needs. 2. SEH has updated its individualized medication guidelines consistent with current standards of care. 3. The facility has maintained caution in the use of high risk medications (e.g., benzodiazepines and anticholinergics in vulnerable populations, polypharmacy, and Stat medications) and made further progress in this area. 4. SEH has completed adequate Drug Utilization Evaluations (DUE) that aligned with the needs of the facility. 5. SEH has maintained progress in the aggregation and presentation of data regarding adverse drug reactions (ADRs) and medication variance reporting (MVR). 6. SEH has maintained some progress in the documentation of medication administration variances and initiated six sigma analysis to assess factors contributing to underreporting of ADRs and medication variances. 7. SEH has made significant progress in its substance use services as outlined in the summary of section V. 8. SEH has made progress in increasing the number and range of pharmacy reviews/interventions, ensuring physicians' responses to these recommendations, and maintaining an adequate system of drug alert notifications. 9. Mall programming on the Transitional Mall and on the Intensive Mall is being efficiently delivered and mall staff must now focus more on the quality of that programming. 10. Individuals in care who are receiving Initial Behavioral Interventions are receiving well-designed programs, but adequate attention to progress is not being found in either progress notes or IRPs.

			Areas of need: 1. SEH needs to increase reporting of ADRs and potential medication variances and improve the analysis of medication variances. The six sigma analysis currently underway is an important step in the right direction. 2. SEH needs to address persistent deficiencies in the laboratory monitoring of female individuals receiving high risk new generation antipsychotic medications and who are at risk of endocrine dysfunction. 3. SEH needs to improve the risk benefit analysis, as part of the psychiatric update, to justify continued treatment of individuals suffering from a variety of metabolic disorders with new generation antipsychotic medications. 4. The facility's mortality review process must be revised to ensure that risk factors that may be contributing to the mortality are addressed in a systematic and interdisciplinary manner. Some significant factors were not addressed in at least two of the mortality reviews during this period, which can have negative implications for the safety of other residents in the facility.

	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, MD, Medical Director 2. Rony Won, Pharm.D., Acting Chief Pharmacist 3. Sheila Stone, Program Administrator of Therapeutic Learning Center 4. Tyler Jones, MD, Director of Psychiatric Services 5. Gerard Fegan, MD, Staff Psychiatrist Reviewed: 1. Charts of the following 24 individuals: DE, LEM, JT, CG, CLT, CM, JC, CC, JW, SAM, LB, KTL, SDG, YL, TS, CC, NAJ, KH, ES, DS, TW, JAR, JW, and JAN 2. SEH Compliance (Self-Assessment Report), April 18, 2011 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 database regarding individuals diagnosed with Tardive Dyskinesia 8. Comprehensive Initial Psychiatric Assessment Summary Data, September 2010 to February 2011 9. Most recent template of the Psychiatric Update 10. Psychiatric Update Audit Summary Data; September 2010 to February 2011 11. SEH Adverse Drug Reaction (ADR) Incident Report September 2010 to February 2011 12. SEH summary data regarding ADRs, September 2010 to

			February 2011 13. SEH ten completed ADR Incident reports 14. SEH Reported Medication Variance Incidents, Updated March 28, 2011 15. SEH ten completed Medication Variance Incident reports 16. SEH Medication Administration Documentation data report 17. SEH Co-occurring Disorders summary data, September 2010 to February 2011 18. SEH Readiness Ruler Assessment 19. SEH list of all current psychiatrists at SEH with their case loads and FTE status March 21, 2011 20. SEH Tardive Dyskinesia (TD) Audit summary data, September 2010 to February 2011 21. Minutes of the SEH P&T Committee meetings, September 8, October 13, November 10 and December 8, 2010, and January 12 and February 9, 2011 22. SEH Pharmacy Drug Interventions and Recommendations, September 2010 to February 2011 23. SEH Pharmacy Drug Alerts during this review period: Risperidone tablets, oral solution and M-Tab, Pioglitazone (Actos), Leuprolide (Lupron), Albuterol Sulfate, and Antipsychotic drugs during pregnancy 24. SEH documents regarding reviews of mortalities during this reporting period (JEW and AW) 25. SEH documents regarding reviews of mortalities in April and May 2011 (PS, DJ and CL) 26. SEH Updated Medication Guidelines regarding the use of clozapine and gabapentin 27. SEH High Risk Indicator Tracking and Review Policy, March 2011 **Observed:** Substance Abuse Education Group: "Relapse Prevention"

			facilitated by Trent Tucker, PhD.
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 address physician practices regarding:	Please see sub-cells for findings and compliance.
MES	VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Recommendations November 2010:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c, and VI.A.7. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c, and VI.A.7 **Compliance:** Partial, improved compared to the last review (this rating considers findings in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments and VI.A.7 regarding psychiatric updates (reassessments)). **Current recommendations:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c, and VI.A.7.
MES	VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	**Recommendations November 2010:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4, and VI.A.7. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4, and VI.A.7. The following are the indicators that are most relevant to this

			requirement (the configuration of the indicators have been modified during this review period): 1. Risk Assessment sections completed 2. Addressed significant developments since last update 3. All sections of the subjective findings are completed and consistent with relevant progress notes 4. Use of Stat medications is addressed specifically if and how the benefits outweigh the risks 5. Response to treatment/progress completed 6. Adverse reactions noted, as appropriate 7. Abnormal laboratory levels are addressed 8. Documented justification for R/O or NOS diagnosis 9. Diagnosis reflects current clinical data or updated based on current data 10. The pharmacological plan of care reflecting the diagnosis, mental status examination and response to treatment; 11. The pharmacological plan of care reflects ongoing monitoring of adverse reactions of antipsychotic medications 12. Noted by attending physician if update completed by a trainee The data showed further improvement compared to the last review period regarding the implementation of this requirement. **Compliance:** Substantial. **Current recommendations:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4, and VI.A.7.
MES	VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Recommendations November 2010:** Same as in VI.A.1, VI.A.3, VI.A.4, and VI.A.7.

			Findings: Same as in VI.A.1, VI.A.3, VI.A.4, and VI.A.7. The following indicators were most relevant to this requirement: 1. The Update reflects the individual's response to treatment/progress; 2. Documented justification for R/O or NOS diagnosis; 3. Diagnosis reflects current clinical data or updated based on current data; 4. The pharmacological plan of care reflects the diagnosis, mental status examination, and response to treatment; and 5. The Update includes an integration of behavioral and psychiatric interventions. The data showed that the facility has maintained progress in the implementation of this requirement since the last review. **Other findings:** Same as in VI.A.1, VI.A.3, VI.A.4, and VI.A.7. **Compliance:** Substantial. **Current recommendations:** Same as in VI.A.1, VI.A.3, VI.A.4, and VI.A.7.
MES	VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Recommendations November 2010:** Same as in VI.A.1 and VI.A.7. **Findings:** The facility's data are presented in VI.A.1 and V.A.7. The following are the relevant indicators: 1. CIPA Audit: Risks associated with prescribed medication

			regimen. 2. Psychiatric Update Audit: a. Use of Stat medications is addressed specifically if and how the benefits outweigh the risks; b. Adverse reactions are noted, as appropriate; c. Medication side effects, risks/benefits are explained; d. Update adequately analyzes risks and benefits of chosen treatment; e. Rationale for use of benzodiazepines for individuals with substance use disorders is present; f. Rationale for use of two or more antipsychotics is present; g. Rationale for use of anticholinergics for individuals with cognitive disorder is present; h. Pharmacological plan of care reflects monitoring of antispychotics for side effects; and i. Pharmacological plan of care adequately addresses use of benzodiazepines in high risk populations. The data showed a positive trend since the last review. **Other findings:** Same as in VI.A.1 and VI.A.7. The risk benefit analyses in the Psychiatric Updates were mostly generic and limited to listing of theoretical risks while ignoring actual side effects and the justification for continued treatment in light of these side effects. **Compliance:** Partial (this rating considered findings in VI.A.1 and VI.A.7). **Current recommendations:** 1. Same as in VI.A.1 and VI.A.7.

			2. Improve the risk benefit analysis, as part of the psychiatric update, to justify continued treatment of new generation antipsychotic medications for individuals suffering from a variety of metabolic disorders.
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;	**Recommendations November 2010:** Same as in V.B.5, VI.A.2, and VI.A.7. **Findings:** Same as in V.B.5, VI.A.2 and VI.A.7. The relevant indicators are as follows: 1. CIPA Audit: Completion of risk assessment; and 2. Psychiatric Update Audit: a. Completion of risk assessment; b. Benefits and risks of restraint or seclusion (new indicator, no data available yet) and; c. Addressing Stat medications. The data showed further improvement compared to the last review regarding the completion of the risk assessment. The indicator that focused on the benefits and risks of restraint or seclusion does not seem to have monitoring value (this was discussed with the medical Director and Director of Psychiatry during the tour). In addition, SEH addressed this requirement through the High Risk Indicator Event System and High Risk Indicator Tracking and Review Policy. In March 2011, the facility finalized and began implementing this policy. Under this policy, categories of behavioral and medical high risks are identified, including, but not limited to assaults, self-harm, and falls. Individuals who met specified triggers/thresholds of high risk are identified and

			tracked until removed from the high risk lists. The policy provided for three levels of interventions, including a first level by the IRP teams, a second level of review by the Director of Psychiatric Services (or designee), and a third level by the clinical consultation team (CCT). The levels of interventions corresponded to the level of risk. This area is assessed further in section IX. **Other findings:** Same as in V.B.5, VI.A.2, and VI.A.7. **Compliance:** Partial (this rating considered findings in V.B.5, VI.A.2, which are improved compared to the last review, and VI.A.7). **Current recommendations:** Same as in V.B.5, VI.A.2.and VI.A.7.
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Recommendations, November 2010:** Same as in VI.A.1 and VI.A.7. **Findings:** Same as in VI.A.1 and VI.A.7. The relevant indicators are the following: 1. CIPA Audit: Risks associated with prescribed medication regimen; and 2. Psychiatric Update Audit: a. Medication side effects, benefits and risks are explained; b. Adverse reactions are noted, as appropriate; c. Abnormal laboratory levels are addressed; d. Pharmacological plan of care reflects monitoring of

			antispychotics for side effects; and e. Pharmacological plan of care adequately addresses use of benzodiazepines in high risk populations. The data showed further improvement compared to the last review period. **Other findings:** Same as in VI.A.1, VI.A.7, and VIII.A.1.d. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1, VI.A.7, and VIII.A.1.d). **Current recommendations:** Same as in VI.A.1 and VI.A.7.
MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Recommendations 1 to 3, November 2010:** • Same as in VI.A.1 and VI.A.7. • Continue to monitor this requirement regarding the use of polypharmacy based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C), and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** The facility assessed its compliance with this requirement using

			the previously mentioned Psychiatric Update audit. The data were presented in VI.A.1 and VI.A.7. The most relevant indicators are as follows: 1. Rationale for use of two or more antipsychotics; 2. Rationale for use of benzodiazepines for individuals with substance use disorders; and 3. Rationale for use of anticholinergics for individuals with cognitive disorder. The data showed further improvement compared to the last review period. The facility discontinued the use of the Medication Monitoring Audit at the recommendation of this expert consultant. **Other findings:** Same as in VI.A.1, VI.A.7 and VIII.A.2.a.i. **Compliance:** Substantial. **Current recommendations:** 1. Same as in VI.A.1 and VI.A.7. 2. Continue to monitor this requirement regarding the use of polypharmacy based on an adequate sample. Present a summary of the aggregated monitoring data including comparative data and analysis of low compliance with plans of correction, as indicated.
MES	VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and	**Recommendations 1-3 November 2010:** • Same as in VI.A.1 and VI.A.7.

		adjustment of regular treatment, as indicated, based on such use.	• Provide monitoring data (Psychiatric Update/Medication Monitoring Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C), and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. • Present comparative data (mean %C for each indicator in current review period vs. last review period). **Findings:** The facility's data were based on the Psychiatric Update Audit (see VI.A.1 and VI.A.7). The following are the relevant indicators: 1. Use of Stat medications is addressed specifically if and how the benefits outweigh the risks; and 2. The pharmacological plan of care addresses diagnosis, mental status examination, and response to treatment. In addition, SEH reported that self-audits showed no use of PRN medications during this review period consistent with the facility's policy. Self-assessment data showed that the facility has maintained progress in the implementation of this requirement. **Compliance:** Substantial. **Current recommendations:**

			1. Same as in VI.A.1 and VI.A.7. 2. Provide monitoring data based on adequate samples. Present a summary of the aggregated monitoring data, including comparative data and 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;	**Recommendations 1 and 2, November 2010:** • Implement corrective actions to correct the deficiencies outlined by this consultant regarding the monitoring of individuals receiving new generation antipsychotic medications. • Continue to monitor this requirement regarding high risk medication uses (Psychiatric Update and Medication Monitoring Audits), based on an adequate sample during the review period. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C), and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:**

			SEH assessed its compliance with this requirement by monitoring the use of high risk medications using the Psychiatric Update Audit. The data were presented in VI.A.1 and VI.A.7. The following are the relevant indicators: 1. Rationale for use of benzodiazepines for individuals with substance use disorders; 2. Rationale for use of two or more antipsychotics; 3. Rationale for use of anticholinergics for individuals with cognitive disorder; 4. Pharmacological plan of care reflects monitoring of antispychotics for side effects; and 5. Pharmacological plan of care adequately addresses use of benzodiazepines in high risk populations. The above data showed further improvement in all indicators since the last review. **Recommendation 3, November 2010:** Continue to provide information regarding the number of individuals receiving high risk medication uses during the review period compared to the last review period. Provide average number of individuals during the review period and address the following types of medication uses: 1. Intra-class polypharmacy (two or more antipsychotics); 2. Inter-class polypharmacy (four or more); 3. Anticholinergics > 90 days for individuals age 65 or above; 4. Anticholinergics > 90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias); 5. Benzodiazepines >90 days for individuals diagnosed with any substance use disorder; and

6. Benzodiazepines >90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias).

Findings:
The facility reported data regarding the number of individuals receiving complex/high risk medication regimens as of February 2011 compared to August 31, 2010, (during the last review, the facility presented data as of September 20, 2010). Additional data were provided for this review period as requested by this consultant. The data showed that the facility has made further progress in reducing the use of high risk medications since the last review. The following is an outline of the data:

Indicator	# individuals as of August 31, 2010	# individuals as of February 2011
Daily census	313	275
Two or more antipsychotic medications	285	258
Four or more psychiatric medications of different classes	44	35
New Generation Antipsychotics with a diagnosis of Diabetes Mellitus	15	17
New Generation Antipsychotics with new onset Diabetes Mellitus during treatment	4	3
Benzodiazepines (>90 days)	44	37
Benzodiazepines (>90 days) in	18	18

presence of cognitive impairment		
Benzodiazepines (>90 days) in presence of substance use disorder	10	11
Anticholinergics (>60 days)	71	54
Anticholinergics (>60 days) in presence of cognitive impairment	13	14
Anticholinergics (>60 days) in presence of Tardive Dyskinesia	14	12
Anticholinergics (>90 days)	30	30
Anticholinergics (>60 days) in individuals age 65 or older	10	11

As mentioned earlier, the facility discontinued the use of the Medication Monitoring Audit during this review period.

Other findings:
This expert consultant 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 and/or tardive dyskinesia;
3. Anticholinergic medications for elderly individuals; and
4. Various forms of polypharmacy.

This expert consultant reviewed the charts of 20 individuals receiving the above types of medication uses. The following is an outline of these review followed by findings regarding compliance (diagnoses are listed only if they signified conditions that increase the risk of use). These findings were based on documentation of the justification for use, monitoring the

individuals for the risks of use, attempts to use safer medication alternatives and risk benefit analysis.

Benzodiazepine use

Individual	Medication(s)	Diagnosis
DE	Lorazepam	Substance use Disorder (unspecified) and Cognitive Disorder NOS
LEM	Lorazepam	Cocaine and Nicotine Dependence
JT	Lorazepam (discontinued)	Cannabis and Nicotine Dependence
CG	Lorazepam	Mild Mental Retardation
CLT	Clonazepam	Dementia of the Alzheimer's type

This review found substantial compliance in three charts (LEM, JT, CG and CLT) and non-compliance in one (DE). However, due to the limited number of individuals in this category, the facility appears to have maintained sufficient progress in this area.

Anticholinergic use

Individual	Medication(s)	Diagnosis
CM	Benztropine	Cognitive Disorder NOS noncompliance

The review found non-compliance in this chart. However, this was the only individual found in this category.

Polypharmacy use

Individual	Medication(s)
JC	Quetiapine, aripiprazole, divalproex, and lorazepam
CC	Divalproex, amantadine, risperidone, and lorazepam
JW	Lorazepam (being tapered), zolpidem, quetiapine, olanzapine, and divalproex
SAM	Zolpidem, fluphenazine, ziprasidone, and trazadone
LB	Divalproex, fluoxetine, ziprasidone, trazadone, and haloperidol
KTL	Amantadine, zolpidem, haloperidol, quetiapine, bupropion, and lithium

This review found substantial compliance in four charts (JC, CC, JW, and KTL) and partial compliance in two (SAM and LB).

This expert consultant reviewed the charts of nine individuals who were receiving treatment with new generation antipsychotic medications, most of whom were diagnosed with metabolic disorders. The reviews are outlined as follows:

Individual	**Medication(s)**	**Diagnosis**
SDG	Olanzapine	Hypercholesterolemia and Overweight
CG	Olanzapine	Hyperlipidemia and Morbid Obesity
YL	Olanzapine	Diabetes Mellitus, Hypercholesterolemia, Obesity, and Hypertension

			TS	Risperidone	Hypercholesterolemia, Obesity, and Hypertension
			CC	Risperidone	Diabetes Mellitus, Hyperlipidemia, and Hypertensions
			NAJ	Risperidone	Diabetes Mellitus, Hypercholesterolemia, and Hypertension
			KH	Clozapine	Morbid Obesity and Hypertension
			ES	Clozapine	No diagnosis
			DS	Clozapine	No diagnosis

This review found general evidence of adequate monitoring of the individuals. However, the following deficiencies were identified:

1. The psychiatric update did not address risks and benefits of continued treatment with olanzapine for an individual at high risk of complications from metabolic dysfunction (CG).
2. There was no evidence of laboratory monitoring for endocrine dysfunction for at least the past year in two female individuals (TS and CC) receiving long-term treatment with a high risk agent (risperidone).
3. There was no evidence of laboratory monitoring for least the past year in a female individual (TS) receiving long-term treatment with a high risk agent (risperidone) and diagnosed with Hypercholesterolemia and Obesity.

