REPORT 4

St. Elizabeths Hospital
Washington, DC

September 21-25, 2009

	V: Integrated Treatment Planning		
MES and RB		By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.	**Summary of Status/Progress:** 1. Although more work is needed, SEH has made some appropriate revisions in its IRP training curriculum, Manual and Policy to address some of the recommendations from the March 2009 report. 2. Although more work is needed, SEH has made some progress in the development and implementation of an IRP training program and a set of monitoring tools. The training and the monitoring indicators included several elements that were aligned with requirements of this Agreement. 3. Although the content of the IRP still falls short of compliance with requirements of the Agreement, the facility has, in general, made progress in the process of the IRP team conference. 4. The facility has implemented new formats for the initial IRP and the IRP revisions. Overall, the implementation has been timely and the organization of information has improved compared to the older format. 5. There continues to be a lack of conceptual clarity in the proper flow from discharge criteria to foci of hospitalization to objectives. Despite this, IRP conferences functioned in a fairly organized manner. 6. Psychologists and Rehabilitation Services therapists are not routinely attending IRP conferences. 7. SEH has increased the number of scheduled active treatment hours for its individuals. 8. SEH has continued the self-assessment process in reference to all provisions of this Agreement. As in its previous report, the facility's self-assessment was comprehensive and candid.
			Methodology: <u>Interviewed</u>:

			1. Bernard Arons, MD, Medical Director 2. Sumit Anand, MD, Medical Director, Civil Service 3. Tyler Jones, MD, Staff Psychiatrist 4. Feng Dong, MD, Staff Psychiatrist 5. Raj Mathur, MD, General Medical Officer 6. Shomarka Keita, MD, General Medical Officer 7. Josephine Reyes, MD, General Medical Officer 8. Hwa Woo, MD, General Medical Officer 9. Peter Thura, MD, General Medical Officer 10. Syed M. Zaidi, MD, General Medical Officer 11. Edger Potter, MD, General Medical Officer 12. Lendicita Madden, MD, General Medical Officer 13. Richard Smith, MD, General Medical Officer 14. Shandra McDawell McKenzie, Clinical Administrator, RMB 8 15. Judy McDowell, Clinical Administrator, RMB 4 16. Henry L. Jackson, Clinical Administrator, RMB 7 17. Nicole Rafanello, Clinical Administrator, JHP-6 18. Beth Gouse, PhD, Chief of Staff 19. Robert Morin, PsyD, Chief of Post-Trial Branch <u>Reviewed</u>: 1. The charts of the following 51 individuals by Dr. El-Sabaawi: AFB, AK, AS, BC, BW, CB, CC, CL, DA, DC, DJ, DM, DT, FW, GH, GL, GS, HR, JA, JL, JW, KE, KH, KL, LW, MA, MJ, MLA, MM, NL, PJJ, RAM, RB, RG, RH, RJ, RM, RP, RW, RW, SC, SK, TD, TJ-1, TJ-2, TN, TVN, VE, WHM, WW and YL 2. The charts of the following 52 individuals by Dr. Boggio: AA, AH-1, AH-2, AP, BC, BS, CE, CH, CL, CM, CW-1, CW-2, DC, DD, DH, DJ, DT, ED, FW, GM, JA, JJ, JL, JT, KEK, KP, LC, LK, LM-1, LM-2, MA, MH, MJ, MS, ND, OM, PN, PT, RB-1, RB-2, RE, RG-1, RG-2, RH, RM, RP, SW, TJ, TK, TT, VA and WC 3. Saint Elizabeths Hospital (SEH) Self-Assessment Report (September 1, 2009)

			4. SEH revised IRP training curriculum (not dated): a) IRP Overview and Basic concepts; b) Introduction to Planning From a Person-Centered Perspective; c) Key Recovery Concepts; d) Stages of Change e) Engagement; f) Discharge/Transition Planning; and g) Interdisciplinary Recovery Plan Team Meeting Coaching and Team Member Coaching. 5. SEH IRP Manual: a) Membership and Responsibilities of the Interdisciplinary Recovery Team; b) Clinical Formulation; c) Operational Instructions for Clinical Formulation; d) Clinical Formulation Update; e) How to Construct the Needs List; f) Operational Instructions for Initial IRP; and g) Tip Sheet for Completing Objectives. 6. SEH data regarding IRP training provided to its teams during this review period 7. SEH Policy #602.2-04: Interdisciplinary Recovery Planning for Inpatient Services, revised August 13, 2009 8. Engagement Tip Sheet 9. Team Checklist for IRP Meeting at Day 7 of admission 10. Team Checklist for IRP Review Meetings 11. SEH template for the Psychiatric Update, revised July 7, 2009 12. SEH Policy #602.1-08: Assessments, revised August 13, 2009 13. SEH Policy #601-02: Medical Records, revised July 21, 2009 14. SEH template for the Psychiatric Update, revised July 7, 2009 15. Department of Mental Health Recovery and Wellness Guide, revised August 13, 2009 16. SEH Medication Information Manual, Draft, August 2009 17. SEH Consumer Survey results, 2009

			18. SEH Risk Manager Alert: Unusual Incidents Log 19. SEH Policy #111.2-08: Patient Transfers, revised August 13, 2009 20. SEH Description of Monitoring System, Draft (not dated) 21. SEH Clinical Chart Audit tool and operational instructions, July 2, 2009 22. SEH IRP Chart Review and Process Observation Audit Tool 23. SEH IRP Chart Review and Process Observation data summary (February to June 2009) 24. SEH Process Observation Tool and Operational Instructions, revised July 13, 2009 25. SEH Patient Transfer Monitoring Tool (revised June 2, 2009) 26. SEH Patient Transfer Monitoring summary data (March to June 2009) 27. SEH Comprehensive Initial Psychiatric Assessment Self-Audit Tool and operational instructions (August 18, 2009) 28. SEH Comprehensive Initial Psychiatric Assessment Self-Audit summary data (April to June 2009) 29. SEH Psychiatric Update Self-Audit tool and operational instructions (not dated) 30. SEH Initial Psychological Assessment Monitoring Tool and Peer review Form (revised July 16, 2009) and operational instructions (revised May 21, 2009) 31. Initial Psychological Assessment Monitoring summary data (April to July 2009) 32. SEH Rehabilitation Services Assessment Self-Auditing Tool (revised December 05, 2008) and assessment guidelines (May 26, 2009) 33. SEH Nursing Assessment Audit Questions (not dated) 34. SEH Nursing Update Audit Tool and instructions (June 30, 2009) 35. SEH Nursing Assessment/Update Self-Auditing summary data (date of audit not specified) 36. SEH Social Work Initial Assessment Audit Tool and assessment instructions (revised January 2009)

			37. SEH Social Work Assessment Self-Auditing summary data (April to July 2009) 38. SEH Social Work Update Self-Audit Tool (June 18, 2009) and update instructions (May 21, 2009) 39. SEH Therapeutic Progress Note Self-Audit Tool and operational instructions, July 06, 2009 40. SEH Restraint/Seclusion Event Review Tool, July 20, 2009 41. SEH Restraint/Seclusion Event summary data (February to June 2009) 42. Outline of Cognitive Remediation training provided to staff at SEH 43. SEH Policy (draft), Medical Response, July 09, 2009 44. SEH Policy #207-09: Hand-Off Communication Guidelines, August 13, 2009 45. SEH template for the Therapeutic Progress Note, revised June 22, 2009 <u>Observed</u>: 1. Team meeting at JHP-1 for IRP review of MM. 2. Team meeting at JHP-6 for IRP review of CB. 3. Team meeting at JHP-6 for IRP review of CS. 4. Team meeting at JHP-8 for IRP review of CD. 5. Team meeting at JHP-8 for IRP review of VA. 6. Team meeting at RMB-1 for IRP review of BS. 7. Team meeting at RMB-4 for IRP review of RN. 8. Team meeting at RMB-7 for IRP review of SD. 9. Team meeting at RMB-8 for IRP review of AH.

	A. Interdisciplinary Teams		
		By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	Please see sub-cells for findings and compliance.
RB and MES	V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Same as in V.A.2 to V.A.5. • Same as in V.B, V.C, V.D and V.E. **Findings:** Same as in V.A.2 to V.A.5, V.B, V.C, V.D and V.E. The following summarizes the facility's efforts during this review period: 1. Revision of the IRP training curriculum, including the development of specific modules on individual engagement, setting of objectives, discharge/transition planning and stages of change as well as overview of the principles of recovery planning; 2. Reorganization of the process of IRP training including didactic, observational and mentoring components; 3. Revisions of the IRP Policy, IRP Manual and IRP forms, including the clinical formulation update forms to address some recommendations from the March 2009 tour regarding the development of individualized foci, objectives and interventions; 4. Completion of IRP training for four of the facility's 17 units (training is underway for the other 13 units) and

			5. Revision of the IRP self-assessment auditing tools and instructions. Results of these efforts indicate some improvements in the process of IRP training during this review period. However, findings in subsections V.A.2 through V.A.5 and in Sections V.B., V.C, V.D., and V.E show that the facility has yet to make progress in the content of the IRPs. The deficiencies outlined in these areas must be corrected to achieve substantial compliance with these requirements. **Compliance:** Partial. **Current recommendations:** 1. *Same as in V.A.2 to V.A.5.* 2. *Same as in V.B, V.C, V.D and V.E.*
RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Continue with current efforts to hire requisite number of psychiatrists and psychologists. **Findings:** Psychology currently has four vacant positions for treatment team psychologists. For one of the observed IRP conferences, the psychologist entered the room but then left prior to the conference. Hospital data indicates that psychologist presence at IRP conferences is no more than 54%. **Recommendation 2, April 2009:** The psychologist leading the PBS team must **not** have the additional duties of being a unit/treatment team psychologist.

			Findings: A position for PBS psychologist has been developed and is in recruit. Currently, a psychologist with no additional duties is performing this function in an acting capacity. **Compliance:** Partial. **Current recommendations:** 1. Fill all team psychology vacancies. 2. Hire PBS psychologist.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop and fully implement a training program in interdisciplinary recovery planning that emphasizes the role of the team leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences*. **Findings:** Observed IRP conferences generally demonstrated adequate or better functioning in organizational leadership of the IRP process. This was true despite the process being cluttered and redundant in many places. **Recommendation 2, April 2009:** *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of interdisciplinary recovery planning, and add additional training modules as necessary to achieve this goal*.