Compliance:
Substantial.

Current recommendations:

			1. Implement corrective actions to correct the above deficiencies regarding the monitoring of individuals receiving new generation antipsychotic medications. 2. Continue to monitor this requirement regarding high risk medication uses based on an adequate sample during the review period. Present a summary of the aggregated monitoring data in the progress report, including comparative data and analysis of low compliance with plans of correction, as indicated. Supporting documents should be provided. 3. Continue to provide information regarding the total number of individuals receiving long-term treatment with the following medications. Provide comparisons between numbers during the last month of the review period and data presented for February 28, 2010: a. Intra-class polypharmacy (two or more antipsychotics); b. Inter-class polypharmacy (four or more); c. New Generation Antispychotics with Diagnosis of Diabetes Mellitus; d. New Generation Antispychotics with new onset Diabetes Mellitus during treatment; e. Anticholinergics > 90 days for individuals age 65 or above; f. Anticholinergics > 90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias); g. Benzodiazepines > 90 days for individuals diagnosed with any substance use disorder; and h. Benzodiazepines > 90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias).

MES	VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.
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;	**Recommendations 1 and 2, November 2010:** • Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature, and relevant clinical experience. • Provide a summary of updates in these guidelines. **Findings:** During this review period, SEH has updated its medication guidelines as follows: 1. The clozapine guideline was modified to include a standard regarding the frequency of monitoring vital signs of individuals receiving the medication. 2. Based on a Drug Utilization Evaluation (DUE) on the use of gabapentin for individuals with Bipolar Disorder, a statement was added that statistically, the medication is not an effective mood-stabilizing treatment and has

			no therapeutic value over better established medications such as lithium and valproic acid. **Other findings:** This expert consultant found that the updates comported with current standards of care. **Compliance:** Substantial. **Current recommendations:** 1. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature, and relevant clinical experience. 2. Provide a summary of updates in these guidelines.
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;	**Findings:** Same as in VIII.A.1.h. **Compliance:** Substantial. **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	**Recommendations 1 and 2, November 2010:** • Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the

			prescribing practitioners. • Present documentation of review of drug alerts by the Pharmacy and Therapeutics (P&T) Committee. **Findings:** During this review period, five drug alerts (for risperidone, actos, lupron, albuterol sulfate, and antipsychotic use during pregnancy) were issued by the facility's Pharmacy, posted on the intranet, and communicated to the facility's P&T Committee. Minutes of the P&T Committee meetings indicated that the committee has reviewed these alerts (see VIII.C). **Compliance:** Substantial. **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 of drug alerts by the P&T Committee.
MES	VIII.A. 2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Recommendations 1 and 2, November 2010:** • Implement corrective actions to address under-reporting of ADRs. • Continue to provide summary data regarding Adverse Drug Reactions (ADRs) including: o Total number of ADRs reported during the review period (specify dates) compared with the number during the previous period (specify dates); o Classification of ADRs by probability category (doubtful,

possible, probable, and definite) compared with the number during the previous period;
- o Classification of ADRs by severity category (mild, moderate, and severe) compared with the number during the previous period;
- o Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;
- o Clinical information regarding each ADR that was classified as "not recovered and/or unresolved;"
- o Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:
  - Date of the ADR;
  - Brief Description of the ADR;
  - Outline of ICA findings and recommendations; and
  - Outline of actions taken in response to the recommendations.
- o Analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.

Findings:
SEH has reported 40 ADRs during this review period (September 2010 to February 2011) compared to 42 during the previous period (March to August 2010).

The following summarizes the facility's data:

	Previous period	Current period

	(March to August 2010)	(September 2010 to February 2011)
Total ADRs	42	40
Classification of Probability of ADRs		
Doubtful	2	0
Possible	21	29
Probable	17	11
Definite	2	0
Classification of Severity of ADRS		
Mild	4	10
Moderate	38	30
Severe	0	0

The facility reported that no ADR met a severity threshold that necessitated an intensive case analysis during this review period. Reportedly, all ADRs were resolved except for the following five reactions:

1. Weight gain and glucose intolerance;
2. Weight gain;
3. Piano-like tardive movements of both upper extremities;
4. Moderate dyskinetic movements; and
5. Increased pigmentation and hyperprolactinemia.

Recommendation 3, November 2010:
Continue to provide a summary of Drug Utilization Evaluations (DUEs) during the review period, including the following information:

- Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of

			evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance; • Date of each DUE; • Description of each DUE including methods used; • Outline of each DUE's recommendations; • Outline of actions taken in response to the recommendations; 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. **Findings:** During this review period, the facility conducted the following DUEs: 1. Use of gabapentin in psychiatric disorders; 2. Use of hypnotics for insomnia; and 3. Medical follow up for individuals with vitamin B12 deficiency. The facility used adequate DUE methodology and the recommendations for corrective actions were, in general, appropriate. **Recommendations 4 and 5, November 2010:** • Improve mechanisms to capture medication variances, including potential variances; • Continue to provide data regarding Medication Variance Reporting (MVR), including: o Total number of actual and potential variances during the review period compared with numbers reported during the previous period; o Number of variances by category (e.g., prescription,

administration, documentation, etc.) and by potential vs. actual, with totals during the review period compared with the last review period;
- Number of variances by critical breakdown point with totals during the review period compared with the last review period;
- Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved;
- Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; also provide summary outline of each analysis including the following:
  - Date of the variance;
  - Brief Description of the variance;
  - Outline of ICA findings and recommendations; and
  - Outline of actions taken in response to the recommendations.
- Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances;
- Evidence of corrective actions to address patterns and trends identified in medication variances.

Findings:
The following summarizes the facility's data during this review period:

Number of Medication Variances	Current Period
Prescribing	41
Transcribing	4

Ordering/Procurement	4
Dispensing	9
Administration	23
# Drug Security, Documentation, other	5
Total variances	75

Total Critical Breakdown Points	Current Period
Total Critical Breakdown Points	75
Potential MVRs	33
Actual MVRs	42
# Prescribing	31
# Transcribing	4
#Ordering/Procurement	4
# Dispensing	9
# Administration	22
# Drug Security, Documentation, other	5
Outcome A	4
Outcome B	29
Outcome C	39
Outcome D	3
Outcome E	0
Outcome F	0
Outcome G	0
Outcome H	0
Outcome I	0

The above data include an adequate classification (and review by the facility) of variances by type (category), critical breakdown

			points, and outcome of the variances. Most of the variances (and critical breakdown points) occurred in the categories of prescription, administration, and dispensing, which is similar to the pattern noted during the previous review. The facility reported a relative decrease in the number of variances caused by missing nursing documentation upon the administration of medications since the last review. No significant changes were reported regarding trends in prescription and dispensing variances However, the facility has yet to correct the problem of underreporting of potential variances or implement corrective actions. Efforts were underway to complete a six sigma analysis in an effort to assess and address factors contributing to patterns and trends of variance reporting. During personal interviews, the Medical Director and Acting Chief of Pharmacy presented an outline of preliminary data from this analysis. The data were adequate. **Recommendation 6, November 2010:** Provide data regarding mortality reviews of all unexpected deaths during the review period. Ensure completion of an external review of all unexpected mortalities and an integration of results of the independent external medical mortality review and post-mortem examinations in the final level interdisciplinary review in a timely manner. **Findings:** SEH is still awaiting results of the external mortality review regarding the two mortalities that had occurred in the previous review period and were discussed in the previous report (AL and DA). This delay is unacceptable and can compromise the timely development and implementation of any needed corrective

			actions. During this review period (September 2010 to February 2011), two mortalities occurred at the facility ([redacted] and [redacted]) and SEH accessed both as to be "expected." However, upon review of these mortalities with the facility's Medical Director, it was determined that both mortalities should have been assessed as "unexpected" and that the facility's current definition of "anticipated" (expected) and "unanticipated" (unexpected) mortalities required revision to ensure that the term "anticipated mortality" is used only for individuals who suffered from terminal illnesses. In April and May 2011, three mortalities occurred at SEH, including two ([redacted] and [redacted]) that were classified as unexpected and one ([redacted]) as ex ted. This monitor reviewed the facility's documents regarding these mortalities. The review found that some significant factors were not addressed in two of the mortalities ([redacted] and [redacted]) and that the current mechanism to assess systemic contributing (and non-contributing) breakdown points in the system of care was inadequate. This can have negative implications for the safety of other indvidiuals in the facility. **Compliance:** Partial. **Current recommendations:** 1. Implement corrective actions to address under-reporting of ADRs. 2. Continue to provide summary data regarding Adverse Drug Reactions (ADRs) including: a. Total number of ADRs reported during the review period

			(specify dates) compared with the number during the previous period (specify dates); b. Classification of ADRs by probability category (doubtful, possible, probable, and definite) compared with the number during the previous period; c. Classification of ADRs by severity category (mild, moderate, and severe) 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. Clinical information regarding each ADR that was classified as "not recovered and/or unresolved;" f. Information regarding any intensive case analysis 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. Brief Description of the ADR; iii. Outline of ICA findings and recommendations; and iv. Outline of actions taken in response to the recommendations. g. Analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns. 3. Continue to provide summary of Drug Utilization Evaluations (DUEs) during the review period, including the following information: a. Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data

			collection form, acceptable sample size, and acceptable thresholds of compliance; b. Date of each DUE; c. Description of each DUE including methods used; d. Outline of each DUE's recommendations; and e. Outline of actions taken in response to the recommendations; f. Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns. 4. Improve mechanisms to capture medication variances, including potential variances, and utilize results of current six sigma analysis in this process; 5. Continue to provide data regarding Medication Variance Reporting (MVR), including: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g., prescription, administration, documentation, etc.) and by potential vs. actual, with totals during the review period compared with the last review period; c. Number of variances by critical breakdown point with totals during the review period compared with the last review period; d. Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved; e. Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; also provide a summary outline of each analysis including the

			following: i. Date of the variance; ii. Brief description of the variance; iii. Outline of ICA findings and recommendations; and iv. Outline of actions taken in response to the recommendations. f. Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances; and g. Evidence of corrective actions to address patterns and trends identified in medication variances. 6. Provide data regarding mortality reviews of all unexpected deaths during the review period. Ensure completion of an external review of all unexpected mortalities and integration of results of the independent external medical mortality review and post-mortem examinations in the final level interdisciplinary review in a timely manner. 7. The facility's mortality review process must be revised to ensure that risk factors that may be contributing to the mortality are addressed in a systematic and interdisciplinary manner.
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.	**Recommendations November 2010:** Continue to provide information to confirm continued compliance with this requirement in all acute care and long-term care units in the facility. **Findings:** The facility presented data regarding current psychiatric staffing that demonstrated continued compliance with this requirement. **Compliance:**

			Substantial. **Current recommendations:** Continue to provide information to confirm continued 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:	**Recommendations November 2010:** Same as in V.A.2.e and VI.A.7. **Findings:** Same as in V.A.2.e and VI.A.7. **Compliance:** Partial; improved compared to the last review (this rating considered findings 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.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	Same as above.
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	**Recommendations November 2010:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.

		of the medication treatment.	**Findings:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Compliance:** Partial, improved compared to the last review (this rating considered findings 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.	**Recommendation 1, November 2010:** Implement corrective actions to improve alignment between the individual's Stage of Change and IRP Objectives/Interventions and the formulation of proper discharge criteria regarding substance use disorders. **Findings:** During this review period (December 2010 and January 2011), SEH suspended the monitoring of the alignment of stage of change to IRP objectives, interventions, and the individuals' discharge criteria. Instead, the facility's internal substance abuse expert (Director, Clinical Training and Consultation) met with each treatment team and, with them, reviewed the record of each individual with a diagnosis of substance abuse to assist in determining the appropriate stage of change and whether it was aligned with IRP objectives, interventions, and development of discharge criteria. Self-audits restarted in February 2011 showing significant improvement in several key aspects of substance abuse treatment. In addition, the facility developed a "readiness" ruler to assess

all individuals with substance abuse diagnoses and to determine the individuals' stage of change. All individuals with these diagnoses completed this assessment during this review period. Training was provided to group leaders on the use of this instrument. In a personal interview, the facility's Program Administrator presented the results of the readiness ruler assessment (May 2011). The data showed 131 individuals completed this assessment and the IRP teams modified the stages of change in 33 cases based on this data. The data also showed that 63 individuals had their group assignments changed to improve alignment with the stage of change during this review period.

Recommendation 2, November 2010:
Continue to monitor this requirement (with the CIPA and Co-occurring Disorders Audits) based on adequate samples.

Findings:
The facility used its CIPA audit (September 2010 to February 2011, mean sample: 21%) to review completion of the substance abuse section of CIPA. The mean compliance rate was 98%, the same rate reported for the last review period.

In addition, the facility used the Co-Occurring Disorders Audit (September to November 2010 and February 2011) to assess compliance with this requirement. The mean sample was 7%. The following is a summary of the data:

#	Indicator	%C (p)	%C (c)
1.	The IRP addressed both the identified mental illness and substance use disorder	80%	65%
2.	The IRP reflected the SOC with	70%	53%

				respect to substance use disorder		
			3.	If #2 is yes, the intervention is appropriately linked to the documented SOC	59%	57%
			4.	The IRP has discharge criteria regarding substance use disorder	23%	33%
			5.	If #4 is yes, criteria is individualized and written properly	100%	85%

During this review period, the facility has maintained the same types of group offerings that were described in the previous report. However, since February 28, 2011, the facility has discontinued the Women's Recovery and Empowerment group and initiated a TAMAR (Trauma Addiction Mental Health and Recovery) group instead. In addition a TAMAR group was added for men.

The following table summarizes the facility's data regarding group offerings during this review period compared to the last review:

Indicator	September 20, 2011	February 28, 2011
Number of substance education groups per week	42	40
Number of distinct group curricula per week	20	21
Number of group sessions per week	65	60
Total capacity of	405	390

groups per week		
Number of individuals enrolled in groups	No data	259
Hospital census	312	276

Some groups were reorganized, which resulted in the decrease of two different groups per week and five group sessions per week as well as a decrease in total group capacity. The decrease in group capacity was insignificant in view of the decrease in the facility's census.

Other findings:
See this monitor's findings in V.D.1.

In addition, this expert consultant observed a group session for individuals in the maintenance stage of change. The lesson plan was relevant to the individuals' needs. During this group, the facilitator assessed the relapse cycle of one participant and used this assessment as a material to successfully engage other individuals and to instruct the group on relapse prevention strategies.

Compliance:
Substantial.

Current recommendations:
1. Continue current efforts to ensure alignment between the individuals' Stage of Change and IRP Objectives/Interventions as well as the formulation of proper discharge criteria regarding substance use disorders.
2. Continue to monitor this requirement based on adequate samples. Present a summary of the aggregated monitoring data, including comparative data and analysis of low

<table>
<tr><td></td><td></td><td></td><td>compliance with plans of correction, as indicated.
3. Same as in V.D.1.</td></tr>
<tr><td>MES</td><td>VIII.A.7</td><td>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.</td><td>Recommendations 1 and 2, November 2010:
• Continue to monitor this requirement (with the CIPA and TD Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C), and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
• Present comparative data (mean %C for each indicator in current review period vs. last review period).

Findings:
SEH identified 35 individuals as having a diagnosis of Tardive Dyskinesia (as of March 16, 2011) compared to 38 (as of August 31, 2010).

Using the CIPA Audit, the facility reported a mean compliance rate of 83% (February 2010 to February 2011) compared to 77% during the last review.

The facility used the Tardive Dyskinesia (TD) Audit and reviewed a 100% sample of individuals diagnosed with TD (September 2010 to February 2011). The following is a summary of the data:

<table>
<tr><td>#</td><td>Indicator</td><td>%C (p)</td><td>%C (c)</td></tr>
<tr><td>1.</td><td>There is evidence of at least semi-annual AIMS</td><td>95%</td><td>91%</td></tr>
<tr><td>2.</td><td>There is evidence of a Neurology</td><td>76%</td><td>69%</td></tr>
</table>
</td></tr>
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				Consultation		
			3.	There is evidence of consideration in medication choices	95%	100%
			4.	There are IRP interventions targeting TD	76%	66%
			5.	Are first generation antipsychotics prescribed?	41%	34%
			6.	If #5 is yes, there is justification in the monthly notes?	87%	100%

The data regarding use of anticholinergic agents were provided in VIII.A.7.

Other findings:
This monitor reviewed the charts of six individuals (SDG, TW, JAR, JW, JAN, and CLT) who had current diagnoses of Tardive Dyskinesia (TD).

This review found evidence of adequate practice as follows:
1. The admission AIMS were completed for all individuals who were admitted since July 2009.
2. The semiannual AIMS tests were completed in accordance with the facility's policy in all the charts reviewed.
3. The psychiatric updates adequately tracked AIMS testing in the charts of SG and TW.
4. With the exception of one individual (JAN), the IRP documented a diagnosis of TD with corresponding foci, objectives, and interventions in all the charts reviewed.
5. There was no evidence of unjustified long-term use of anticholinergic medications in most charts.
6. There was evidence that the treating psychiatrist had considered safer antipsychotic medications, as indicated, in the cases of JAR and JW.

			However, the following deficiencies were identified: 1. The psychiatric update notes did not provide any tracking of the status of TD in the chart of JAR. 2. The psychiatric update did not establish a current diagnosis of TD despite results of AIMs that were consistent with this diagnosis (JAN). 3. In general, the description of side effects section on the psychiatric update was limited to listing the diagnosis of TD (without comment on the progress of the movement disorder during the interval) and the results of the clinical rating scales did not address the most recent AIMs score. 4. There was no justification for the use of high risk treatment with anticholinergic agents in SDG's chart. 5. The IRP objectives related to TD were unattainable for the individuals and did not include learning outcomes in all the charts reviewed. In one chart (JAR), the AIMs testing results (September 2010 and March 2011) indicated no evidence of movements suggesting TD. However, these findings were inconsistent with findings on the neurological consultation (December 2010), which noted the presence of oral and facial movements indicative of TD during the same time period. No justification was noted in the record for this discrepancy. However, in a personal interview, the treating psychiatrists provided an adequate explanation. **Compliance:** Partial, improved compared to the last review. **Current recommendations:** 1. Implement corrective actions to address the above-mentioned findings of deficiencies.

			2. Continue to monitor this requirement based on adequate samples. Present a summary of the aggregated monitoring data, including the comparative data and analysis of low compliance with plans of correction, as indicated.