			Findings: There is still a lack of conceptual clarity in the flow from discharge criteria to foci of hospitalization to measurable objectives despite reported revisions to the training modules. **Recommendation 3, April 2009:** *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference.* **Findings:** While the checklists were modified, observed IRP conferences routinely took more than 1 hour, when checklists indicate that they should have been accomplished within 45 minutes. **Compliance:** Partial. **Current recommendations:** 1. Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. 2. Enhance training efforts to assure that IRP conferences can be completed in the time indicated on the checklists.
RB	V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Develop and (or if developed) implement training in effective ways to engage individuals and their families in the treatment planning conference.

			Findings: A training module entitled "Engagement" was developed and an appropriate training outline was supplied. To date 71.7% of the clinical staff has attended the training. Neither an explanation as to why the other almost 30% was not trained nor a roll-out plan was provided. Additionally, only 5.4% of the clinical staff has completed the module "Planning from a Person-Centered Perspective, and no roll out plan for the remaining training was provided. **Recommendation 2, April 2009:** *Provide a roll out plan for when this training will begin and by what date completion is anticipated.* **Findings:** A roll out plan for the completion of this training was not provided. **Compliance:** Partial. **Current recommendation:** Develop and provide a roll out plan for the completion of training modules related to the IRP process.
RB	V.A.2.c	require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop and implement an auditing tool that monitors for all aspects of the progress note template.* **Findings:** An appropriate audit tool was developed, but no results were available at the time of the visit.

			Recommendation 2, April 2009: Train all auditors to acceptable levels of reliability. **Findings:** Auditors have been identified and trained. **Recommendation 3, April 2009:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Completed. **Recommendation 4, April 2009:** *Ensure that one of the monitored elements includes the alignment of the progress note with the IRP.* **Findings:** Completed. **Compliance:** Partial. **Current recommendation:** Begin monthly audit of 20% of records and present trended data by month.
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop and fully implement a training program in person-centered treatment planning that emphasizes the role of the team*

			leader/facilitator in providing organizational leadership in the conduct of treatment planning conferences. **Findings:** While all observed IRP conferences were organized and run in an appropriate interdisciplinary fashion, it is concerning that only a little over 5% of the clinical staff has completed the training module entitled "Planning from a Person-Centered Perspective," and that no plan for completing the training has been developed or implemented. **Recommendation 2, April 2009:** *Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal*. **Findings:** There continues to be a lack of conceptual clarity in the proper flow from discharge criteria to foci of hospitalization to objectives. None of the reviewed IRPs contained discharge criteria that meet acceptable community standards. **Recommendation 3, April 2009:** *Revise the IRP conference checklists based on auditing data to determine appropriate time allotments for each Phase of the IRP conference*. **Findings:** While the checklist has been revised, none of the observed teams were able to accomplish the IRP conferences in the time allotted. **Recommendation 4, April 2009:** *Separate process auditing of the IRP conference from content*

			auditing of the IRP in the medical record. **Findings:** Completed. **Recommendation 5, April 2009:** Audit a sample of all conferences and charts on a monthly basis and present resulting data aggregated by month for the next 6 months. Continue to audit monthly thereafter. **Findings:** Process has begun. **Other findings:** While the hospital's self-assessment indicated that training had been done on individualized discharge planning and referenced the IRB Manual, no discussion of this topic was found in this manual and none of the reviewed IRPs were found to contain discharge criteria that meet acceptable community standards. **Compliance:** Partial. **Current recommendations:** 1. Revise or provide evidence of training related to the development of individualized discharge criteria. 2. Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. 3. Enhance training efforts to assure that IRP conferences can be completed in the time indicated on the checklists.

MES and RB	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Current findings on previous recommendations:** **Recommendations 1-4, March 2009:** • *Implement the draft behavioral interventions policy and templates.* • *Ensure consistent training of direct care providers on the principles and practice of PBS.* • *Ensure attendance and participation by psychologists in IRP reviews.* • *Ensure documentation, in the psychiatric progress notes, of proper integration of psychiatric and behavioral treatment modalities.* **Findings:** SEH acknowledged that it has made minimal progress in meeting this requirement. The facility reported that no additional training was provided in the implementation of positive behavior support (PBS), that planned recruitment of a dedicated PBS team was delayed and that the contract with the PBS consultant was suspended during this review period due to budgetary issues. The facility also reported that several vacancies at the Psychology Department (currently four) have limited psychologists' attendance at the IRP conferences. Data presented by SEH showed that psychologists' attendance at these conferences has ranged from a low of 44% in March 2009 to a high of 67% in May 2009, averaging 55% for the period. However, vacancies alone cannot explain the low attendance rate; in one IRP conference attended by this consultant, the team psychologist initially entered the room but left before the conference began. SEH reported that several PBS were completed by the team psychologists during this review period. Since the last review, SEH has implemented its new template for the

			psychiatric reassessment (update). The facility expects that this format can improve the integration of psychiatric and behavioral modalities because it includes a prompt to identify specific behavioral and/or psychodynamic issues affecting the individual's lack of progress. Reviews by this expert consultant found that the facility has yet to document proper integration of behavioral interventions and psychiatric treatment. In addition, chart reviews found that too many individuals who were appropriate candidates for behavioral interventions did not receive this modality. **Compliance:** Partial. **Current recommendations:** 1. *Implement the draft behavioral interventions policy and templates.* 2. *Resume and ensure consistency of training of direct care providers on the principles and practice of PBS.* 3. *Ensure attendance and participation by psychologists in IRP reviews.* 4. *Ensure documentation of the psychiatrists' review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation.* 5. *Ensure documentation in the psychiatric progress notes of an exchange of data between the psychiatrist and the psychologist for individuals receiving PBS interventions. This exchange must be utilized to distinguish learned behaviors from those that are targeted for pharmacological therapies and to update diagnosis and treatment, as clinically appropriate.* 6. Re-start work with consultant. 7. Fill vacant treatment team psychologist positions.

			8. Develop a corrective action plan for low attendance rate of psychologists at IRP conferences if this practice continues and is not simply a result of vacancies.
RB	V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Revise audit tool and train auditors. **Findings:** Completed. **Recommendation 2, April 2009:** Audit monthly and present trended data. **Findings:** Completed and ongoing. Hospital data and observations of this consultant are in agreement that problems exist in assuring that PNAs/FPTs, psychologists and rehabilitation therapists are regularly at IRP conferences and that there is little to no input into the conference from the Mall Progress Notes that are in the medical record. **Other findings:** The hospital's self-assessment found that only 44% of IRP conferences occurred according to hospital policy, while in previous months more than 75% occurred according to policy. **Compliance:** Partial. **Current recommendations:** 1. Assure that the Rehabilitation Therapy and Psychology

			Departments are fully staffed. 2. Revise IRP checklists to assure that teams routinely review the Mall Progress Note findings with the individual.
RB	V.A.3	provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Same as V.A.2.a. **Findings:** See V.A.2.a. **Compliance:** Partial. **Current recommendation:** See V.A.2.a.
RB	V.A.4	consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Provide data on the hospital's current progress toward achieving stable core team membership.* **Findings:** There are four vacancies for treatment team psychologists and three stated vacancies in Rehabilitation Services (RS). However, it was reported that RS staff routinely carry a caseload of 50 patients and that there is need for increased recreation therapist, occupational therapists, creative arts therapists and vocational and educational specialists. **Compliance:**

			Partial. **Current recommendations:** 1. Fill current vacancies in the Psychology and Rehabilitation Services Departments. 2. Develop staffing plans to assure that PNAs and FPTs are able to attend IRP conferences on a regular basis.
RB	V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Audit each type of treatment plan monthly. **Findings:** No data was presented for 30 days teams and it is not clear that the hospital currently has implemented the requirement for 30 days teams. **Recommendation 2, April 2009:** Present as trended data. **Findings:** Data is not being presented in a trended format. **Other findings:** Self-assessment data indicates that currently an average of 72% of 60-day teams are occurring as scheduled and an average of 82% of 30-day teams are occurring as scheduled. **Compliance:** Partial. **Current recommendations:**

			1. Present auditing data as trended data. 2. Implement requirement for 30 day teams as per the Agreement. 3. Develop supervisory processes to increase the rate of compliance with 30-day and 60-day teams.

	B. Integrated Treatment Plans		
		By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:	
MES	V.B.1	where possible, individuals have input into their treatment plans;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure that the IRP Manual includes appropriate and clear expectations and operational guidance regarding the process and outcomes of engagement of individuals during IRP meetings.* **Findings:** SEH has revised its IRP Manual to include specific guidance to the teams regarding the engagement of individuals during the IRP conferences and a team checklist for the IRP conference to facilitate the process of obtaining the individual's input. This guidance is consistent with the strength-based, recovery-oriented system of IRP. **Recommendation 2, March 2009:** *Ensure that each IRP team has a dedicated mentor and that mentors provide feedback to the teams and to the facility management regarding the IRP process.* **Findings:** SEH did not provide information to specify if each IRP team has been assigned a mentor, who the mentors are and how they function. The facility provided general information indicating that it has assigned some IRP observers to provide immediate feedback to the teams and that each observer has a limited number of teams to facilitate a mentoring relationship with the

			team. Reportedly, the observers are sending score sheets to the teams as a written feedback. **Recommendation 3, March 2009:** *Ensure that the revised IRP Process Observation Monitoring Form include operational instruction to assess if the team has made clinically appropriate revision in the case formulation, objectives and/or interventions in response to the individual's expressed cultural preference/needs.* **Findings:** In its self-report, the facility made reference to a revision of the Clinical Chart Audit tool, but did not specify if this recommendation was implemented. This consultant reviewed the revised audit tool and found that some indicators in the revised tool indirectly addressed the intent of this recommendation. **Recommendation 4, March 2009:** *Develop and implement a training module focused on Engagement of Individuals to ensure that the individuals provide substantive input in the formulation and review and revisions of treatment objectives and interventions. The module should include lesson plans, process outcomes and post-tests.* **Findings:** As mentioned above, the revised IRP Manual includes a training module regarding the engagement of individuals. The facility did not present information regarding lesson plans, process outcomes and post-tests. The facility provided training on this module (four units completed the training and the training in ongoing for the remaining 13 units). **Recommendations 5 and 6, March 2009:**