	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. Richard Gontang, Ph.D., Chief of Psychology 2. Richard Boesch, Ph.D., PBS Psychologist Reviewed: 1. Medical Records: MP, AH, AA, TD, AB, CD, JN, MC, CL, SC, DJ, CK, GS, EC, TJ, SS, AP, PW, JD, JD1, CS, AH1, VG, VS 2. Fidelity Check Form 3. PBS Training Data and Curriculum
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 hospital has chosen to complete the PBS team so that it includes: 1 PBS psychologist, 3 PBS specialists and 1 data analyst. This marks a change from the plan provided during the November 2010 tour in which the team was going to include a half-time RN. Psychology leadership reported that this change in approach was due in part to the difficulty in hiring a part-time RN given the hospital's overall need for RN positions. Additionally, it was indicated that the lack of an RN had not caused problems with understanding or implementing PBS philosophy at the level of care, which indeed is one of the reasons that an RN has typically been recommended as an important PBS team member. The hospital has presented data indicating that in those cases where an

			active PBS plan is operational, there is indeed adequate knowledge and follow through with respect to the plan by level of care staff. Given the hospital's overall critical need for RNs to ensure an adequate staffing mix among nursing personnel, the DOJ consultant remains open to the current staffing configuration of the PBS team as long as the hospital's data continues to support understanding and implementation of PBS philosophy at the level of care. However, as the hospital increases its level of RNs, it may become important to reconsider the staffing of the PBS team. The data from the hospital's self-assessment indicated satisfactory compliance with the provision that psychology adequately assess individuals for the appropriateness of behavioral interventions, in that the audit of Part B of the IPA has found that these recommendations have been made when appropriate. However, it will be important to also audit Part A of the IPA for such compliance as well, given the large number of individuals in care that never proceed to Part B of the IPA, and given the case of CL, where the need for behavioral interventions was clear upon admission. Since the November 2010 tour, the hospital has improved the linkage between risk management data and the psychology department, such that this data is shared with the PBS team on a weekly basis and, furthermore, the PBS psychologist is now included in the distribution list for High Risk Indicator Events. When individuals in care are triggered for a review to determine the appropriateness of behavioral interventions, it is the responsibility of the treatment team psychologist to assess the individual and write a progress note indicating the reasons that the individual would or would not benefit from the inclusion of behavioral interventions. Unfortunately, the psychology department is not currently auditing these progress notes. As a result, the hospital is unable to say for certain if there has been follow up for all such individuals. Auditing these progress notes is the

			only way that the hospital can ensure that the assessment has been made and documented and that it has been clinically sufficient. Finally, psychology leadership was quick to point out that the required progress notes for individuals who are receiving IBIs are not currently being audited, and a review by the DOJ consultant found that these progress notes were not present in a majority of cases. **Compliance:** Partial **Current recommendations:** 1. Quickly initiate an audit for the presence and quality of the psychologist progress note that is to be written following an individual in care reaching a threshold/trigger for behavioral review. 2. Quickly initiate an audit of the psychology progress notes required for individuals in care who are recipients of any type of behavioral intervention, including IBIs. 3. Continue to 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.
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 individual were chosen and what input the individual had in their development, and the	**Findings:** The results of both the hospital's self-assessment data and an independent review by the DOJ consultant indicated that the great majority of behavioral interventions have been well-designed. **Compliance:** Substantial

		system for earning reinforcement;	**Current recommendations:** 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.
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:** While this factor is audited, one IBI was found that contained the use of a restrictive intervention. When this was discovered and brought to the attention of the Chief of Psychology and the PBS team leader, it was immediately rectified. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
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	**Findings:** Appropriate fidelity checks are occurring for individuals on formal PBS plans and data indicates that staff at the level of care are appropriately implementing these plans. **Compliance:**

			Substantial **Current recommendations:** 1. Maintain current practice. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
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:** As indicated in the report following the November 2010 tour: > According to the hospital's report, there remains only one psychology vacancy; however, two psychologists are currently on maternity leave. The hospital has requested three additional psychology positions for FY 2011 depending on funding availability. It is likely that an increased number of filled psychology positions will also help with the timeliness of psychology assessments. In the months since the last tour, the above-indicated three positions have remained unfilled due to budgetary reasons according to the hospital's self-assessment report. While psychology was able to differently utilize a psychologist following the closure of the Annex, this did not appreciably alter the problem in the timely completion of IPAs and other Psychological Evaluations. Additionally, psychology department leadership indicated that, with the current caseloads assigned to psychologists on the admission units, follow up documentation on behavioral assessment and progress for those individuals in need of behavioral interventions is not routinely occurring. Indeed, the Chief of Psychology made clear that, in order for the

			department to meet its demands under the Settlement Agreement, both the above-indicated three positions as well as two positions currently on hold due to labor disputes must be filled. **Compliance:** Partial **Current recommendations:** Increase by five FTEs the staffing of the psychology department.
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.	**Findings:** The instructions for the initial assessments completed by Psychology, Social Work, and Rehabilitation Services have all been updated to include specific instructions for providers completing these assessments to indicate specific groups from the TLC catalogue from which they think the individual in care would benefit. The Nursing Initial Assessment is undergoing revision within AVATAR to determine if this item can be added to that instrument. Given that these instructions were fairly new, up to date audit results were not available for assessments other than the RSA. Both the hospital's data and an independent review by the DOJ consultant found that the RSA is routinely meeting this requirement. Since Social Work did not change their instructions until April 1, 2011, the SWIAs were not reviewed by the consultant for this provision. Psychology IPAs were reviewed and recommendations for specific TLC groups were found in 60% of the reviewed IPAs when only Part A had been completed, but in 100% of reviewed IPAs when Part B had also been completed. **Compliance:** Partial **Current recommendations:** 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.
RB	VIII.B.3	By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.	**Findings:** All individuals except those newly admitted continue to attend the treatment mall programs for at least half day increments. Additional, on-unit programming is being provided on the admission and geriatric units, but it is not clear that this programming is being well-attended. Rehabilitation Services continues to regularly offer evening and weekend programming. Finally, the hospital undertook an effort to identify individuals assigned to the Intensive Mall that were not regularly attending treatment. After these individuals were identified, assessment of them by psychology staff helped to better determine their needs and how they might best be engaged, and Rehabilitation Services began to offer extra incentives. While anecdotal reports from mall staff appear to indicate that these efforts have led to increased participation, staff also reported that they had not analyzed attendance enough following their efforts to be able to better report on outcomes. At the time of the tour, both the transitional and intensive malls were clearly well run, with 90% or more of individuals in care found to be in their assigned groups/activities within several minutes of their start. This marks good maintenance of effort for the transitional mall and a significant increase in efficient treatment delivery for the intensive mall. The hospital has also begun to monitor/audit clinical groups on both malls with a well-designed audit tool. One month of data was available for review and it showed promising trends, although mall staff reported that they knew they were going to have to devote more attention to

			the quality of the treatment groups. This parallels the DOJ consultant's experience: Four treatment groups were attended; one was excellent, the remaining were poor to fair. What was most noteworthy in the latter three groups was the lack of any indication that the provider was using a standardized curriculum. **Compliance:** Partial **Current recommendations:** 1. 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. 2. Follow up with data indicating the level of outcome for those individuals on the intensive treatment mall who had presented with engagement issues.
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:** Substantial **Current recommendations:** Maintain current level of practice.
RB	VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance	**Findings:** Substance abuse programs continue to be offered in both of the

		abuse and mental illness problems;	treatment malls. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Findings:** A random review of the newly developed (11/10) Discharge Plan of Care (DPC) found that the document was cut off in AVATAR, such that it could not be read. Since the document has been live since 11/10 with no reports of this problem, it suggests that clinical staff are not reviewing this document when readmissions occur. Furthermore, since the focus of this cell is on the appropriateness of the community living plan for those with cognitive disorders, the current audit tool for the DPC is inadequate as it only monitors for whether or not all five DSM Axes are completed, **not** if they are completed appropriately. This is an important difference, as in many of the DCPs reviewed by the DOJ consultant, cognitive disorders that appeared in the individual's most recent IRP prior to discharge did not also appear on the DCP. Additionally, when a cognitive disorder was specified, the plan of care was quite generic, e.g., "would benefit from a structured environment" – something that could probably be said about any individual with a cognitive disorder. Furthermore, Discharge Summaries continue to be missing from the medical record or incomplete, despite this issue having been raised in previous tours. **Compliance:** Partial **Current recommendations:** 1. Provide staff training to ensure that Discharge Plan of Care

			accurately reflects all of the patient's diagnoses and that specific and individualized recommendation are in place for the treatment and/or support needed for individuals with cognitive disorders. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
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 for post-trial forensic patients, and attendance at one treatment team demonstrated how a forensic individual was making substantial progress toward discharge. **Compliance:** Substantial **Current recommendations:** Maintain current level of progress.
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:** The hospital's own data indicated that this criterion was being met by less than 50% of audited IRP conferences, although the DOJ consultant observed this occurring in both of the observed IRP conferences. **Compliance:** Partial **Current recommendations:**

			1. Continue with present corrective action plan. 2. Continue to present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B. 4.f	clinically relevant information remains readily accessible; and	**Findings:** This requirement is being routinely met. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
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 hospital's data indicated that close to 100% of clinical staff have received training in the principles of positive behavior support. Fidelity checks for formal PBS plans have now been implemented and also show similar results. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. Present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean

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

	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. Bernard Arons, Medical Director 2. Rony Won, Pharm.D., Acting Chief Pharmacist Reviewed: 1. SEH Pharmacy Drug Interventions and Recommendations for this review period 2. SEH Worx Intervention Category Definitions
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	**Recommendations 1-3, November 2010:** • Implement corrective actions to address the significant drop in the pharmacy interventions/recommendations since the last review. • Continue to provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department, with comparisons to the previous review period. • Provide clear operational definitions for all categories of the recommendations. **Findings:** SEH presented data showing a significant increase in the recommendations made by pharmacists during this review period (September 2010 to February 2011) compared with the last review period (121 vs. 48). The recommendations addressed a sufficient range of medication practices, including, but not limited to, the types mentioned in the previous report. The facility reported that the physicians responded to all the recommendations during this review period.

			The facility provided adequate definitions of the types of recommendations. **Compliance:** Substantial. **Current recommendations:** Continue to provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department, with comparisons to the previous review period.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Findings:** Same as above. **Compliance:** Substantial. **Current recommendations:** 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:** 1. SEH Nursing Department is to be commended for the progress made on developing or revising over 15 key nursing policies and even more associated procedures and forms. 2. There are some improvements in the Comprehensive Initial Nursing Assessment and in the quality of the nursing assessment when individuals experience a physical status change that requires transfer to a medical hospital. 3. Unresolved AVATAR issues influence SEH's ability to meet requirements in key areas including: the inclusion of nursing interventions in the Initial Individual Recovery Plan; medication administration; timely identification of individuals' changing physical status. 4. VIII.D.1, VIII.D.5, VIII.D.6 and VIII.D.10.a were in substantial compliance following the last visit and were not re-reviewed. During this review period, SEH achieved substantial compliance in VIII.D.10.b – f. 5. SEH does not have an adequate number of Registered Nurses to provide direct services to individuals and to supervise the nursing care provided by non-licensed nursing care providers and Licensed Practical Nurses. This has had a negative influence on several important outcome indicators and contributes to rising levels of violence and rising numbers of transfers to medical settings. Because of this, the issue needs to be addressed immediately in order to protect the health and safety of the individuals served and to meet the requirements of this agreement. 6. More specificity will be needed in the CAP to adequately address findings in this report.

LDL			**Methodology:** Interviewed: 1. Elizabeth Unaegbu RN, NUM 2. Ulrich Patterson RN 3. Martha Burwell RN 4. Daphne Jackson RN, NUM 5. Funmilaya Olugbemi RN 6. Enyioma Anyatonwu RN 7. Oluwakemi Ogunseye RN 8. Georgia Freeman RN 9. Theresa Aruna RN 10. Christianah Awosika LPN 11. Delores Hawkins RN 12. Cathy Ford, Program Assistant 13. Elayne Tu Yi Ling RN, NUM 14. Florence Opina LPN 15. Christianah Fayomi RN 16. Deana Owusa RN 17. Merriem Davis RN 18. Christine Brown Acosta RN 19. Margaret Tabod RN 20. Malcomb Cook RN, Infection Control Officer 21. Dr. Bernard Arons, Director of Medical Affairs 22. Martha Pontes RN, Assistant Chief Nurse Executive 23. Michael Spencer, Program Analyst to CNE 24. Shirley Quarles RN , Director of Nurse Education and Research 25. Michael Hartley, RN, Chief Nurse Executive Reviewed: 1. SEH Compliance Report 7 and Corrective Action Plan (March 4, 2011).

			2. SEH documents and reports prepared in advance of visit including those referenced in the progress report. 3. SEH and Nursing Reports, Policies, Procedures, and Forms, relevant to the provisions in Section VIII.D and provided in advance of, as well as during, the visit. 4. SEH April 2011 PRISM report. 5. Monthly Nursing Care Hours and Skill Mix Summary reports for each unit from September – April, 2011. 6. By day/shift nursing staffing reports for each unit from April 17 – April 30, 2011. 7. Daily Average of One to One Observations per Month (September – April, 2011). 8. Nursing Overtime Reports Pay Period 10 (graphs include October – May, 2011) 9. Various on-unit documents, e.g., nursing assignment sheets; schedules for unit based groups/activities; control drug logs; emergency cart checklists. 10. Meeting minutes for the Infection Control Committee, Pharmacy and Therapeutics Committee, Violence Reduction Initiative, Nursing Management group. 11. Records of the following 20 individuals in care: FR, HH, TL, PC, MC, SS, JF, OH, DN (1), RN, DG, CD, TA, DN (2), DJ, SB, MF, RK, TJ, DS <u>Observed</u>: 1. Various nursing functions on units: 1A, 1B, 1C, 1D, 1E, 1F. 2. Intensive TLC
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	**Findings:** SEH has developed a clear description of the structure, content, and processes for the nursing education program including orientation and annual training requirements. The content meets the requirements of this agreement and includes relevant

		of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;	curriculum and competency measures. In addition, the data provided now distinguish training attendance from competency achievement. A follow up mechanism has been established to temporarily limit the independent functions of staff members who do not achieve or maintain competency in designated areas. The tables that were provided in advance of the tour were clarified during discussions with the Director of Nursing Education and Research (DNER). Specifically, the denominator used to calculate the percent of newly hired nursing staff who achieved competency was corrected (i.e. staff who hadn't yet undergone training were removed). When corrected, the percent of newly hired staff who achieved competency in *Mental Health Diagnoses, Stages of Change, and Therapeutic Communication* during orientation was 100%. This module also includes other content required in this provision such as monitoring symptoms and target variables. The percent of existing staff who achieved competency in these areas was 90%. This represents a substantial improvement. In addition, 100% of newly hired and existing staff achieved medication competency. The *Nursing Competency Plan* (NCP) (SDR 302; Revised: 3-10-2010) indicates that responsibility for determining contract nursing staff competency is shared between the contract agency and SEH. A review of the *Human Care Agreement* (1-10-08) for contract nursing staff revealed that although required knowledge and skill statements are included, no competency measures are required other than those associated with CPR. This means that SEH would be responsible for measuring competencies for the functions that contract personnel are authorized to perform. Although the NCP contains evaluation forms for contract personnel, actual competency measures were not included. Several potential approaches to address this matter were

			discussed with the Chief Nurse Executive (CNE). **Other findings:** Evidence that nursing staff have been trained in new/revised policies and procedures was provided, consistent with information that emerged from a staff interview. As in the previous tour, the DNER described several creative ideas that have potential to maximize learning opportunities for existing staff who are often unable to leave active units. In addition to the self-study packet that has been developed, SEH would like to develop brief training fliers that could be used on the units to enhance knowledge in high priority areas such as mental health diagnoses. SEH also discussed implementing an "annual training day" format to make it easier for staff to complete all required annual update competencies on one day. This format is an efficient approach that has been effectively utilized in other hospitals. Immediate implementation of these ideas would be likely to improve annual competency achievement. This could be done on an interim basis while CNE pursues his goal of one educator for each 50 beds in order to implement a more individualized training approach. The current nurse educators provide both nursing department specific as well as hospital-wide orientation and annual update. The frequency of high priority education offerings has been increased in an effort to increase the number of staff who meet annual mandatory training requirements. The SEH hospital-wide education program now contains clear descriptions of orientation and annual update programs that include objectives, course outlines, and teaching strategies. This also represents substantial improvement. However, the SEH report on annual mandatory training requirements reflects that

			all relevant personnel have not been trained or achieved competency in high priority areas. Actions to address this are being implemented. **Compliance:** Substantial **Current recommendations:** 1. The October 7, 2010 SEH Corrective Action Plan (CAP) goals relative to nursing training appear to have been met. Compliance should be maintained. 2. The CAP contains adequate steps to address continued hospital wide training program development as well as improved employee attendance at competency based annual updates. 3. The CNE should consider and implement approaches to ensure that contract nursing personnel demonstrate competency consistent with the functions they are authorized to perform.
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;	**Findings:** SEH continued to implement the plan designating one Registered Nurse to conduct the Comprehensive Initial Nursing Assessment (CINA). Both SEH audit findings and results from on site chart reviews show general improvement with the exception of interventions. Interventions documented on the CINA remain generic, are not prioritized, do not adequately address the individuals' priority needs, and are not incorporated into the Initial Individual Recovery Plan (IIRP). RNs still cannot enter nursing interventions directly into the IIRP despite two previous SEH progress reports indicating that AVATAR adjustments would be made to accomplish this. Furthermore, some documents continue to reference "recommended" nursing interventions, e.g., the RN recommends and the physician determines whether or not

			the interventions will be included. In the records that were reviewed, no nursing interventions documented on the CINA were integrated into the IIRP. As stated before: An RN is legally responsible to delegate/give ***direction*** for nursing care through nursing interventions. The RN *may* make ***recommendations*** for specific other disciplines' consideration or for inter-disciplinary review. This long-standing AVATAR issue needs to be resolved immediately. Once resolved, the initial nursing interventions need to be prioritized and individualized. As in the previous tour, the CNE indicated that he plans to separate the CINA into two parts. His rationale for doing so is sound; however this refinement is also awaiting AVATAR testing. SEH audit findings for the Nursing Update Assessment (NUA) (November – February) show considerable variability across time and among criterion. Criteria that seem to involve the *presence* of current information are generally met, e.g., current mental status described. However, criterion that require review, evaluation, and critical thinking about an individual's status over time are generally low (60 – 75%), e.g., summaries of medically necessary routine and non-routine measures/information, evaluations of an individual's progress toward goals, evaluation of an individual's milieu relationships including conflicts). This is not surprising in light of the inadequacy of the RN staffing levels (see D.11 for further discussion). When an RN does not have the time to systematically review information in the record, identify and critically evaluate subtle changes in individuals' conditions or responses to interventions, important opportunities to avert violence or a medical emergency may be missed. This is likely to be one contributor to the increased levels of violence and

			transfers to emergency departments/medical hospitals (see D.11 for specifics). SEH is to be commended for the quality of over 15 newly developed or revised nursing policies and even more associated procedures and forms. These documents are orderly, aligned with one another, reflect current practice standards, and clearly communicate what staff are expected to do. Standardized processes reflected in the policies should influence positive outcomes, provided that the RN staffing requirements are met. Since none of the policies had been implemented for more than a month at the time of the visit, it was difficult to fully evaluate the impact. There are plans to implement new assignment sheets that will support better management of the unit work flow and clarify assignments/accountability for each staff member. However, charge nurses will still face considerable challenges ensuring that all of the required tasks and functions are accomplished. Because of insufficient nursing staffing numbers and skill mix (see D.11), on a daily basis there is considerable temporary movement of staff from their home unit to another unit. This is required to attempt to cover serious baseline staffing deficiencies as well as provide coverage for unscheduled absences or 1:1 observations. The result is that nursing staff who work on a unit may not be familiar with specific unit operations and "house rules." They also do not know the individuals or their treatment plans, contributing to little engagement with individuals. Specifically, on one unit at mid-day only one individual was in the scheduled "group" (though in reality this was not a group, but rather was a time when chaplains saw individuals 1:1) and two were on the TLC. This left 21 individuals without any organized active treatment. However, nearly half the nursing staff on duty were from other units,

			making it difficult for them to initiate unscheduled activities. The combination of few individuals attending the TLC, an inadequate unit based group schedule, and nursing staff who did not know the individuals, contributed to the following observations: six individuals were asleep, two staff were playing cards with one individual who had been agitated earlier, and about 16 individuals were silently sitting in common areas. SEH reported many activities related to EARN including several special committees and unit based activity. However, the direction and outcomes of this program are unclear at this time. Based on unit discussions, there are opportunities to better align EARN processes with those associated with a recovery oriented environment. For example, as EARN operates, specific staff do not make contact with specific individuals in care. Rather, all the staff "try" to be sure that someone checks in with the individual every 30 minutes to ask if the person needs anything. A review of the EARN board indicated this does not consistently occur. SEH is encouraged to link the EARN program with: consistent assignment of individuals to specific nursing staff so that a trusting relationship can be developed; integration of EARN contacts with the IRP; integration of EARN documentation into existing documentation requirements. Based on IRP Observation Monitoring, SEH reported that RNs were present at 87% of the IRP meetings that were audited. **Other findings:** The Nursing Management minutes that were reviewed did not reflect the complete quality assurance/performance improvement process that would be expected by this senior nursing body i.e. review and analyze findings, identify trends and drill down as needed, formulate actions to resolve identified problems, and

			evaluate the effectiveness of those actions. Without a systematic and orderly process to review key indicators, it will be difficult for the nursing department to identify and resolve issues that impact SEH's ability to meet the requirements of this provision. **Compliance:** Partial **Current recommendations:** 1. Resolve AVATAR barriers that prevent RNs from entering relevant nursing interventions into the IIRP. Train the designated RN to prioritize and individualize interventions. 2. Expedite implementation of new policies and forms including assignment sheets. Monitor implementation and make operational adjustments as indicated. 3. Align EARN with recovery principles and link activities with established basic nursing functions, e.g., consistent assignment to work with specific individuals, integration with IRP, integration with routine documentation requirements. 4. Develop a structure and process for nursing management to analyze findings from relevant reviews, document actions to address findings, and evaluate the effectiveness of those actions. Consider devoting one meeting per month to reviewing aggregate data so that real trends (versus practitioner specific issues or normal variation) can be identified and acted upon. 5. See VIII.D.11
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,	**Findings:** Nursing procedures and hospital policies are now well aligned and clearly address RN and physician responsibilities when an individual experiences a change in physical status and is

		temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	transferred. Forms to structure and ensure documentation of the nursing assessment and communication to the physician, as well as forms to document transfer to and from an emergency room or medical hospital, have been revised. SEH is to be commended for the excellent policies, procedures, and forms that address all previous findings in this area. The structure is now in place to ensure standardized processes at critical times during an individual's hospital experience. Most importantly, SEH is to be commended for developing a physical assessment course for ensuring that nearly all the RNs attended the course and demonstrated competency in physical assessment, and for implementing a model for real time coaching by the Assistant Directors of Nursing. These activities, combined with the new policies and structure for assessment and documentation, supported improvements that were evident in the records of individuals most recently transferred to a medical hospital. When there were indicators that an individual's physical status may have changed, RN assessments included: determining location, severity and intensity of pain; measurement of all vital signs; assessment of lung sounds as indicated; abdominal palpation and auscultation of bowel sounds as indicated. In general, the time and name of the physician notified, as well as the time of transfer out and return, was also documented. SEH is encouraged to keep attention on this matter in order to sustain these early signs of improvement. Policies, procedures and forms associated with nursing documentation of medically necessary measures have also been revised. These could not be located in the records. It is not clear if this is due to the recent implementation or if there is an

			issue in AVATAR. Despite some early signs of improved nursing assessment and documentation at the time of transfer to a medical hospital, there were several indicators of inadequate monitoring prior to the urgent or emergent physical status change. Individuals were transferred to an emergency room or hospital for conditions that mostly likely would have begun to be revealed at an earlier time. Some individuals were transferred repeatedly for the same or related issues. These situations reflect that subtle indicators of a status change are not being identified and addressed prior to an urgent or emergent situation, e.g., gradually increasing, decreasing, or significantly fluctuating vital signs or labs. Although several factors contribute to the failure to address emerging indicators that a person's physical status is changing, two key factors that influence this involve AVATAR and insufficient RN staffing levels (see D.11 for a discussion of RN staffing). AVATAR issues have been previously summarized by both SEH staff and reviewers. These include: extremely slow response time making it nearly impossible for busy staff to look back over the various notes, forms, and sections of the record that need to be reviewed in order to properly evaluate a person's status; difficulty/sluggishness when trying to move in and out of different screens in order locate all relevant documentation; getting "kicked off" and having to re-enter the system or re-enter dates; and many more problems that the staff can more fully describe. The second influence on the failure to monitor subtle status changes is the insufficient number of RNs. Despite their best efforts, it is very clear that the RNs on duty cannot possibly

			attend to all of the issues that require their attention on any given shift. RNs are forced to "triage" and respond to the most urgent situation. There are many urgencies on the unit -- some related to individuals and some related to the staff -- that require assistance and supervision. Non-licensed nursing care providers may document information, but not verbally report subtle changes to the RN at the time they are observed. In addition, subtle status changes typically emerge over time, may wax and wane, and require synthesizing information derived from vital signs, labs, individuals' subjective concerns, and staff members' observations about the individual's appearance and level of activity over several 24 hour periods. Currently, an RN simply does not have the time to put this puzzle together, especially in light of the AVATAR challenges. SEH audits of Nursing Updates and progress notes reveal the evidence that the necessary review, evaluation, and critical thinking is not occurring. There are unacceptably low findings related to: summarizing vital signs and weight (74); summarizing pertinent lab changes (79); and identifying issues not currently covered in focus areas that have potential to become issues (71). SEH reported that Nurse Managers (NM) and Clinical Administrators were trained to develop IRP focus areas, objectives, and interventions for individuals with physical conditions. Plans were for the NMs to work with RN staff on their units. In the records that were reviewed, IRPs often did not address physical problems. SEH reports that audit tools for this provision are under development with implementation targeted for May 2011. **Other findings:** None

			Compliance: Partial **Current recommendations:** 1. Resolve AVATAR issues. 2. Implement audit tools in order to identify improvements necessary to meet the requirements of this provision. 3. See VIII.D.11
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Findings:** SEH is to be commended for the significant effort put into understanding the med administration process and resolving some of the barriers experienced by the staff, e.g., availability of computers, re-training staff, and re-reviewing competencies. Significant improvements were noted during a number of medication administration observations made on the units and in the TLC. These included: utilizing two methods of identifying individuals; following expected hand-hygiene; and conducting checks to ensure that the right medication was being administered at the right dose and the right time. For the most part, staff were knowledgeable about the actions and side effects of medications. Administration of insulin met all requirements, e.g., second RN check of dose. However, there were some continued practice variances that included pre-signing control drug records for medication not administered, incomplete number of checks prior to administering medication, and passing control drug keys between nurses without counting. As nurses have gained more experience with AVATAR, some of the problems identified during other visits have been resolved. However, there continue to be numerous problems that are not associated with user error and that force any reasonable nurse to

			develop workarounds. The problems include: difficulty getting into the system (despite following expected steps); getting kicked off the system and having to re-enter again; extremely slow system response at several steps in the medication administration process; and time-consuming electronic documentation that sometimes requires documentation in a number of areas within the eMAR. Because of the amount of time it takes a nurse to administer medications to one person, it is not uncommon for other individuals to become agitated because they have to wait for medication. Therefore, in order to avoid violence on the unit, nurses resort to workarounds. Examples of this include "grouping" together documentation of medications administered to three or four individuals'. Most individuals receive multiple medications and relying on memory is a dangerous practice that presents serious risks, e.g., documenting a medication that wasn't given, or not documenting a medication that was given. The Medication Administration policy has not been finalized, reportedly because of the need to resolve numerous system level issues related to medication processes. It is critical that these issues be resolved, that AVATAR resolutions be a part of the discussion, and that the policy be expedited for implementation. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Identify and implement opportunities to streamline the eMAR requirements.

			2. Resolve issues associated with AVATAR. 3. Complete the medication administration policy.
LDL	VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	**Findings:** SEH no longer authorizes "certified medication givers" to administer medication. Course outlines for medication administration are comprehensive. In addition, all nursing staff have been trained and achieved 100% competency in medication administration. This, coupled with the observation that the findings in VIII.D.4 involved management level nurses as well as nurses who have been employed at SEH for many years, suggests that the identified issues may be associated with a practice culture that merits review, rather than training per se. **Other findings:** None **Compliance:** Substantial **Current recommendations:** The CAP goals relative to competency based medication administration training have been met. Additional goals and strategies may be necessary relative to the actual practice on the unit. See VIII.D.4
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;	**Findings:** SEH has successfully focused efforts on decreasing the rate of missed documentation for routinely scheduled medications. Monthly reports show reductions in rates of missing documentation from a high of 1.22% in May to 0.57% in August. In addition, SEH is monitoring missing

			documentation at both the unit and practitioner-specific levels, noting that 48% of the nurses had no missing documentation in August. The success of this effort suggests that SEH will be able to take other effective actions to address findings in VIII.D.4. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;	**Findings:** See VIII.D.4 During medication administration observations, staff did not ask individuals about side effects. However, due to the slowness of AVATAR and the resulting agitation among individuals waiting for medications, it was appropriate that the nurse did not hold up the line to discuss these matters. Although it is likely that TLC group sessions offer opportunities for general discussion about side effects, those offerings are not sufficient for proper side effect assessment. There needs to be 1:1 follow up with an individual at the time of medication administration or at some other regular intervals by the RN. eMARS were not reviewed for this item during this review visit. **Other findings:** None

			Compliance: Partial **Current recommendations:** 1. See VIII.D.4 2. Determine how and when this activity will take place as well as how it will be documented. Ensure integration into appropriate policies and procedures.
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;	**Findings:** See VIII.D.2, D.3, D.4, and D.9 A new procedure for nursing documentation has been developed. The template for periodic RN progress notes has been revised and contains information that the treatment team would need to evaluate the individual's status and the effectiveness of the treatment plan. The new procedure requires that both the RA and the RN document at the same intervals. The expectations for the structure and content of RN documentation are clear. However, there is less clarity relative to the Recovery Assistant (RA) documentation expectations. The records that were reviewed showed wide variation in the structure (e.g., open narrative, BIRP, Behavior Intervention, Response, Plan) as well as the content of RA notes. **Other findings:** None **Compliance:** Partial **Current recommendations:**

			1. See VIII.D.2, D.3, D.4, and D.9 2. Develop clearer expectations for RA documentation with a close eye on minimizing potential for duplication of/conflict with the RN note content.
	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;	**Findings:** See VIII.D.2, and VIII.D.3 SEH reported that from September 2010 through February 2011, 91% of the records reviewed met this provision. However, in the records that were reviewed during this visit, most of the IRP objectives related to TLC groups. Nursing interventions were rarely specified. IRPs were notably silent on nursing interventions related to violence and physical health status. Nursing staff are responsible for providing interventions during the 18 hours each day when TLCs do not operate, as well as 24/7 on weekends and holidays. Interventions must be developed to provide individualized treatment during these times. **Other findings:** The new nursing policy/procedure addressing choking risk and dysphagia was signed on May 1. The policy is excellent. At the time of the visit there was insufficient opportunity to evaluate implementation because the policy is new and because AVATAR CINA testing is not yet completed. The intensive TLC now provides a small dining area for individuals who are on special diets or are at risk for choking or seizures. This area is monitored at all times by an RN. During the visit, the RN monitoring this area identified the individuals at risk for

			choking, was knowledgeable about the specific reasons for the individual's risk, described the different circumstances that pose choking risk, and described appropriate interventions. **Compliance:** Partial **Current recommendations:** 1. Explore and resolve factors that contribute to an absence of nursing interventions in the IRPs, especially interventions to address violence and physical health status. 2. Monitor policy implementation, identify trends, take action to address trends, and monitor effectiveness of actions taken.
LDL	VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Findings:** See VIII.D.2, D.3, D.4, D.8 and D.9.a. The SEH clinical chart audit for September 2010 through February 2011 found that 78% of the records reviewed met the requirements of this provision. In the records that were reviewed during the tour, the symptoms and target variables to be monitored by nursing were rarely documented in the IRP. It is possible that the discrepant findings relate to the audit tool instructions. The instructions for scoring the audit tool that addresses this provision state: Score as Yes, if the IRP interventions identify symptoms and target variables that will be monitored by nursing and other staff. In contrast, the scoring instructions for VIII.D.9.a specify that the reviewer should score yes only if the diagnoses, treatment, and interventions required by *nursing* are present. It would be

			useful to align these two scoring instructions. Furthermore, in light of the issues associated with violence and physical status, SEH should consider monitoring the degree to which *nursing* (i.e. not "other unit staff") monitoring and interventions are specified in the IRP. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1.See VIII.D.2, D.3, D.4, D.8 and D.9.a 2. Align audit scoring instructions to ensure monitoring of interventions that nursing staff will implement.
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Findings:** See VIII.D.2, D.3, D.4, D.8, D.9.a, and D.9.b The SEH clinical chart audit for September 2010 through February 2011 found that 80% of the records met this provision. In the records that were reviewed during the tour, the frequency by which staff needed to monitor symptoms was rarely included. **Other findings:** None **Compliance:** Partial **Current recommendations:** See VIII.D.2, D.3, D.4, D.8, D.9.a, and D.9.b
	VIII.D.	Establish an effective infection control program to	Please see sub-cells for findings and compliance.

	10	prevent the spread of infections or communicable diseases. More specifically, SEH shall:	
LDL	VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Findings:** SEH is actively collecting routine surveillance data for appropriate types of Hospital Associated Infections, patients with Multi-Drug Resistant Organisms, and patients cultured for MRSA on admission. They are also collecting data on Hand Hygiene Compliance. SEH has begun to collect data relevant to employee infections that includes work restrictions due to a communicable disease, blood borne pathogen exposure, numbers of employees receiving influenza vaccine, and employees with a PPD conversion. SEH is in the process of developing a working database relative to monitoring PPD status. SEH conducted two focused reviews/special studies: Hep C screening and treatment; and an employee exposure to Blood Borne Pathogens. Both reviews revealed relevant data assessment, trend identification, determination of actions, and a plan for ongoing monitoring to determine the effectiveness of those actions. **Other findings:** Tables and reports that identified "conversion" were clarified. There were no actual PPD conversions. This will be corrected in future reports. Additional table corrections are needed (see "Mean – C" columns). In an effort to clarify previously discussed alternative methods to accomplish Hep B, C, and HIV data reviews, it was apparent that the Infection Control Officer (ICO), Infection Control Committee Chair (ICCC), and Director of Medical Affairs understood both requirements and recommendations.