			• *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* • Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. **Findings:** SEH reported that training on the engagement of individuals was provided as part of the IRP overview training and that 95% of staff completed this training. In addition, the facility's consultant provided training to senior clinical staff (75% of the seniors completed this training). The facility did not provide documentation that training was competency-based. **Recommendations 7 and 8, March 2009:** • Monitor this requirement using process observation data based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH provided data based on a review of a 20% sample of the IRP meetings (February to June 2009). The tool assessed the individual's attendance and participation in the IRP conference. The participation was assessed based on 12 indicators. The indicators were appropriate to this requirement of the Agreement. The attendance data showed compliance ratings

			that varied from a low of 83% in March 2009 to 100% in May 2009. The participation data were not aggregated. **Other findings:** The expert consultants attended nine IRP meeting conferences to assess the IRP conference process. There was evidence that the facility has made some progress since the last review as evidenced by the following: 1. In general, the meetings started on time; 2. Most of the core disciplines attended and participated in the meetings; 3. The individuals attended eight out of nine meetings; 4. In most of the meetings, the teams conducted a review of the clinical formulation; 5. In most of the meetings, the teams conducted an adequate review of disciplinary assessments; 6. In all the meetings, the teams conducted a review of the individuals' risk status; 7. In most of the meetings, the teams discussed key questions to be addressed during the individual's presence; 8. In general, the IRP team members made adequate efforts to engage the individuals into the process of the meeting and approached the individuals with respect; 9. In some meetings, the teams reviewed the objectives and interventions with the individuals; and 10. In some meetings, the teams reviewed the individual's life goals and strengths. 11. Three teams conducted an overall adequate IRP reviews. However, process deficiencies were noted in the following areas: 1. Participation by all core members, particularly psychologists

			and direct care staff; 2. Adequate update of the present status of the clinical formulation (symptoms, functional status, cultural issues, interventions and response, use of restrictive interventions, discharge criteria, progress towards discharge and other factors contributing to hospitalization); 3. Review of the diagnosis with the individuals; 4. Review of foci, objectives, and interventions with the individual; 5. Revision of foci, objectives and interventions with input from the individual; 6. Data-based review of the individual's participation in PSR Mall activities; 7. Linkage within the IRP (foci, objectives and interventions) and between Mall activities and objectives in the IRP; 8. Update of the individual's life goals and strengths and utilization of these goals and strengths in the IRP; and 9. Review of progress towards individualized discharge criteria with input from the individual. In addition, this expert consultant interviewed the clinical administrators of five units in the facility. For the units that completed the training, the administrators verified that didactic and observational training has been provided as reported by the facility and that observational training, including feedback has resulted in over all improvement in the process of the IRP team conference. However, the administrators reported that the teams have received inconsistent guidance from different trainers regarding content of the IRPs and some aspects of the process. **Compliance:** Partial.

			Current recommendations: 1. *Provide specific information to indicate that each IRP team has a dedicated mentor and that mentors provide consistent feedback to the teams and to the facility management regarding the IRP process. Ensure the self-report specifies the number of mentors, their disciplines and the process of mentoring the teams.* 2. *Ensure that team mentors address the process deficiencies (1 to 9) outlined in other findings above.* 3. *Ensure that the revised IRP Process Observation Monitoring Form includes operational instruction to assess if the team has made clinically appropriate revision in the case formulation, objectives and/or interventions in response to the individual's expressed cultural preference/needs.* 4. *Ensure that the IRP training Module regarding the engagement of individuals includes lesson plan and post-tests.* 5. *Ensure that the self-report contains a summary outline of the engagement training provided during the review period. Specify the participating disciplines in the training and the training process (didactic, observation, feedback to teams) and content.* 6. *Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.* 7. *Monitor the individual's attendance and participation in the IRP conferences using process observation data based on at least 20% sample during the review period.* 8. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of*

			low compliance with plans of correction. Supporting documents should be provided.
	V.B.2	treatment planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
MES	V.B.2.a	initial assessments are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Same as in VI.A.1. • Same as in VI.2.b, Recommendation 5. **Findings:** Same as in VI.A.1. **Other findings:** This expert reviewed the charts of 10 individuals (AK, CB, DA, GS, JA, JW, KE, MLA, PJJ and RW) who were admitted during this review period (June and July 2009). The review found that the initial assessments were completed within the required time frame in all cases and that several improvements in content were noted (see VI.A.1 to VI.A.5). However, there were many deficiencies (see VI.A.5) that must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations:** 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	**Current findings on previous recommendations:**

			Recommendation 1, March 2009: *Ensure consistent implementation of a time frame of seven calendars days for completion of the comprehensive IRP and consistency between the IRP Process Observation Monitoring Form and the revised Policy #602.2-04, regarding all time frames for implementation of the IRPs.* **Findings:** SEH has reportedly implemented the recommendation regarding completion of the comprehensive IRP within seven calendar days of admission. The time frames for implementation of the initial and comprehensive IRP and IRP reviews are consistently specified in the IRP Policy and the Process Observation Monitoring Form. **Recommendations 2 and 3, March 2009:** • *Monitor the timeliness of the initial and comprehensive IRP based on at least 20% sample 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.* **Findings:** In its self-report, SEH presented two different tools (IRP Chart Review and Process Observation Tool and IRP Process Observation Tool) that appeared to address similar IRP processes. However, some indicators on these tools were different and the facility did not specify the purpose of each tool.