			Compliance: Substantial **Current recommendations:** SEH CAP includes adequate actions to address PPD tracking. Since the proposed system relies on the Nurse Manager (NM), SEH will need to closely monitor the effectiveness of the plan. SEH may need to consider alternative approaches that are not reliant upon NM data entry.
LDL	VIII.D. 10.b	assess these data for trends;	**Findings:** SEH has decided to document data assessment for trends in the Infection Control Committee (ICC) minutes. Minutes consistently reflected that data were assessed for trends. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
LDL	VIII.D. 10.c	initiate inquiries regarding problematic trends;	**Findings:** The ICC minutes reflected that problematic trends and occurrences were identified, e.g., low compliance with hand hygiene and MRSA screening, and blood and body fluid exposure in the dental clinic. Inquiries were made relative to the reason for the trends. **Other findings:** None

			Compliance: Substantial **Current recommendations:** Maintain current level of practice.
LDL	VIII.D.10.d	identify necessary corrective action;	**Findings:** The ICC minutes identified necessary corrective action when trends were identified, e.g., ensuring that adequate hand washing supplies are available on the unit, stocking the Admissions Suite with swabs for MRSA screening, ensuring that eye shields are used, and exploring opportunities to adjust suction equipment in the dental clinic. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
LDL	VIII.D.10.e	monitor to ensure that appropriate remedies are achieved;	**Findings:** Although the mechanism and accountability for monitoring was sometimes not clear, the ICC minutes did reflect continued attention to ensure that actions taken resolved identified issues. If problematic trends were not resolved, plans were developed to address the issues or barriers to resolution, e.g., PPD follow up. **Other findings:** None **Compliance:** Substantial

			Current recommendations: Maintain current level of practice.
LDL	VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Findings:** Linkages between the ICC and hospital-wide Quality Assurance/Performance Improvement reviews are clearly described in the appropriate section of the Infection Control Policy (Section 10.0). **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current linkage.
LDL	VIII.D. 10.g	ensure that nursing staff implement the infection control program.	**Findings:** There was some documentation in the records indicating that nursing staff implemented special precautions, e.g., RN narrative notes that described wound care and appropriate implementation of contact precautions. However, this was not consistent. Since the IRP usually did not reference special precautions there is no other natural structure to ensure consistent documentation in Nursing Updates or Progress Notes. Trash cans, including those labeled "biohazard" and containing a red bag, were readily accessible to individuals on a unit. One individual was observed going through the trash without staff intervention. This particular unit generates a very high volume of soiled linens and other items in the morning. The volume requires that staff balance the need for proximate receptacles with the need to ensure that individuals do not access the containers. The

			ICC was encouraged to collaborate with the nursing staff in order to find a workable solution to this challenging problem. At the end of this visit, reports indicated that unit nursing staff, medical staff, and the Infection Control Officer need to address issues associated with lice in newly admitted individuals. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Identify and resolve barriers to consistent documentation of infection control program implementation. 2. Ensure that individuals do not access trash containers containing gloves and/or biohazardous substances. 3. Address issues associated with lice in newly admitted individuals.
LDL	VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services.	**Findings:** The SEH CNE has developed a nursing staffing plan that establishes very conservative baseline nursing staffing requirements. Staffing requirements are expressed in two different ways: Nursing Care Hours Per Patient Day (NCHPPD) and Registered Nurse (RN) Skill Mix. NCHPPD is a single number that takes into account the unit census and the ***minimum total numbers of nursing staff*** who must be on duty in a 24 hour period to meet individuals' requirements for nursing care. The RN Skill Mix is the ***minimum percentage of all nursing staff who must be RNs*** in order to provide direct services that require an RN's knowledge and skill, as well as to supervise the care provided by non-licensed nursing care providers and Licensed Practical

			Nurses. The SEH staffing plan requires 6.0 NCHPPD and a 40% RN skill mix. From November 2010 through April 2011, SEH failed to provide the required 6.0 NCHPPD. Specifically, NCHPPD fell below 5.0 for four out of the six months reported. Even with the addition of overtime and agency staff, an average of only 5.4 NCHPPD was provided during this period. The baseline requirement for 6.0 NCHPPD was never met. The gap between the numbers of RNs employed and the required RN Skill Mix was even greater. During the same reporting period SEH failed to provide the required 40% RN skill mix. The average RN Skill Mix was 26% - 30%* during the reporting period. (*This is an artificial "range" influenced by the way positions were counted over the six month period in terms of budgeted, filled, and/or not filled). The work schedule for all units/all shifts from April 17 - April 30, 2011 confirmed the above described staffing shortages. It is especially alarming that 41 of the units/shifts during this two-week time period **required** overtime or agency staff coverage in order to have only one RN on duty. This reflects that the number of RNs at SEH falls seriously below what is required to meet basic health and safety needs. Other outcome indicators reflect the inadequacy of the current RN Skill Mix. Examples involve medication variations, the increased level of violence, increased numbers of major incidents, and increased numbers of emergency medical transfers. Specifically: • Although medication variations are woefully under

			reported, nearly half of those that were reported actually touched patients. Though these variations reportedly did not cause harm, individuals were exposed to significant potential for harm through medical error. • Despite a declining census, using assault as an indicator, the level of violence has increased from an average of 34 per month (for **six** months; May – October 2010) to an average of 48 per month (for **five** months; November – March, 2011). • Despite a declining patient census, the number of emergency medical transfers increased from a total of 106 (May – October, 2010) to 131 (November, 2010 – April, 2011). • During the same reporting periods, major incidents rose from 755 to 873. Audits that address the nursing quality reflect unacceptably low findings in areas in RN progress note documentation. These included: summarizing vital signs and weight (74); summarizing pertinent lab changes (79); and identifying issues not currently covered in focus areas that have potential to become issues (71). See D.3 for additional detail. Lastly, a series of very serious situations, including some that involved seclusion or restraint use, have occurred over the past six months. These situations reflect the absence of a professional practice environment and are influenced by the insufficient number of RNs. **Other findings:** None **Compliance:**

			Partial **Current recommendations:** 1. Immediately hire additional RNs. At this time, an RN skill mix of at least 50% will be needed to meet the provisions in this agreement. Although this figure can be reconsidered in 2 – 3 years when new processes have taken hold, in light of the SEH service population, the RN Skill Mix should not go below 40%. 2. Monitor the total NCHPPD to ensure that the addition of required numbers of RNs brings the NCHPPD up to the minimum required level (6.0).

	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 seclusion and restraint use remains below national benchmarks. 2. X.B.3 and 4, and X.C.1 – 5 were in substantial compliance following the last visit and were not re-reviewed. During this reporting period SEH reached substantial compliance in X.A.3, 3.a and b; X.D; and X.G.
LDL			**Methodology:** Interviewed: See VIII.D Reviewed: See VIII.D Observed: See VIII.D.
	X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	Please see sub-cells for findings and compliance.
LDL	X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Findings:** SEH reported that restraint and seclusion policy/procedure alignment was still underway, thus the revised Restraint or Seclusion for Behavioral Reasons policy was not reviewed. Previously reviewed SEH policies addressing requirements for seclusion and restraint use have adequately described the range of restrictive alternatives available to staff. Nursing has completed development or revision of numerous policies associated with medical and protective devices, e.g.,

			padded mittens, side rails, and helmets. All of the completed policies are comprehensive, orderly, contain clearpoints and levels of accountability a, and integrate contemporary standards. SEH is to be commended for completing that work and is encouraged to finalize the revisions in the policy addressing seclusion or restraint. During initial SEH visits, there was evidence that SEH had successfully eliminated prone restraint. During the last visit, SEH reported that there was <u>one</u> incident of prone restraint. The circumstances flagged potential issues within the SEH practice culture. During this review period, SEH reported that there were <u>two</u> incidents of prone restraint. Both of these incidents were identified after the Risk Manager investigated the restraint event. **Other findings:** None. **Compliance:** Partial **Current recommendations:** 1. Finalize revisions to the restraint and seclusion policy. 2. Evaluate and resolve factors contributing to prone restraint use.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Findings:** Both the Non-Violent Crisis Intervention (NVCI) and the Restraint and Seclusion (R/S) competency-based training for new hires are at 100%. There has been improvement in the numbers of existing employees who have achieved competency following Restraint and Seclusion training (92%). However, there continues

			to be a substantial number of staff who have not had NVCI training in over two years. For example, 53% of the Nurse Managers, 42% of Clinical Administrators, 40% of RNs, 39% of RAs, and 37% of LPNs have not been trained as required. The increased level of violence reflects ineffective management of individuals in crisis and is influenced by significant gaps in training. SEH is reportedly close to purchasing an alternative program for crisis intervention training. It is expected that this program will put more emphasis on prevention. In view of the existing insufficient nursing staffing levels, it was reasonable to have delayed NVCI training since the new program is on the horizon. However, in light of the findings from the SEH study on violence (four of the six behavioral emergency precipitating factors related to the quality of staff interactions and the ability of staff to recognize early cues to agitation), SEH is urged to move quickly to implement the new program. If there is further delay, nursing staff should be scheduled to attend the NVCI offering immediately, using overtime and agency staff to cover units. SEH has trained several units in Collaborative Problem Solving. This evidence based approach should be helpful in assisting staff response to actual and potential conflicts in a manner that de-escalates the situation. **Other findings:** None **Compliance:** Partial **Current recommendations:**

			Proceed quickly to implement the new training module. If this cannot be implemented quickly, train nursing staff using NVCI.
LDL	X.A.3	the use of side rails on beds, including a plan:	**Findings:** SEH has successfully implemented a system to ensure the accurate reporting of side rail use. SEH reported that between November and February 2011, eight individuals have used side rails, all for safety and not restraint. A comprehensive and well-organized nursing policy on side rail use has been completed. In the records that were reviewed, time limited physician orders were present, nursing documentation reflected appropriate implementation and monitoring of side rail use, and the IRP reflected appropriate integration of relevant issues. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Findings:** See X.A.3 **Other findings:** None **Compliance:** Substantial **Current recommendations:**

			Maintain current level of practice.
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	**Findings:** See X.A.3 **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
LDL	X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	Please see sub-cells for findings and compliance.
LDL	X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Findings:** SEH continues to report that restraint and seclusion use is well below the national public rates in the percent of individuals restrained or secluded and in the hours of use. SEH also reported that the requirements of this specific provision were met in 94% of the records reviewed. However, there is inconsistent evidence that a hierarchy of less restrictive measures were considered and documented prior to restraint or seclusion use. The interventions most frequently documented and described verbally are "redirection" and "counseling." A key strategy for developing less restrictive measures at SEH involves the use of a "comfort plan" that documents the individual's preferred less restrictive measures. However, these strategies are rarely integrated into the IRP and are not

			specifically utilized during crises. In addition, there is some evidence that the value of the plan and the need for regular updates may not be taken seriously. For example, over a period of approximately two months, an individual who repeatedly engaged in violent behavior had four comfort plans with the exact same boxes checked in all categories (triggers, strategies, etc). These were completed by the same Recovery Assistant (RA) and were not signed by the individual. Given the individual's level of psychosis, is quite unlikely that he would have said the exact same thing each time the plan was updated. Although the use of seclusion and restraint remains low, violence has increased. In order to utilize least restrictive measures, triggers for the individual must be identified and monitored. However, the trigger for the violence was considered to be "unknown" in 34% of the violent events. Triggers typically are "known" and the fact that a substantial number were reported to be "unknown" reflects that early cues were not recognized and that least restrictive interventions were not implemented soon enough to diffuse a violent event. **Other findings:** SEH reported that treatment teams reviewed the SEH Psychiatric Emergencies study and responded to findings by adjusting some "house rules" in order to eliminate triggers. SEH hospital also : plans to purchase a new nonviolent crisis intervention program; initiated Collaborative Problem Solving training; and developed a position called Recovery Assistant Peer Specialist ("RAPS"). This experienced and skilled RA will become a trainer when the new prevention based program is implemented and will also provide support and mentoring for other staff on the units. Provided that the role/duties are closely monitored, the identification of skilled RAs to participate as trainers and to act

			as role models for other staff is an excellent approach that holds promise to increase the use of a hierarchy of least restrictive measures when an individual experiences a crisis. Although it is not clearly articulated, it is reasonable to assume that these RAs will be assigned to work with individuals who exhibit challenging behaviors. In this way they can model how to prevent and deal with crises. Skilled RAs would be expected to identify early cues of agitation, to intervene using the strategies in the IRP and comfort plan, and to model effective de-escalation of behavioral crises. In other words, the advanced skills of these RAs should be directed to the individuals in care <u>first</u>, and then to the staff as they explain in de-briefings why they selected particular approaches. The success of this new venture will be partially dependent on role clarity. Currently some written materials about the role functions need more specificity and/or reflect some role confusion that needs clarification before the pilot is completed. Three specific areas need clarification. First, the term "peer specialist" has a very specific meaning in recovery-oriented environments and should not be used for this position. "Peer Specialist" is the designation used for individuals who self identify as mental health consumers and who work in specific peer specialist roles. Second, unless SEH plans to remove these RAs from nursing staffing allocations, they must remain fully available to perform unit assignments. Third, some of the examples of role activities have potential to blur the new RA role with the role of the unit Charge Nurse. **Compliance:** Partial **Current recommendations:** 1. Reinforce the use of comfort plans and ensure integration into the IRPs.

			2. Adjust the RA role title and clarify job functions before the pilot is completed.
LDL	X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Findings:** SEH reported that 88% of the episodes of restraint/seclusion met this requirement. This represents a decrease from 100% during the previous tour. In addition, following the investigation of a series of episodes involving seclusion use, there was some indication that seclusion was used for staff convenience. SEH has taken appropriate action. Group offerings are a primary means of providing active treatment at SEH. However, unit-based group offerings for individuals not attending the TLC remain inadequate, e.g., despite the fact that seven individuals were not in the TLC, one unit had no unit-based group offerings; another unit had only one offering per hour; offerings that appeared on the group schedule were in fact limited to 1:1 interventions and attended by only one person. Where unit-based schedules do exist, it is hard to determine the applicability of specific groups to a newly admitted population or an individual with challenging behaviors. The potential relationship between hours of active treatment and seclusion or restraint use merit review. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Determine and resolve barriers to unit-based groups as well as TLC attendance. 2. Review the number of active treatment hours provided to

			individuals involved in seclusion or restraint use.
LDL	X.B.3	are not used as part of a behavioral intervention; and	**Findings:** See VIII.B.1.c **Other findings:** See VIII.B.1.c **Compliance:** Substantial **Current recommendations:** See VIII.B.1.c
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Findings:** SEH audit findings show that this provision was met in 100% of the situations that were audited. In the charts that were reviewed during the tour the findings were the same. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.
LDL	X.C.1	the specific behaviors requiring the procedure;	**Findings:** SEH reports that audit findings from March – August revealed that the order specified the behaviors requiring R/S in 94% of the situations reviewed. 100% of the charts reviewed during the

			tour met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.2	the maximum duration of the order;	**Findings:** SEH reports that audit findings from March – August revealed that 100% of the records reviewed met this requirement. 100% of the charts reviewed during the tour also met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain 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;	**Findings:** SEH reports that audit findings from March – August revealed that 88% of the records reviewed met this requirement. 100% of the charts reviewed during the tour met this requirement. **Other findings:** None **Compliance:** Substantial

			Current recommendations: Maintain compliance.
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Findings:** SEH reports that audit findings from March – August revealed that in 100% of the records reviewed (that involved an ordering physician different from the attending physician) met this requirement. 100% of the charts reviewed during the tour met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain 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;	**Findings:** SEH reports that audit findings from March – August revealed that 71% of the records reviewed met the requirement to re-inform the individual every 15 minutes (SEH policy requirement). This requirement was not applicable to the charts reviewed during the tour because the individuals were released. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Proceed with plan to adjust audit tool to align with the provision

			and maintain compliance.
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Findings:** SEH reports that this requirement was met in 88% of the records that were reviewed, representing a considerable improvement over the previous reporting period which was 18%. However, it is not clear how or if the information from debriefings is being used to adjust treatment since a number of the same individuals are repeatedly involved in restraint or seclusion. **Other findings:** None **Compliance:** Partial **Current recommendations:** Continue monitoring to evaluate the degree to which the current improvement plan is effective.
LDL	X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Findings:** SEH reports that audit findings revealed that 88% of the records reviewed met this requirement. **Other findings:** None **Compliance:** Partial **Current recommendations:** Continue monitoring.
LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who	**Findings:** SEH reports that 65% of the records revealed that this

		has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	requirement was met. This is likely to be heavily influenced by the findings relative to NVCI training and should be improved if plans to implement a new module are expedited. See X.A.2 **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.2
LDL	X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	**Findings:** SEH has resolved database issues and now accurately monitors the use of restraints, seclusion, and emergency involuntary psychotropic medications. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current practice.
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	**Findings:** SEH has implemented a High Risk Indicator Tracking and Review Policy as well as a "Tracking Report for High Risk Indicators." The report is maintained on an excel spreadsheet, is extremely detailed, and contains notes reflecting tiered levels of review,

		seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	e.g., by the Directors of Psychiatryand Medical Affairs. Recommendations are reflected in the report. However there was no documentation of follow up to see if treatment plans were modified or if the rationale for not doing so was documented. **Other findings:** Various tracking logs provide detailed information about specific incidents with a heavy emphasis on follow up with specific staff. In most instances, the recommendations that appear on these logs involve sanctions for identified staff members or direction to a department head. On the face of it, the recommendations seem reasonable. However, the fact that some of the recommended actions are already taking place, e.g., competency-based training in specified topics, suggests that further analysis is needed. Looking more broadly at event patterns and at clinically relevant variables would support a more thorough analysis to inform necessary system and process changes. It appears that a huge volume of data emerges from very complex and detailed systems. Not all data sets contain clinically relevant variables, especially those that may be associated with violence as well as seclusion or restraint use. In addition, analysis of the data is at times limited and fragmented. This situation may well distract from and obscure the ability of hospital leadership, and especially clinical leadership, to identify root causes of emerging issues across the hospital. It may be time for SEH to evaluate the utility of the massive amount of data being collected, with an especially critical eye on whether or not the data inform or distract from necessary clinical improvements. **Compliance:** Partial

			Current recommendations: 1. See X.A.1 and X.B.1 2. Review and evaluate the utility of existing data sets. Determine if different data sets and/or summaries for trend analysis are needed.
	X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	Please see sub-cells for findings and compliance.
LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Findings:** SEH has successfully developed a database enabling them to evaluate Emergency Involuntary Psychotropic Medication (EIPM) use. The Pharmacy and Therapeutics Committee is reportedly responsible for reviewing these data. A review of the data base and individuals' records revealed that a number of individuals received EIPM over the course of several weeks. In some instances, the IRPs did not include strategies to deal with repeated violent episodes. Often there was no evidence of IRP review or adjustment following the repeated use of EIPM. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Monitor the use of EMIP. 2. Determine barriers to addressing violence in IRPs.

			3. Develop a simple mechanism to evaluate IRP changes following tiered levels of review.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Findings:** See X.F.1 SEH reports 90% adherence to this provision. In the records that were reviewed, there was consistent evidence of physician assessment immediately prior to the administration of the emergency involuntary psychotropic medication. **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.F.1
LDL	X.F.3	the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.	**Findings:** See X.E and X.F.1 Although SEH reported 100% adherence to this provision, the findings of record review, as well as other reports and data, do not confirm this level of adherence. The "Tracking Reports for High Risk Indicators" tracks individuals who have met designated thresholds, and documents tiered levels of review. Recommendations are reflected in the report; however there was no documentation of follow up to see if treatment plans were modified or if the rationale for not doing so was documented. This report also does not appear to contribute to the identification of trends. For example, the Pharmacy and Therapeutics Committee minutes (February 9, 2011) reflect that

			44 individuals had more than three EIPMs in January. This is a substantial number. However, there was no documented analysis, trend identification, or proposed actions. Trended data from the high risk tracking logs could be useful to this committee. **Other findings:** A review of the Pharmacy and Therapeutics Committee minutes reveals *summaries* of the EIPM data, but not an *analysis*. While there is a lot of data being collected for this issue and others, the data sets do not contribute to an understanding of the factors contributing to repeated use of EIPM. For example, one would expect to see clinically relevant data that will assist SEH to understand the clinical circumstances associated with EIPM such as diagnoses, length of stay, categories of individuals' triggers, whether or not processes to provide medication over objection were initiated in a timely manner, whether or not the IRP addressed issues associated with repeated administration of EIPM. **Compliance:** Partial **Current recommendations:** Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes.
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	**Findings:** See X.A.2 Emergency involuntary psychotropic medication use has been integrated into the competency-based training on restraint and seclusion. 100% of new employees and 92% of existing employees have received this training.

		less restrictive interventions.	**Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain current levels of practice.

	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.

BJC		By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.	**Summary of Progress:** 1. Since the last review, the hospital has closed Annex A and Annex B, the last remaining units in the old hospital buildings. Presently, all individuals in care are housed in the new hospital—a state-of-the-art facility designed with attention to providing a safe physical environment. Each unit has a comfort room where individuals in care can move away from activities on the unit and access sensory comforting materials. The seclusion room is located directly behind the nursing station separated by clear plastic windows that permit direct observation of the individual in the seclusion room by staff in the nursing station. The hospital is equipped with video cameras in strategic locations. As illustrated in a later section of this report, these video tapes have been helpful in determining the actions (and timing) of individuals and staff during incidents. Crowding and its potential for aggression is diminished with the availability of two common sitting and television viewing areas on each unit. Bedrooms and bathrooms are designed to minimize the risk of self-harm. Wardrobes have sliding doors rather than hinged doors, and bathrooms provide privacy through curtains hung from ceiling tracks, eliminating stall uprights. Furniture in the courtyards is bolted to the patio, so that it cannot be used as a weapon. 2. The hospital's policies clearly state the responsibility of all staff members to report allegations of abuse and neglect. They state further that staff who fail to report are subject to disciplinary action, which could include termination. Reporting responsibilities are also covered during orientation training and in annual A/N/E reporting training. The Risk Manager is responsible for notifying the DMH Office of Accountability of any major unusual incident and he investigates or supervises the investigation of all major unusual incidents. He is presently assisted in investigating incidents by the Incident Review Specialist who began these duties in

			September 2010. 3. As stated in earlier reports, the review of criminal background checks is completed by the licensing body for all licensed staff members. This practice has not changed.

	XII. Incident Management		
BJC		By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	**Summary of Progress:** SEH policies define incidents and address the reporting, investigation and review of incidents. Incident reports are entered into a database that includes essential variables, such as persons involved, incident type, date, time, location, level of injury, a rating of the severity of the incident and a short description of the circumstances of the incident. Each day the Risk Manager reviews the nursing report to identify any events that would constitute an incident but which were not reported as such. If he finds such an event, he makes a call to the unit and requires that an incident report be completed. The SEH Risk Manager, assisted by the Incident Review Specialist, investigates major unusual incidents at the hospital. In compliance with hospital policy, the investigations include face-to-face interviews with the parties involved, a review of the incident history of the alleged perpetrators and victims, and a determination of whether the allegation under review is substantiated or not substantiated. The investigation report may conclude with recommendations for correction or prevention of recurrence of similar incidents. Each investigation is documented in an investigation report which is approved by the Risk Manager and the Director of Performance Improvement.
BJC			**Methodology:** <u>Interviewed</u>: S. Bergmann, Director, Performance Improvement Department A. Kahaly, Risk Manager and Supervising Investigator J. Rich, Incident Review Specialist/Investigator <u>Reviewed</u>: 1. Policy 302.1-03: Unusual Incident Reporting and

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<td>Documentation
2. 14 investigation reports
3. A/N/E annual training dates for staff members
4. Aggregate incident data from PRISM
5. Frequency of Assaultive Behavior Study
6. Recommendations database
7. Risk Management Investigation Log
8. Unusual Incidents and Time Study
9. Falls study
10. Recommendations Database print-out
11. CFRs and IRPs of eight individuals on High Risk lists: PN, JV, BW, CT, AB, FH, HM, EO</td>
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<tr>
<td>BJC</td>
<td>XII.A</td>
<td>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:</td>
<td>Findings:
Policy 302.1-03: Unusual Incident Reporting and Documentation was revised effective April 5, 2011. It requires that investigations be completed in 45 days unless the Office of Accountability is notified that an extension is required for completion.
Those investigations not completed by the Risk Manager are supervised by him and he indicates his approval by his signature on the last page of the report. All investigation reports are then reviewed by the Director of Performance Improvement who indicates her approval by her signature.
As shown in the table below, 8 of the 14 sampled investigations were completed within 45 days. Review of the opening and closing dates of investigations on the Investigations Log indicates that investigations closed in February and later generally met the 45-day timeline.

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<tr><td>Incident Type</td><td>Incident</td><td>Date Rec’d in</td><td>Date Closed</td></tr>
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<tr><th>Allegation of:</th><th>Date</th><th>Risk Mngment</th><th></th></tr>
<tr><td>Neglect</td><td>2/28/11</td><td>2/28/11</td><td>4/8/11</td></tr>
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<tr><td>Abuse</td><td>10/22/10</td><td>10/22/10</td><td>1/11/11</td></tr>
<tr><td>Neglect</td><td>11/16/10</td><td>11/16/10</td><td>1/18/11</td></tr>
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<tr><td>Abuse</td><td>1/21/11</td><td>1/21/11</td><td>3/15/11</td></tr>
<tr><td>Neglect</td><td>12/5/10</td><td>12/5/10</td><td>2/8/11</td></tr>
<tr><td>Neglect</td><td>2/10/11</td><td>2/14/11</td><td>3/25/11</td></tr>
<tr><td>Neglect</td><td>3/28/10</td><td>3/28/10</td><td>5/13/11</td></tr>
<tr><td>Abuse/ Neglect</td><td>10/27/10-11/5/10</td><td>11/5/10</td><td>12/20/10</td></tr>
<tr><td>Abuse/Neglect</td><td>10/27/10-11/5/10</td><td>11/5/10</td><td>11/24/10</td></tr>
<tr><td>Abuse/Neglect</td><td>10/27/10-11/5/10</td><td>11/5/10</td><td>11/22/10</td></tr>
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Compliance:
Substantial

Current recommendations:
1. Continue current investigation report approval processes and recent timely completion of investigations.
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<td>BJC</td>
<td>XII.A.1</td>
<td>identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;</td>
<td>Findings:
All of the investigation reports reviewed identified the type of allegation using the definitions of the 21 types of major incidents in the Unusual Incident Reporting and Documentation policy.

In two investigations reviewed, the summary of the incident did</td>
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			not match its identification as an allegation of abuse. • The report of the investigation of the sustained alleged physical abuse of AP (10/22/10) labels the incident as an abuse allegation and identifies the alleged staff perpetrator. Yet, the Unusual Incident Report written by a direct support staff member describes only the out-of-control behavior of AP and her placement in four-point restraints. • Similarly, in the investigation report of the sustained allegation of physical abuse of CD (1/21/11), the summary of the incident as written on the Unusual Incident Report by a direct support staff member describes only CD's threatening behavior and the staff's action in taking him to the floor, asking him to calm down and escorting him to the quiet room. **Compliance:** Partial **Current recommendations:** In instances where the UI report does not accurately describe the allegation under investigation, the investigator should insert a description of the alleged misconduct that is actually under investigation.
BJC	XII.A.2	immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Findings:** The Unusual Incident Reporting and Documentation policy clearly states the responsibility of each staff member involved in the identification, reporting and investigation of incidents and the timeframes within which the required actions are to be completed. See XII.B.1 for discussion of staff members' failure to report the abuse and neglect of [redacted], who was confined in the locked seclusion room for portions of evening and night shifts for ten days

			(October 27-November 5, 2010) without a physician's order. **Compliance:** Partial—in view of the failure of staff to report the incidents of [redacted] mistreatment. **Current recommendations:** Continue current practice.
BJC	XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Findings:** In 9 of the 14 investigations reviewed, one or more alleged staff perpetrators were identified by name. In four investigations the named staff members (alleged perpetrators) were removed from all patient contact and in an additional two investigations the named staff members were removed from contact with the alleged victim. In the remaining eight investigations either the alleged perpetrators were not identified (these were primarily investigations of neglect) or, although identified, were not removed from contact with the victim. **Other findings:** The policy that addresses the removal of staff members named in A/N/E allegations, Unusual Incident Investigation (302.4-09), was revised effective April 4, 2011. The policy calls for the named staff member to be "immediately removed from any individual in care areas, assigned to other duties pending the outcome of the investigation, or placed on administrative leave consistent with any collective bargaining agreement or DC law." The exception to the above occurs in the following circumstance: "Upon the written request of the employee's supervisor, the Assistant Director of Nursing or applicable Executive Staff member shall consult with the Risk Manager and determine whether the staff member may be permitted to provide clinical

			services. In the event that the applicable Executive Staff member concludes the employee does not need to be reassigned from clinical duties or placed on administrative leave, he or she shall ensure that the employee does not have contact with the putative victim." In 3 of the 14 investigations reviewed the alleged perpetrator was identified but was not removed from contact with the alleged victim. These investigations included the following: • The sustained abuse allegation in which a staff member failed to follow hospital policy for initiating four-point restraint for AP, an individual in care. However, the staff member was not a regular staff member on the unit in question and so did not have regular contact with AP. • The sustained abuse allegation in which the staff member was found to have used more force than was necessary in reacting to CD, an individual in care, and to have placed him in a physical prone restraint. • The substantiated neglect allegation in which CD, while on 1:1 observation, was not prevented from swallowing pieces of a compact disk. The Charge Nurse was also found to have failed to provide adequate supervision to the staff member providing the enhanced observation. In each of these three instances and in all of the investigation reports reviewed, the investigation report states that the decision to remove or not remove the alleged staff perpetrator was made in agreement with the Risk Manager. **Compliance:** Partial **Current recommendations:**

<table>
<tr><td></td><td></td><td></td><td>1. When a staff member named in an allegation of A/N/E is not removed under the exception in Policy 302.4-09, the investigation should include documentation of this circumstance.</td></tr>
<tr><td>BJC</td><td>XII.A.4</td><td>adequate training for all staff on recognizing and reporting incidents;</td><td>Findings:

The hospital's data indicates that in the review period March 1-September 20, 2010, 691 staff members were required to attend annual A/N/E training, and 601 (87%) actually attended. All staff who attended the training successfully demonstrated competency, according to the hospital.

As shown below, in a sample of staff members selected from the investigations reviewed and provided to the hospital, 2 staff in the sample of 12 were two years tardy in attending annual A/N training. Two other staff members were overdue by about a month.
<table>
<tr><th>Staff</th><th>Date of Hire</th><th>Most recent A/N Training</th></tr>
<tr><td>_M</td><td>8/29/73</td><td>2/5/09</td></tr>
<tr><td>_G</td><td>7/31/97</td><td>3/10/11</td></tr>
<tr><td>_J</td><td>11/12/98</td><td>3/28/11</td></tr>
<tr><td>_G</td><td>9/27/99</td><td>3/8/09</td></tr>
<tr><td>_Z</td><td>12/19/90</td><td>5/2/11</td></tr>
<tr><td>_S</td><td>2/17/98</td><td>3/23/11</td></tr>
<tr><td>_D</td><td>9/2/08</td><td>3/24/11</td></tr>
<tr><td>_D</td><td>11/12/85</td><td>3/23/11</td></tr>
<tr><td>_M</td><td>7/28/03</td><td>2/16/11</td></tr>
<tr><td>_S</td><td>10/6/03</td><td>3/22/10</td></tr>
<tr><td>_M</td><td>1/7/87</td><td>3/19/10</td></tr>
<tr><td>_A</td><td>5/12/08</td><td>4/29/11</td></tr>
</table></td></tr>
</table>

			* Only last initials are provided to protect confidentiality. **Compliance:** Substantial **Current recommendations:** 1. Continue to monitor attendance at annual A/N training. Consider linking attendance with performance evaluations.
BJC	XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	**Findings:** The obligation to report incidents is covered in New Employee Orientation training (two hours) and in annual A/N training (one hour). Hospital policy clearly states this obligation and the procedures for reporting incidents. **Compliance:** Substantial **Current recommendations:** Continue current practice of requiring annual A/N training for all staff members and monitoring attendance.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Findings:** The units toured had a rights poster in a common area. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Findings:** On the face sheet of each investigation report reviewed, the

			question "Has there been an arrest in this case?" was asked and answered. None of the reports reviewed indicated an arrest had been made. This was appropriate in all cases reviewed. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Findings:** The Unusual Incident Reporting and Documentation Policy (revised 4/5/11) addresses the issue of retaliation in stating that any staff person, individual, family member, or visitor who, in good faith, reports an allegation of suspected abuse, neglect, or exploitation of an individual shall not be subject to retaliatory action by SEH, DMH, and/or the Government of the District of Columbia, including, but not limited to threats, reprimands, discipline, harassment, or censure, except for appropriate counseling, reprimands, or discipline due to an employee's failure to report an incident in an appropriate or timely manner. **Other findings:** The hospital reports that there were no instances of retaliatory action against a person reporting an allegation of A/N/E. I saw no evidence of or reason to suspect retaliation in the investigation reports reviewed. **Compliance:** Substantial-based on a limited sample. **Current recommendations:** Continue current practice of being mindful of the possibility of

			retaliation for reporting or promises of favor for not reporting.
BJC	XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Findings:** The Unusual Incident Reporting and Documentation Policy (revised effective 4/5/11) and the Unusual Incident Investigation Policy (302.4-09), (revised effective 4/4/11) collectively address the components of an incident management system from identification, reporting, investigation and review. Incidents are entered into a database which can be queried on numerous essential variables: persons involved, type of incident, location, day and time, injury, and severity of incident, as examples. Major unusual incidents are investigated or supervised by the Risk Manager. Investigation reports are approved by the Director of Performance Improvement. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Findings:** Policy 302.09 Unusual Incident Investigation (revised 4/4/11) specifically states the expectation that investigations will be independent, thorough, and comprehensive, and will reach fair and unbiased findings based on the preponderance of evidence. The hospital conducted three investigations into the abuse and neglect of [redacted], who was confined in locked seclusion for portions of the evening and night shifts for ten days (October 27-November 5, 2010) without a physician's order. The investigations

			were comprehensive, addressed issues of abuse and neglect, violations of nursing policy and restraint/seclusion policy, and failure to report incidents. The investigation reports are clear and thoughtful, and call for disciplinary action and programmatic changes. The time stamped video of the seclusion room permitted investigators to identify the exact times and length of [redacted]'s confinements. This information permitted the investigators to identify those staff members who had documented that they were observing [redacted] in the day room, bedroom, or elsewhere at the same time he was filmed in the seclusion room. At the conclusion of the three investigations, which named 17 staff members alleged to have engaged in misconduct, 15 were found to have neglected and abused [redacted] by placing or maintaining him in locked seclusion without a physician's order, 10 staff were found to have falsely documented enhanced observation checks or security checks, and seven staff were charged with failure to report the incidents. Clearly, many of the 17 named staff were cited for more than one violation. Ten staff members were placed on administrative leave. Other disciplinary actions have been taken or are in process. The video footage documenting the restraint of CD on 1/21/11 was essential in verifying the prone restraint of CD and the position of the staff member executing the restraint. **Compliance:** Substantial **Current recommendations:** Continue current attention to comprehensiveness and fairness in

			investigations and clarity in investigation reports.
BJC	XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	**Findings:** The hospital remains in substantial compliance with this portion of the Settlement Agreement, as both the Risk Manager and the Incident Review Specialist have received investigator training and have years of experience in investigating incidents. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	**Findings:** Two investigations reviewed evidenced needed improvement related to the timeliness of interviews. In the investigation of neglect of BH, who was left behind on the unit on 2/28/11 when all other individuals had left for the TLC, BH was interviewed on March 1. However, all staff members involved were not interviewed until March 31, including the staff member who found BH. In the investigation of the allegation of abuse of AP (10/22/10), the initial interview was conducted on December 3 and the remaining interviews between December 3-8, 2010. Notwithstanding the isolated problems with the interviews cited above, in contrast to the findings in the previous report, all identified victims, alleged perpetrators and identified witnesses were interviewed and a summary of each interview was provided along with the date and time it was conducted in the investigation reports reviewed. For example, AO initially alleged that he was verbally abused by a staff member while he was in the medication line. During his interview, the investigator asked AO if any other

			individuals in care saw or heard the incident; AO offered the names of two individuals. These individuals were interviewed and denied hearing the staff member use offensive language toward AO, but rather said that it was AO who was verbally abusive toward the staff member. AO acknowledged these same two individuals chastised him at the time for the offensive language he used with the staff member in question. **Compliance:** Substantial **Current recommendations:** 1. Conduct interviews as near to the time of the incident as possible to avoid raising questions about the validity of the information provided.
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.	**Findings:** The hospital investigated three incidents involving the same individual in care, CD, who swallowed inedible, harmful objects and was on 1:1 enhanced observation during two of these events. Specifically, CD swallowed two toothbrushes on 11/29/10, broken pieces of a compact disc on 12/5/10, and a fork, pen, and pen top on 1/29/11. The investigation of the 12/5/10 incident (approved on 2/9/11) concluded with four recommendations, one of which was to update the current Level of Observation policy. The policy was revised and is awaiting approval. The anticipated effective date is June 1, 2011. The corrective actions taken in regard to three of the staff members involved in the repeated locked seclusion of [redacted] indicated that the hospital treated these incidents seriously: Misconduct — Hospital HR Response

			<table><tr><td>Falsification of records, failure to cooperate with the investigation, failure to observe safety precautions</td><td>Proposed: several weeks suspension</td></tr><tr><td>Unauthorized use of seclusion</td><td>Termination</td></tr><tr><td>Unauthorized use of seclusion</td><td>Termination</td></tr></table> Disciplinary action was taken in other of the investigations reviewed as well. In an investigation that included the allegation that a staff member was arguing with a co-worker which contributed to the co-worker neglecting an individual, the case is under review by HR for disciplinary action. The Recommendations Database also tracks recommendations made at the conclusion of investigations for disciplinary action and retraining on specific topics for specific staff members. One staff member's name appears several times as referred for possible discipline. In following up, I learned that this staff member resigned in September 2010. **Compliance:** Substantial **Current recommendations:** 1. Continue tracking recommendations for programmatic and staff-specific corrective actions identified in investigations.
BJC	XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Findings:** Since the last review, the Performance Improvement Department has developed the Recommendations Database by compiling (from current documents and some dating back several years), reviewing and presenting to hospital leadership for approval recommendations for improving hospital performance made as a

			result of incident investigations, studies of specific issues, or submitted by a hospital committee. This database includes the following elements: the issue (from which one learns the source of the recommendation), the recommendation, the staff member responsible for implementation, the target date for implementation and the current status (e.g., initiated but not implemented). A current print-out from this database shows a total of 89 recommendations — eight of which are identified as Initiated but not Implemented, 55 as Implemented/Closed, and 26 identified as Implemented and Requiring Continuing Monitoring. The hospital was able to produce on request documents supporting the identification of several systemic recommendations as Implemented: • Recommendation: Ensure restraint and seclusion training includes completion of the Levels of Observation Flowsheets in AVATAR. The hospital produced the Power Point used in this training which addressed the use of the flowsheets. Familiarity with the Level of Observation Flowsheet for use in an episode of R/S is one of nine objectives for the training. • Recommendations: Training should consider implementing a training for all clinical staff and Security personnel on how to appropriately respond to psychiatric emergencies to ensure the safe management of staff and individuals in care. Training should consider offering Nonviolent Crisis Intervention Training at least twice a year. The hospital produced a report from the training database showing that 272 staff members attended and passed Nonviolent Crisis Intervention training from September 2010 to the present. **Compliance:** Substantial