			The facility presented data based on the Chart Review and Process Observation tool (February to June 2009). The facility acknowledged that the sample was inadequate. Based on these data, SEH reported compliance rates ranging from lows of 0% (initial IRP) in March 2009 and 33% (comprehensive IRP) in June 2009 to highs of 67% (initial IRP) in May 2009 and 50% (comprehensive IRP) in March through May. **Recommendation 4, March 2009:** Present monitoring data regarding both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences. **Findings:** SEH gathered data using the IRP Chart review and Process Observation Tool (February to June 2009). The self-report did not summarize the data and the sampling information. **Other findings:** This expert consultant reviewed the charts of 10 individuals (AK, CB, DA, GS, JA, JW, KE, MLA, PJJ and RW) who were admitted during this review period (June and July 2009). The review found that the initial IRPs were completed as required in all cases. However, the content of these plans contained numerous deficiencies as outlined in each corresponding section of this report. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance**: Partial. **Current recommendations**:

			1. *Monitor the timeliness of the initial and comprehensive IRP based on at least 20% sample during this review period.* 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.* 3. *Present a summary of the aggregated monitoring data in the progress report of both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.*
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure monitoring instructions regarding the identification by the IRP team of some one to be responsible for scheduling the IRP meetings in accordance with the required time frames. **Findings:** SEH self-report did not adequately address this recommendation. **Recommendations 2 and 3, March 2009:** • Monitor this requirement using the process observation tool based on at least 20% sample during the next 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. **Findings:** SEH self-report did not adequately address this recommendation. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during this review period (AK, CB, DA, GS, JA, JW, KE, MLA, PJJ and RW) and found compliance in all cases except two (AK and CB). However, the content of these reviews contained numerous deficiencies as outlined in each corresponding section of this report. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations:** 1. *Ensure monitoring instructions regarding the identification by the IRP team of some one to be responsible for scheduling the IRP meetings in accordance with the required time frames.* 2. *Monitor the treatment plan reviews using the process observation tool based on at least 20% sample during the next review period.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting*

			documents should be provided.
MES	V.B.3	individuals are informed of the purposes and major side effects of medication;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.* **Findings:** SEH self-report did not adequately address this recommendation. The most recent revision of the Clinical Chart Monitoring Form does not address the recommendation. **Recommendation 2 March 2009:** *Provide a sample of information regarding the content of informed consent for specific medication classes.* **Findings:** The Office of Consumer Affairs had developed a Medication Information Manual that contained adequate information to consumers regarding psychotropic medications, including benefits and risks of use. The facility has yet to determine the best way to present this information to the individuals. **Recommendations 3 and 4, March 2009:** • Monitor this requirement using clinical chart audit based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of

			low compliance with plans of correction. Supporting documents should be provided. **Findings:** The facility monitored this requirement using a consumer satisfaction survey process. According to the most recent survey of 212 individuals, 59% of individuals agreed that their physicians discussed with them why the medication was given and 55% reported that they were given information about potential side effects of medications. The facility has yet to provide data based on the Clinical Chart Audit tool. **Compliance:** Partial. **Current recommendations:** 1. *Implement a mechanism to provide individuals with information in the Medication Information Manual.* 2. *Continue the process of Consumer Satisfaction Surveys and provide a summary of results.* 3. *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.* 4. *Monitor this requirement using clinical chart audit based on at least 20% sample during the review period.* 5. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 6. *Continue the process of Consumer Satisfaction Surveys and*

			provide a summary of results.
MES	V.B.4	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Same as in V.D.1, V.D.2 and V.D.3. • Same as in V.D.4 and V.D.5. **Findings:** Same as in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5) **Compliance:** Noncompliance. **Current recommendations:** 1. Same as in V.D.1, V.D.2 and V.D.3. 2. Same as in V.D.4 and V.D.5.
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in XII.E.2. **Findings:** Same as in XII.E.2. **Other findings:** SEH reportedly initiated a process for review and tracking by the Medical Director and the Risk Manager of the repeated use of seclusion and/or restraints. In August 2009, the Risk Manager began this tracking using the RM Alert: Unusual Incidents Log.

			Compliance: Same as in XII.E.2. **Current recommendations:** 1. *Same as in XII.E.2.* 2. *Provide documentation of the Medical Director's review of the use of seclusion and/or restraints during the reporting period.*
RB	V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Continue monitoring of treatment team response to FRB recommendations and presentation of data to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement. **Findings:** The hospital's auditing data showed that, over the past 6 months (12/08-05/09), 88-92% of the responses to FRB recommendations had been followed up within appropriate time frames. **Recommendation 2, April 2009:** Revise Risk Factor section and final section of FRB submissions so that each FRB submission contains a **list** of all relevant risk factors from the time of the instant offense and from subsequent history of hospitalization. After each factor, a sentence explaining its relevance to the individual can be added. Scores should, however, not be reported in this section. In the later section of the report where the recommendation is justified on the basis of progress/lack of progress, each risk

			factor should again be **listed** and updated based on the findings in the body of the report. This section is also the appropriate section to report **current** scores from actuarial risk assessment instruments. **Findings:** All of the reviewed records showed evidence of having revised the Risk Factor and later justification sections according to this recommendation. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Track percentage of cases presented to FRB every 6 months.
MES	V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in V.E.3, V.E.4 and V.E.5. **Findings:** Same as in V.E.3, V.E.4 and V.E.5. **Recommendation 2, March 2009:** Same as in VIII. **Findings:** Same as in VIII. **Compliance:** Partial.