			Current recommendations: Continue maintaining the Recommendations Database and monitor implementation on at least a sample basis.
BJC	XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	**Findings:** The hospital remains in substantial compliance with this Settlement Agreement requirement. The incident database records relevant information on each incident reported. The database also includes recommendations made at the close of investigations. This database can be queried by staff name, name of individual, incident type or date, and other factors as well. **Compliance:** Substantial **Current recommendations:** Continue current practice.
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:	**Findings:** As identified in the cells below, the hospital tracks incidents by several variables, including type and location. Aggression among peers and aggression directed toward staff is a matter of concern to the hospital. The hospital expanded its study of violence to look at its characteristics on each unit and undertook to identify some of the causes of violence and the factors that contribute to violence. Please see the cells below for more detailed descriptions of this work. **Compliance:** Substantial **Current recommendations:**

			Continue implementation of the Risk Indicator policy, maintenance of the Recommendations database and the study of specific issues and concerns, as continued work will yield the ability to assess outcomes.
BJC	XII.E.1	Track trends by at least the following categories:	Please see sub-cells for findings and compliance: The hospital has consistently demonstrated its ability to track and trend data and present it in a useful format. Additionally, various hospital committees and studies have made recommendations for decreasing violence based on this data. These recommendations have been compiled in the Recommendations Database.
BJC	XII.E.1.a	type of incident;	**Findings:** The hospital completed a study of assaults during the period September - November 2010 finding that there were 93 assaults reported—roughly one assault per day, distributed as follow: September -30, October- 26, November- 37 In 28 of the assaults (30%) staff were the target of the assault. Injuries were associated with 45 of the assaults. When an individual in care was involved in an assault, 42% required treatment for an injury. When a staff member intervened in an assault, 17% required treatment for an injury, and when an individual in care assaulted a staff member, 46% required treatment. In a study of assaults resulting in injury for the period May 2010 - March 2011, the hospital found that the monthly number of injury-related assaults ranged from a low of 7 (May 2010) to a high of 32 (February 2011). The monthly mean for May - October 2010 was 16; the monthly mean for November 2010—March 2011 was 19, indicating an upward trend. The March PRISM report indicates that despite a drop in census, the hospital is reporting more unusual incidents and major unusual

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<td>incidents in recent months as shown below. There are 20 types of major unusual incidents,,including A/N/E, death, physical injury, sexual abuse, sexual assault, suicide attempt or SIB, crime, restraint and seclusion, physical assault, medical emergency, and psychiatric emergency.

<table>
<tr><th>Month</th><th>Census</th><th>Total # Unusual Incidents</th><th># Major Unusual Incidents only</th></tr>
<tr><td>May 2010</td><td>313</td><td>207</td><td>138</td></tr>
<tr><td>June</td><td>316</td><td>172</td><td>113</td></tr>
<tr><td>July</td><td>319</td><td>211</td><td>142</td></tr>
<tr><td>August</td><td>317</td><td>220</td><td>143</td></tr>
<tr><td>September</td><td>313</td><td>212</td><td>117</td></tr>
<tr><td>October</td><td>308</td><td>207</td><td>107</td></tr>
<tr><td>November</td><td>303</td><td>236</td><td>181</td></tr>
<tr><td>December</td><td>300</td><td>195</td><td>130</td></tr>
<tr><td>January 2011</td><td>299</td><td>214</td><td>143</td></tr>
<tr><td>February</td><td>292</td><td>217</td><td>146</td></tr>
<tr><td>March</td><td>276</td><td>222</td><td>153</td></tr>
</table>

Compliance:
Substantial

Current recommendations:
1. Continue current practice collecting and analyzing incident data, particularly aggression data.
2. Advance plans to identify injury by victim type—staff or individual in care.</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.b</td>
<td>staff involved and staff present;</td>
<td>Findings:
In each of the investigation reports reviewed where the alleged staff perpetrator was identified, the staff member's incident</td>
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			history was provided. For example, in the report of the investigation of the alleged abuse of LB, two staff members were named as alleged perpetrators. The incident histories showed that one staff member had been a witness in three prior incidents and the other staff member had been the alleged victim of a verbal threat by an individual. Close review of the Risk Management Investigation log found that 55 investigations were conducted during the 9/1/10-4/30/11 review period. Two staff members were named as the alleged perpetrator in more than one investigation during the period. Each was named in two investigations. In 20 of the investigations, specific staff could not be identified as the responsible party for the alleged misconduct; many of these were investigations of neglect. **Compliance:** Substantial **Current recommendations:** 1. Create a list of individuals in care involved in multiple incidents and a list of staff members involved in multiple incidents on a periodic basis.
BJC	XII.E.1.c	individuals involved and witnesses identified;	**Findings:** In response to a request for the identity of individuals in care on Units 1D, 1E and 1F (units with the highest rates of aggression) who were involved in incidents of aggression in December 2010—March 2011(months of highest rates of aggression), the hospital responded with a list of the individuals, the role of each (victim, aggressor, involved), and the date of the incident. Analysis of this list found that several individuals on each unit were aggressors and/or victims in multiple incidents:

			• On Unit 1D, TB was involved in five incidents; in three as aggressor and in two as victim. AW-B and VS were each involved in four incidents as an aggressor. EO and AM were each the aggressor in three incidents. SH was the aggressor in two incidents and the victim in one. • On 1E, TH was the aggressor in six incidents; JN was the aggressor in 11 incidents and the victim in one; CD was the aggressor in one incident and the victim in two. DS was the aggressor in seven incidents. • On Unit 1F, AJ was the aggressor in two incidents and the victim in one; MB was the victim in three incidents; CM was the victim in three incidents and the aggressor in two; WB was the aggressor in four incidents, and AA was the aggressor in seven incidents. Several of the individuals in the incidents cited above were involved as victim or aggressor nearly daily during specific periods of time. For example: JN was involved in 12 incidents in the 19-day period (2/19-3/10/11), SH was involved in three incidents between 3/20-3/23), and AA was the aggressor in seven incidents between 2/2-2/16/11. VS was the aggressor in three incidents on 2/25-2/26/11 and JN was the aggressor in six incidents from 2/19-2/26/11. This finding suggests that it may be helpful for the hospital to include a short-term criterion for inclusion on the high risk list for aggression, such as involvement in two incidents of aggression in seven days. Since the high risk list is published nearly weekly, this criterion would ensure the list is identifying individuals who are currently or very recently have had severe behavioral difficulty and need immediate clinical attention. It would also allow the hospital to evaluate the effectiveness of the clinical intervention provided if these same individuals did not continue to

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<td>appear on the list or did not also appear on the list of individuals involved in three or more incidents in 30 days.

Other findings:
Analysis by the hospital of the 93 assaults noted in XII.E.1.a found that 56 individuals in care were identified as the aggressor. Five of the 56 individuals in care were responsible for 34% of the assaults.
• One individual accounted for 11 assaults,
• One individual accounted for 7 assaults,
• One individual accounted for 6 assaults, and
• Two individuals accounted for 4 assaults each.

Compliance:
Substantial

Current recommendations:
Consider the advisability of identifying individuals on the high risk aggression list who have been involved in multiple incidents of aggression within a short period of time.</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.d</td>
<td>location of incident;</td>
<td>Findings:
The hospital identified the location of the 93 assaults reported in September-November 2010. Units 1A and 1B each had three assaults, while Units 2A, B, C and Annex A had two assaults each. Annex B and TLC Transitional had no assaults at these locations. Those locations accounting for four or more assaults are cited below:
<table>
<tr><th>Location</th><th># assaults</th><th>% assaults</th></tr>
<tr><td>1C</td><td>7</td><td>7.5%</td></tr>
<tr><td>1D</td><td>14</td><td>16%</td></tr>
<tr><td>1E</td><td>7</td><td>7.5%</td></tr>
<tr><td>1F</td><td>15</td><td>16%</td></tr>
</table>
</td>
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</table>

			<table><tr><td>1G</td><td>12</td><td>13%</td></tr><tr><td>2D</td><td>19</td><td>20.4%</td></tr><tr><td>TLC Intensive</td><td>4</td><td>4.3%</td></tr></table> The Performance Improvement Department produced a study of Unusual Incidents and Time (beginning in 6/1/10 to the present) that identified nearly 1500 unusual incidents, nearly 400 of which were incidents of violence/aggression. This study identified the characteristics of incidents, i.e., type, day of the week, and time of day for each unit and the TLCs. The study found that House 1A had the highest number of falls, which made up more than half of the incidents reported by this unit. House 2A had the fewest occurrences of violence in the hospital. House 2B also has a low rate of violence. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XII.E.1.e	date and time of incident;	**Findings:** The hospital identified the time of day of 90 of the 93 assault incidents occurring in September - November 2010. The incidents were distributed as follows: PM shift (3:00-11:00) = 43 (48%), AM shift (7:00-3:00) =38 (42%), and Night shift (11:00PM-7:00AM = 9 (10%). The Unusual Incidents and Time study found that hospital-wide violence peaks around 9:00AM, 1-2PM and 5-7PM. Saturday and Sunday have the fewest reported incidents, followed by Wednesday and Friday. The highest number of incidents was reported on Tuesdays.

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<td>Compliance:
Substantial

Current recommendations:
1. Continue current practice of identifying factors that correlate with incidents of aggression.</td>
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<tr>
<td>BJC</td>
<td>XII.E.1.f</td>
<td>cause(s) of incident; and</td>
<td>Findings:
The hospital reviewed the descriptions of the 93 assault incidents and attempted to identify and categorize the causes as follows:

<table>
<tr><th>Reported Reason</th><th>Frequency</th></tr>
<tr><td>Unknown</td><td>32</td></tr>
<tr><td>Prior Dispute</td><td>14</td></tr>
<tr><td>Impulse Control</td><td>7</td></tr>
<tr><td>Intrusion</td><td>7</td></tr>
<tr><td>Theft</td><td>4</td></tr>
<tr><td>Verbal Argument</td><td>4</td></tr>
<tr><td>Angry with rules-anger directed at staff</td><td>3</td></tr>
<tr><td>Medication Concerns</td><td>3</td></tr>
<tr><td>“No reason”</td><td>3</td></tr>
<tr><td>Paranoid thoughts</td><td>2</td></tr>
<tr><td>Sexual Advance-perceived or actual</td><td>3</td></tr>
<tr><td>Perceived threat, attempt to stop violence, food, lost item, money, frustration with another’s symptoms</td><td>1 each</td></tr>
</table>

Compliance:
Substantial.</td>
</tr>
</table>

			Current recommendations: 1. Continue the work of identifying factors that contribute to violence in the hospital in order to reduce the number of violent incidents whose cause or contributing factors cannot be identified. This may require additional training/mentoring of staff in writing incident reports.
BJC	XII.E.1.g	actions taken.	**Findings:** The incident database includes investigation report recommendations. These recommendations are also compiled in the Recommendations Database which tracks the status of implementation. **Compliance:** Substantial **Current recommendations:** 1. Continue maintaining databases tracking the implementation status of investigation recommendations.
BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Findings:** Effective February 28, 2010, the hospital adopted the High Risk Tracking and Review Policy (Policy 302.5-10), which identifies the criteria for placing an individual on the Behavioral High Risk List for violence, inappropriate sexual behavior, self-harm, suicide, victimization, medication refusal, elopement, and falls, as well as for placing an individual on a Medical High Risk List, which also has eight indicators. This policy identifies three levels of intervention. The first level begins with review by the IRP team and the psychiatrist. In the second level review, the Director of Psychiatric Services reviews individuals involved in three or more unusual incidents in a 30-day period, engaged in multiple or lengthy

			episodes of restraint or seclusion, or who have three or more episodes of emergency involuntary medication administration in a 24-hour period. A third level review by the Clinical Consultation Team is required for an individual who meets the high risk threshold more than once in six months, remains on the high risk list for six consecutive months, or requires placement on the list for the second time within a six month period. The hospital had not yet used the services of the Clinical Consultation Team as of the time of the DOJ tour. Documentation requirements for each level of intervention are specified in the policy, as are monitoring mechanisms. Please see the cell below for findings related to implementation of the High Risk Tracking and Review Policy. **Compliance:** Substantial **Current recommendations:** Consider adding to the criteria for falls and choking a recent history of these events in addition to risk assessments indicating high risk. Add a recent suicide attempt as a risk factor indicating high risk for suicide as well.
BJC	XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Findings:** Please see the cell above for a description of the procedures in the High Risk Indicator Tracking and Review policy for identifying individuals at high risk for specific behavioral and medical conditions and for the review of the treatment of these individuals. **Other findings:** The most recent summary of aggregate data on individuals on high

risk lists (May 12, 2011) states that 46.2% of the hospital population is on a high risk list. Hospital-wide totals are as follows:

Behavioral Risk	# individuals
Violence	40
Inappropriate sexual behavior	16
Self-harm	11
Suicide	2
Victimization	8
Treatment refusal	62
Unauthorized leave	26
Falls	23

Individuals with 3 or more unusual incidents = 23

During the months of April and May 2011, the High Risk Lists were provided to each unit on 3/31, 4/18, 4/20, 4/25, 4/29, 5/2, 5/9, 5/12.

The units display the high risk lists discretely covered on a wall, so that staff can use this reference to learn which individuals are at risk. The list is constructed with the 16 risk areas along the top and the names of the individuals along the left-hand column. An X in the box under a specific risk area aligned with an individual's name indicates the individual is at risk for that behavior or medical condition. The frequency with which the lists were revised and the format used for a display document meant to alert staff who may be unfamiliar with the unit population to those individuals who are at particular risks raise questions that SEH will be addressing as implementation of the policy matures.

Additionally, SEH staff have acknowledged that some timelines

and other requirements in the High Risk Tracking and Review Policy may need to be revised as they are not consistent with the directions sent weekly to the psychiatrists, psychologists, TLC administrators, social workers, nurse managers, and PBS teams identifying the individuals who have been involved in three or more unusual incidents and three or more major incidents in a 30-day period and the responsibilities of the various parties to review the treatment of these individuals.

The May 11, 2011 document titled Risk Indicators includes a listing by name of individuals who have been involved in three or more major unusual incidents in the last 30 days along with the number of each type of incident. This listing yielded findings that: 3 individuals were involved in 5-8 major incidents , and 9 individuals were involved in 3-4 major incidents.

The document also includes a list of individuals identified as the aggressor in 3 or more incidents in the 90 day period 02/01/11-04/30/11. Review of this list found:

# of incidents as aggressor in 90 days	# of individuals
3-4	5
5-6	7
7-9	2
12	2

The document lists 3 individuals as the alleged victim in 3 incidents in the 90-day period and 1 individual who was allegedly the victim in 4 incidents in the same time period.

The Performance Improvement Director explained that the

hospital's expectation is that an individual's high risk status would be identified in the Clinical Formulation Report. Review of the CFRs and IRPs of eight individuals on Behavioral High Risk list and Medical High Risk list yielded the following variable findings:

Individual	Risk Area	Findings
PN	aggression	Current risk factors in CFR include property destruction and aggression. IRP (3/31/11) addresses aggression.
JV	aggression suicide	Current risk factors in CFR include suicide but not aggression. IRP (4/5/11) addresses suicidal ideation and threatening behavior.
BW	Victimization choking & falls	IRP has no objective or interventions related to victimization. IRP addresses choking with a diet modification and several other interventions. IRP addresses falls with PT and use of a walker.
CT	aggression	CFR lists no risk factors. IRP (4/25/11) addresses aggression with medication, and supportive psychotherapy.
AB	sexually in-appropriate behavior	CFR risk factors make no mention of sexually inappropriate behavior. IPR (3/3/10) addresses inappropriate sexual behavior by encouraging attendance at groups addressing sexual addictions.
FH	aggression & falls	CFR makes no mention of either risk. IRP (4/25/11) addresses aggression through verbalizing thoughts of hurting self or others and other interventions.

					IRP addresses falls through attention to post-operative care.	
			HM	aggression & inappropriate behavior	CFR does not specifically address any risk factors. IRP (3/30/11) addresses inappropriate sexual behavior by attendance at relapse prevention groups for sex offenders. Aggression addressed in IRP through attendance at anger management and other groups.	
			EO	aggression	IRP (3/14/11) addresses aggression through development of skills to manage negative impulses and anger.	

Compliance:
Partial –the hospital has developed policies and procedures governing the identification and treatment of individuals at high risk for behavioral and medical conditions. Implementation of this policy began only recently (within the last two months)—making judgments about effective and consistent implementation premature.

Current recommendations:

1. Revise format, production, and distribution schedule of the High Risk lists as necessary to meet the needs of the IRP teams. For example, a bolded list of individuals on high risk lists or revisions in the size of the grid might be more useful to unit staff than the present format which is difficult to read when posted on the wall.
2. Reconcile the timeframes and review requirements in the High Risk Tracking and Review Policy and the directions in the weekly notification of individuals who have reached the 3 or more incidents threshold.