			Current recommendations: 1. Same as in V.E.3, V.E.4 and V.E.5. 2. Same as in VIII.
MES	V.B.8	an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure that the current policy regarding Patient transfers also address the mission of each unit in the hospital.* **Findings:** SEH revised Policy #111.02-08: Patient Transfers has incorporated this recommendation. **Recommendation 2, March 2009:** *Implement corrective actions to ensure that the transfer assessment meet requirements of the facility's policy.* **Findings:** SEH reported that it has implemented an oversight system to track implementation of the facility's policy requirements regarding the inter-unit transfers. **Recommendations 3 and 4, March 2009:** • Monitor this requirement using the inter-unit transfer assessment tool based on at least 20% sample during the next 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.

Findings:
SEH has initiated monitoring using the Patient Transfer Monitoring Form (March to May 2009). The facility did not present an adequate summary of the data. However, review by this expert consultant found that the facility monitored a sample of 20% of the transfers and reported variable compliance rates from month to month regarding the presence of the notes and the quality of documentation. Overall, the facility acknowledged that data showed a marked decline in compliance with the policy requirements. The facility's Performance Improvement (PI) Committee has reportedly identified this area as a focus for PI efforts.

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

Initials	Dates of inter-unit transfer
DJ	7/10/09
JA	7/29/09
KH	6/11/09
RP	8/3/09
RW	7/7/09
TJ	6/30/09

None of these assessments adequately met this requirement. The transfer assessment of RP adhered to the new template of Transfer Summary, which included adequate outline of required areas. However, the content of information regarding the

			description of hospital course, risk assessment, discussion of barriers to discharge and review of the plan of care did not provide meaningful data to ensure continuity of care. The assessment of KH did not address the benefits/reasons for the transfer, course of hospitalization, risk factors, or barriers to discharge. The assessment of JA was limited to a statement about lack of known allergies, a reference to the individual's condition as "guarded", a listing of diagnoses and an incomplete listing of medications. The assessment of KH did not address the benefits/reasons for the transfer, course of hospitalization, risk factors, or barriers to discharge. No transfer assessments were found in the charts of RW, TJ and DJ. **Compliance:** Partial. **Current recommendations:** 1. *Implement corrective actions to ensure that the transfer assessments meet requirements of the facility's policy.* 2. *Monitor this requirement using the inter-unit transfer assessment tool based on at least 20% sample during the next review period.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators,	**Current findings on previous recommendations:** **Recommendation, March 2009:**

		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.	Ensure adequate completion of the following items (from findings in March 2009 report): 1. The newly developed self-audit tools for initial/comprehensive disciplinary assessments) (Psychiatry, Psychology, Social Work and Rehabilitation Therapy) included adequate indicators and instructions regarding the content of these assessments. The facility began implementation of the Psychology, Social Work and Rehabilitation tools, but has yet to implement the Psychiatric tool. 2. SEH developed an adequate auditing tool to assess the content of social work reassessments, but has yet to develop and implement similar tools for psychiatry, psychology and rehabilitation therapy. 3. SEH has yet to develop and implement tools to assess nursing assessments and reassessments. 4. SEH has yet to develop and implement indicators regarding psychiatric reassessments. 5. SEH developed a Medication Monitoring/Review Form that contained some appropriate indicators regarding high risk medication uses and began implementation of this tool. The facility has yet to refine some of the indicators to ensure the safety and appropriateness of medication uses and clinical and laboratory monitoring of the individuals. 6. SEH developed an adequate Discharge/Outplacement Assessment Tool and began its implementation. The facility has yet to present monitoring data for the entire review period. 7. SEH has yet to develop and implement individualized medication guidelines to serve as the basis for the peer review/self-audit indicators regarding appropriateness of medication uses. 8. SEH has yet to refine some of the indicators regarding high risk medication uses to ensure the safety and

			appropriateness of medication uses. 9. SEH has developed indicators regarding the assessment and management of tardive dyskinesia. The facility has yet to implement this tool and to refine some of the indicators to provide operational criteria regarding appropriate management. 10. The facility has yet to develop complete monitoring data for all its tools based on adequate sampling and auditing methodology. 11. The facility has yet to delineate patterns and trends and to implement corrective/educational actions, as needed, to improve its performance. **Findings:** SEH presented a description of its current system of monitoring and set of monitoring tools and operational instructions in response to previous findings 1-4 and 10. In addition to the IRP monitoring tools (Process Observation and clinical Chart Auditing), the facility presented the following tools, operational instructions and data: 1. Comprehensive Initial Psychiatric Assessment Self-Audit Tool and operational instructions (August 18, 2009). 2. Comprehensive Initial Psychiatric Assessment Self-Audit summary data (July 2009). 3. Patient Transfer Monitoring Tool (revised June 02, 2009). 4. Patient transfer monitoring summary data (March to June 2009). 5. Psychiatric update Self-Audit tool and operational instructions (not dated and no data). 6. Initial Psychological Assessment Monitoring Tool and Peer review Form (revised July 16, 2009) and operational instructions (revised May 21, 2009).