	XIII. Quality Improvement		
BJC		By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	**Summary of Progress:** 1. The hospital has taken steps to reduce the level of violence, the prevalence of which has continued to increase. The initiatives include the development or revision of policies that form the framework of a risk management system that provides a hierarchy of clinical review for individuals who reach any of eight behavioral and eight medical risk categories, and who reach a threshold of three or more incidents in 30 days (described in XII.E.2] 2. This policy requires some revision to ensure that the timeframes set for clinical staff to respond are achievable and to ensure that terms, such as trigger and threshold, which have a specific definition in the policy, are used consistently in training and in instructions to staff and other documents. 3. Implementation of this risk management system began in mid-March. High risks lists identifying individuals at risk for behaviors and medical conditions are developed by the Performance Improvement Department and provided weekly to each unit. 4. Under the direction of the Performance Improvement Director, the hospital has compiled into a database (effective the end of February 2011) recommendations from investigations, studies, and committee deliberations. This database includes the name of the staff member responsible and the target date for implementation. As recommendations are implemented, this information is entered into the database, permitting the reader to learn the current status of each recommendation. 5. The hospital has recently revised, developed or has under development policies directly affecting the safety of individuals in care. These include: • Security Checks and Unit Safety (5/16/11) • Levels of Observation (6/1/11-expected date of finalization)

			• High Risk Indicator Tracking and Review (2/28/11) • Quality Assessment/Performance Improvement (4/4/11) • Unusual Incident Reporting and Documentation (4/5/11) 6. SEH has reviewed incidents of violence in the hospital using different time frames, and has sorted the data by variables such as individuals involved, the day of the week, and location of the incident. It has identified individuals who are frequent aggressors and frequent victims, and has attempted to identify the causes of violence and circumstances that are associated with violence. 7. A study of falls, prompted by data indicating that Unit 1A had a disproportionate number of fall incidents, resulted in corrective actions by unit staff. 8. Since the last review, the hospital has revitalized the Violence Reduction Initiative. In addition to the initiatives described above, the hospital has undertaken projects such as: • House Support and Analysis Project—the goal of which is to establish a positive, interactive working relationship between house-based staff and PID staff so that house-based staff will advise PID of issues/concerns to address systemically and so PID staff can fill requests from units for specific data and analysis. • PID's continuing study of physical assaults. Completed thus far: study of aggression on a unit-by-unit basis and analysis of unusual incidents and times. • The Recovery Assistant Peer Support Leadership Program • Food Service Review • Special Studies—beginning in the third quarter 2011, PID and the Office of Statistics and Reporting will conduct a special study designed to highlight emerging issues and improve clinical practice.

<table>
<tr>
<td>BJC</td>
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<td>Methodology:

<u>Interviewed</u>:
1. S. Bergmann, Director, Performance Improvement
2. R. Gupta, MD, President of the Medical Staff
3. R. General, Lead Recovery Assistant
4. G. Tyler, Lead RA on 1E

<u>Reviewed</u>:
1. High Risk Lists for 4/18/11-5/12/11
2. Weekly Assault Data
3. Psychiatry notes for seven individuals involved three or more major incidents in 30 days: FH, LS, EO, VS, AA, HJ, TH
4. Violence Reduction Initiative presentation
5. Violence Reduction Initiative Meeting minutes, November 2010—April 2011
6. Performance Improvement Projects document
7. Performance Improvement Committee minutes, September 2010 – February 2011
8. Falls study</td>
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<td>BJC</td>
<td>XIII.A</td>
<td>Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.</td>
<td>Findings:
Consistent with its concern about violence in the hospital, the Performance Improvement Department produces weekly assault data. Review of this data for each week in the 18-week period 12/31/10-5/05/11 reveals that the number of weekly assaults ranged from 7 (three separate weeks, including 4/29-5/5/11) to 19 (4/22-28/11). The remaining distribution:

<table>
<tr><td># of weekly assaults</td><td># of weeks</td></tr>
<tr><td>8-9</td><td>6</td></tr>
<tr><td>11-13</td><td>4</td></tr>
<tr><td>16-18</td><td>4</td></tr>
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The High Risk Indicator Tracking and Review policy states that the Director of Psychiatric Services or designee shall review an individual who has been involved in 3 or more incidents in a 30-day period "regardless of whether that individual is a victim, aggressor or witness." This review follows a review by the IRP team and the psychiatrist. The policy requires the psychiatrist and the Director of Psychiatric Services to document their findings and recommendations.

Review of the clinical records of seven individuals who met the threshold for review by the Director of Psychiatric Services yielded positive findings:

Individual	Incident Type (frequency)	Psychiatrist's review documented	Dir. of Psychiatric Services' review documented
FH	Falls (3)	Yes on 4/16/11	NA—computer difficulty
LS	Violence (2) Medical Em-ergency (1)	Yes on 4/5/11 w/ recommendations	Yes on 4/13/11 w/ recommendations
EO	Violence (3)	Yes on 4/7/11 w/ recommendations	Yes on 4/27/11 w/ recommendations
VS	Violence (4)	Yes on 4/5/11 w/ recommendations	Yes on 4/11/11 w/ Recommendations
AA	Violence (7)	Yes on 2/5-8/11 w/ recommendations	Yes on 2/28/11 w/ recommendations
HJ	Violence (8)	Yes on 3/21,22/11 w recommendations	Yes on 4/25/11 w/ Recommendations
TH	Violence (4)	Yes on 2/28/11 w/ recommendations	Yes on 2/28/11 w/ recommendations

For the time periods March 23 - April 21, March 9 - April 7, and March

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<td>16 - April 14, 2011, the hospital monitored the clinical response to individuals who met the threshold for three or more incidents in 30 days. The findings were reported as follows:
<table>
<tr><th>Time period</th><th># individuals</th><th># incidents documented</th><th># individuals for which a Psychiatrist review was documented</th><th># individuals for which a Medical Dir. review was documented</th></tr>
<tr><td>3/9-4/7</td><td>4</td><td>20</td><td>1</td><td>3</td></tr>
<tr><td>3/16-4/14</td><td>10</td><td>32</td><td>7</td><td>0</td></tr>
<tr><td>3/23-4/21</td><td>5</td><td>17</td><td>3</td><td>0</td></tr>
</table>
The hospital's policy regarding the conditions under which a review by the Medical Director is required and the directions sent to treatment teams are not consistent. This may account for the low number of Medical Director reviews in the hospital's sample.

Compliance:
Substantial — based on a limited sample and at early stage of implementation.

Current recommendations:
1. Continue to review implementation of the High Risk Indicator Tracking and Review policy as staff become more familiar with their duties and responsibilities.
2. Ensure consistency in documents defining timeframes and the conditions when a review by the Medical Director is required.</td>
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<td>BJC</td>
<td>XIII.B</td>
<td>Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement</td>
<td>Findings:
The hospital addressed the problem of falls with the collection of data sorted by multiple variables and identified the factors contributing to these incidents. SEH identified that Unit 1A was the scene of a</td>
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		process. Such plans shall identify:	disproportionate number of falls. The data indicated that in the period May –O ctober 2010, 1A was the scene of 40 falls involving 26 unique individuals. The study determined whether the individuals were on fall precautions, the individuals' level of activity, the location of the fall and whether the fall was witnessed. In looking for outcomes, the study found that 20 falls resulted in a change in the plan of care. The study determined that the primary factors precipitating the falls were improperly fitting footwear, dayroom seats that do not have arms or arms of sufficient height, and the slightly protruding legs of the chairs in the dining room. Staff responded by providing closer monitoring and assisting individuals as they change position, making sure individuals' shoe laces are tied, and reminding individuals to pick up their feet (rather than shuffle). The hospital is considering the use of non-slip socks. See also XIII.C for follow-up regarding the hospital's identification of the need for a clearer policy on levels of enhanced observation. **Compliance:** Substantial—based on a limited sample and at early stage of implementation. **Current recommendations:** 1. Continue to comprehensively study factors that impact the safety of individuals in care and identify and track implementation of corrective measures.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Findings:** As described in XII.C, the hospital has compiled recommendations from investigations, studies, and committees. Review of this document indicates that the following sample of recommendations have been implemented, sustained, and closed (monitoring is not warranted). • Creation of a policy for drug and alcohol screening of new

			employees and of employees that are reasonably suspected of being under the influence or using illicit drugs. • Development of a procedure for correcting errors in AVATAR. • Circulation to medical affairs and nursing of a tip sheet on how to access the immunization record for individuals in AVATAR. • Provide retraining for staff on the timely reporting of unusual incident reports. • Creation of a system and timelines to routinely check and inspect doors and gates throughout the facility to ensure they are closing and securing properly. • Staff use of eMar in the administration of medication. • Updating of the Level of Observation policy. • Discussion with nursing and recreation staff who work in the TLCs the importance of adequately supervising and monitoring individuals who come into their area. **Compliance:** Substantial—based on a limited sample and at early stage of implementation. **Current recommendations:** Continue current practice of tracking recommendations and updating the database to include the current status of implementation as determined by monitoring on at least a sample basis.
BJC	XIII.B.2	the anticipated outcome of each step; and	**Findings:** Enhancing the safety of individuals in care and reducing aggression and violence directed against peers and staff are the anticipated outcomes of the initiatives undertaken by the hospital in the last several months. More specifically, in the review of individuals at risk for aggression to self or others or victimization, the risk management system embodied in the High Risk Tracking and Review Policy provides for clinical review starting with the treating psychiatrist and team, and continues with

			consultation with a team of senior clinicians if the problem behaviors continue. Studies of specific issues and tracking of the recommendations made similarly advance the desired outcome of a safer therapeutic environment. **Compliance:** Substantial **Current recommendations:** Continue implementation of initiatives aimed at reducing violence and improving the quality of care provided.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	**Findings:** The Recommendations Database includes the name of the staff member responsible for ensuring the implementation of the recommendation and the target date for implementation. **Compliance:** Substantial—based on early implementation of the Recommendations database. **Current recommendation:** Continue current practice.
BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Findings:** A document entitled "Performance Improvement Projects" lists the completed, current, and planned performance improvement projects. The completed projects are listed as: • An analysis of Code 13 alerts • An audit of falls to determine whether there is any correlation between falls and staffing levels, shift, unit, or day of the week • Finalization of the High Risk Indicator policy

			• Creation of a spreadsheet for tracking high risk indicators • A study of the variance between the length of time from admission to SEH to entering treatment at the TLC • Analysis of the frequency of assaults on a unit-by-unit basis • Analysis of unusual incidents and times Projects currently underway include: • A study of STAT medications—whether given voluntarily or involuntarily as well as the frequency of use • Continuing monitoring of recommendations in the Recommendation Database to assess implementation and effectiveness and sustainability • Evaluation of food services and food delivery leading to recommendations and audited for sustainability • Maintaining all lists and information related to the High Risk Indicator Policy Several sets of minutes of the Performance Improvement Committee were difficult to interpret, as they did not clearly identify the issue under the discussion and the "next steps" upon which there was agreement. See particularly the December 2010 minutes which contain, under the topic of physical assault data, the comments: [The chairperson] "would like to have the issue of security walking onto the units with the temperature reading "guns" drawn addressed" and [name] "indicated that staff will be learning violence reduction techniques and will undergo training by self-defense/skilled instructors to held reduce injury to staff." Notwithstanding these issues, the October 27, 2010 minutes include the suggestion that recommendations from investigations and any incident trending data be included as a standing agenda item. In the January 26, 2011 minutes the Risk Manager brought forward a concern from the Risk Management Committee regarding the need for clearer

			definitions in policy of the levels of observation (1:1, 2:1) and staff responsibilities for the observation of individuals on enhanced observation levels. This issue was also raised in the February 23, 2011 minutes. To demonstrated how this concern was addressed, the hospital provided a copy of a draft policy "Levels of Observation" with a proposed effective date of June 1, 2011 ready for approval by the Executive Director. The draft policy clearly defines three levels of special observation and the attendant responsibilities of staff assigning and staffing the special observation. **Compliance:** Substantial—based on early implementation of several projects **Current recommendations:** 1. Work to improve the content of the Performance Improvement Committee minutes so that they clearly identify the issue, why it is an issue, and any resolution agreed upon, including further study or discussion at a later meeting. 2. Clarify the intent of the phrase in the December PIC minutes that suggests staff will be receiving self-defense training.
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	**Findings:** The Performance Improvement Department provided the Violence Reduction Initiative presentation to all staff. It notes that the VRI is run by a committee chaired by the President of the Medical Staff and the Director of Performance Improvement. It identifies as accomplishments: the creation of the Clinical Behavioral Consult Team to provide recommendations and assistance regarding individuals with complex clinical behavioral presentations, enhanced training for Recovery Assistant Peer Specialists—one designated Recovery Assistant on each shift in every house who mentors peers and models de-escalation techniques, and initiation of training by PBS on pilot units in Collaborative Problem Solving Skills.

			As noted, lists of individuals at high risk for behavioral and medical conditions are provided to units weekly, as is aggression data. On a daily basis, psychiatrists receive an e-mail advising them of individuals on the list. The PRISM publication is produced monthly and provides a great deal of data on census, incidents, readmission rates, etc. A list of the 39 Recovery Assistant Peer Specialists finds that about half were previously forensic therapy assistants and the remainder worked on the civil side of the hospital before the merger in the new hospital. In discussions on the units toured with a Lead RA and with several nurses, each spoke positively about the initiative. The Lead RA on 1E explained his responsibilities as attending rounds and report, orienting any floating staff, assisting the Charge Nurse, actively engaging with all of the individuals in care, making sure the other RAs are current in training, and providing any other assistance the individuals, nurse, or other RAs require. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	**Findings:** Because the Recommendations Database was compiled at the end of February and the High Risk Tracking and Review policy had been operational for only 6-8 weeks at the time of the review, it would be premature for either the hospital or a reviewer to comment on the outcomes of these initiatives. The same is true of other initiatives undertaken or under study to address the problem of violence. During the next review, the hospital should be able to demonstrate its internal audit of outcomes achieved and the monitoring team will be able to

			assess with greater confidence the implementation and sustainability of the initiatives. **Compliance:** Partial **Current Recommendations:** 1. Continue implementation of Performance Improvement projects and monitoring of their effectiveness.
BJC	XIII.C.3	modifying corrective action plans, as necessary.	**Findings:** The Violence Reduction Initiative Committee minutes follow several proposals from presentation through revision, dismissal, or implementation. For example: • The January minutes cite the development of a subcommittee to develop a new policy for Code 13s. The minutes ask for volunteer members and for someone to assume responsibility as the Chair. Questions/issues posed include the use of the public address system to announce the codes, mock Code 13 training for unit staff, and the advisability of establishing Code 13 teams. In following up, I learned that the issues are still under discussion. The Medical Officer does not believe a code team is a good solution. • The question of whether to provide staff with shields and heavier gloves when dealing with individuals who are exhibiting very dangerous behaviors or for those situations where individuals need special precautions was raised in the December meeting. In following up, I learned that the decision was made not to invest in shields and heavier gloves. • The November minutes address food issues, such as the timing of meals, eating in shifts, portion size, and the effect of high sugar consumption. Some of these issues have caused aggravation to individuals in care and have led to incidents of

			aggression. In following up, I learned that a workgroup is studying the issue further and making recommendations. **Compliance:** Partial—Many Performance Improvement projects are in the early stages of implementation, as are many of the systemic recommendations from investigations and studies. Thus, it is premature to apply a compliance rating to the hospital's ability/willingness to make changes when implementation did not meet expectations. **Current recommendations:** 1. Continue implementation plans for monitoring the effective implementation and sustainability of initiatives to reduce violence and improve quality of life of individuals in care.
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Findings:** In response to questions about the accomplishments of the Violence Reduction Initiative, Dr. Gupta, Medical Officer, Mr. R. General, and the Performance Improvement Director identified, in addition to the creation of the Behavioral Consult Team and the Recovery Assistant Peer Specialists project, increased activities provided to individuals in care (open gym time, chess tournaments, weekly photography group, movie night [2xmonth] and poetry class). Some of these activities are available only to non-forensic individuals. The hospital hopes to have the resources to expand some of these opportunities to forensic individuals. They also cited the standardization of EARN (a nursing practice requiring two contacts by a member of the nursing staff with each individual each shift), the soon-to-be designated new curriculum and provider of non-violent crisis intervention training, and the revisions in the Restraint and Seclusion policy that are being made. SEH documents attached to Violence Reduction Initiative Committee minutes describe in detail five major PID initiatives:

			• House Support and Analysis Project—the goal of which is to establish a positive, interactive working relationship between house-based staff and PID staff so that house-based staff will advise PID of issues/concerns to address and so PID staff can fill requests from units for any specific data and analysis. • A continuing PID study of physical assaults • The Recovery Assistant Peer Support Leadership Program • Food Service Review • Special Studies—beginning in the third quarter 2011, PID and the Office of Statistics and Reporting will conduct a special study designed to highlight emerging issues and improve clinical practice. **Compliance:** Substantial—based on early implementation of substantive clinical initiatives. **Current recommendations:** Continue implementation of Performance Improvement Initiatives.

	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 new state-of-the-art hospital was designed with safety as a prime consideration, particularly in the elimination of smoking porches, the design of secure courtyards, and in the construction and equipping of bathrooms and bedrooms. 2. The hospital continues to conduct a quarterly environmental survey of 16 areas and 113 standards in all residential units and treatment locations. The first quarter FY 2011 survey found 82% of the houses received an overall rating of acceptable, while 18% were rated problematic; no house was rated unacceptable. Unit 2C received the lowest score (3.1, with a perfect score of 4.0) and Units 2B, 1D, and 1E tied with the highest scores (3.9 each).
BJC			**Methodology:** Interviewed: 1. Several staff on units and in treatment area 2. S. Bergmann, Director of Performance Improvement Reviewed: 1. Environmental Self-assessment Survey Report-First quarter FY 2011 Toured: 1. Units 1A (Allison), 1B (Barton), 1E (Haydon, Civil Admissions), 1F (Shields, Forensic Admissions), 1G (Howard), Transitional TLC
BJC	XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Findings:** The new hospital has maintained substantial compliance in this area. **Compliance:**

			Substantial **Current recommendations:** Maintain vigilance in identifying individuals at risk of suicide and minimizing their opportunities for self-harm.
BJC	XIV.B	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Findings:** No new findings to report. The Control of Contraband policy, effective February 24, 2009 remains in effect. **Compliance:** Remains in Substantial Compliance **Current recommendations:** 1. Continue current practice.
BJC	XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	**Findings:** The single observation that raised the most concern during the tours was the practice on Unit 1E of requiring newly admitted individuals to wear hospital gowns for up to three days, according to the nurse on the unit. She explained that the purpose of this practice is to enable staff to immediately identify new admissions. During our observation, a newly admitted female was wearing a hospital gown without undergarments. This compromised both her safety on a co-ed unit and her dignity. Upon our request the nurse agreed to provide the individual with undergarments. Follow-up on the next day found that the individual was fully dressed in street clothes. For information about staffing, please see the nursing section of the report. **Compliance:** Partial

			Current recommendations: Identify and implement another manner of identifying newly admitted individuals that does not violate the individuals' dignity and place them at risk of harm.
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.	**Findings:** No new findings to report. **Compliance:** Substantial Compliance **Current recommendations:** 1. 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.	**Findings:** No new findings to report. **Compliance:** Substantial Compliance **Current recommendations:** 1. 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.	**Findings:** During the tours, I made no observations of hazardous or unsanitary conditions. Housekeeping staff were working on several units visited. The hospital is in substantial compliance following the closing of Annex A and Annex B. **Compliance:** Substantial

			Current recommendations: 1. Continue current practice.