			7. Initial Psychological Assessment Monitoring summary data (April to July 2009). 8. Rehabilitation Services Assessment Self-Auditing Tool (revised December 05, 2008) and assessment guidelines (May 26, 2009), no data. 9. Nursing Assessment Audit Questions (not dated). 10. Nursing Update Audit Tool and instructions (June 30, 2009). 11. Nursing Assessment/Update Self-Auditing summary data (date of audit not specified). 12. Social Work Initial Assessment Audit Tool and assessment instructions (revised January 2009). 13. Social Work Assessment Self-Auditing summary data (April to July 2009). 14. Social Work Update Self-Audit Tool (June 18, 2009) and update instructions (May 21, 2009), no data. In general, the monitoring tools contained many indicators that addressed the corresponding requirements of the Agreement. However, more work is needed to streamline the indicators, align them more clearly with requirements of the Agreement, refine and complete the operational instructions, standardize and integrate the monitoring methodologies, including data presentation and improve data analysis. SEH's self-report did not address the facility's response to findings 5-10. In addition, the facility has yet to provide more complete data and data analysis that can serve as the basis for corrective actions regarding patterns and trends (finding 11). These findings will be addressed in corresponding cells in other sections of this report. The facility has yet to provide more complete data and data analysis that can serve as the basis for corrective actions

			regarding patterns and trends (item 11). **Compliance:** Partial. **Current recommendation:** In the future, this requirement will be assessed in other corresponding sections of the Agreement (VI and VIII). These sections address the specific processes in the implementation of this requirement (self-monitoring of psychiatric assessments and reassessments, including medication management).

	C. Case Formulation		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:	Please see sub-cells for findings and compliance.
MES	V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure that the IRP manual adequately addresses the individual's needs in the domains of social skills/functional status.* **Findings:** SEH has made significant revisions in its IRP regarding the development of the case formulation. The facility reported that these revisions included an emphasis on the individual's social skills and functional status. However, reviews by this expert consultant of the clinical formulation update section of the IRP found that the instructions regarding the present status section did not clearly address a review by the team of the individual's social skills. **Recommendations 2-4, March 2009:** • *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.* • *Provide summary outline of the participating disciplines in*

			the above training and the training process (didactic, observation, feedback to teams) and content. • Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation. **Findings:** SEH did not implement this recommendation. As mentioned earlier, the facility has implemented IRP training including specific modules that address the following topics: a) IRP Overview and Basic concepts; b) Introduction to Planning From a Person-Centered Perspectives; c) Key Recovery Concepts; d) Stages of Change e) Engagement; f) Discharge/Transition Planning; and g) Interdisciplinary Recovery Plan Team Meeting Coaching and Team Member Coaching. The current IRP modules did not include development of the Case Formulation. Although the IRP Manual was revised to provide further instructions to the teams in the development and updates of the Case Formulation, these instructions did not adequately address this requirement (see other findings). **Recommendation 5, March 2009:** *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* **Findings:**

			SEH has yet to implement this recommendation. The most recent revision of the Clinical Chart Audit did not adequately address the 6Ps of the Case Formulation (the present status section was listed as "presenting problems," which indicates an incomplete understanding of this model). **Recommendations 6 and 7, March 2009et:** • Monitor this requirement using the Clinical Chart Audit tool based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH has did not implement this recommendation. Instead, the facility presented data based on Process Observation. Most of these data were tangential to the recommendation. **Other findings:** Reviews by this expert consultant found that the revisions in the IRP Manual and the team's implementation of the instructions in the Manual do not adequately address this recommendation. The following are examples: 1. The structure of the case formulation is problematic for the following reasons: a) The organization of information in the 6ps does not accurately reflect the model (e.g. there is confusion between presenting problems and review of the present

			status of the individual). b) The present status section requires significant refinements to adequately address the teams' review of the following areas: i) Symptoms; ii) Functional status; iii) Response to interventions; iv) Risk factors; and v) Results of rating instruments/laboratory testing and current medications. c) The present status requires significant update to address: i) Discharge criteria; and ii) The individual's progress towards discharge. d) The separate formats of the clinical formulation and the list of needs reflect duplicative and parallel processes in the establishment of the individual's needs. This can result in significant disarray in the proper delineation of the treatment and rehabilitation needs and a serious breakdown in addressing high risk situations, whether proactively or reactively. In general, there continued to be inadequate linkage within the 6-p components of the case formulation and between the material in the case formulations and the foci, objectives and interventions of the IRPs. **Compliance:** Partial. **Current recommendations:** 1. *Revise the IRP Manual to provide instruction that the present status section of the Case formulation includes a*

			review by the team of the social skills/functional status. Specific examples should be provided to facilitate implementation. 2. *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation properly meets the principles of individualized recovery-focused planning. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.* 3. *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* 4. *Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.* 5. *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* 6. *Monitor this requirement using the Clinical Chart Audit tool based on at least 20% sample during the review period.* 7. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Current findings on previous recommendations:** **Recommendation, March 2009:** Same as above.

			Findings: Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	**Current findings on previous recommendations:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Current findings on previous recommendations:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial.

			Current recommendations: Same as above.
MES	V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	**Current findings on previous recommendations:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Current findings on previous recommendations:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.7	make preliminary determinations as to the setting	**Current findings on previous recommendations:**

		to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.	**Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.

	D. Individualized Factors		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	Please see sub-cells for findings and compliance.
MES	V.D.1	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Revise the IRP Manual to ensure the following:* *a) The outline of foci (goals) includes social skills/functional impairments;* *b) Issues of dangerousness and impulsivity are adequately addressed in the IRP;* *c) Operational guidance, including adequate clinical examples, are provided to facilitate the following:* *i. Development of foci, objectives and interventions based on learning outcomes;* *ii. Linkages within the IRP (assessments to case formulation to foci to objectives to interventions);* *iii. Linkage between Mall interventions and IRP objectives;* *iv. Strength formulation for IRP purposes;* *v. Revisions of Foci, objectives and interventions to reflect the changing needs of the individuals; and* *vi. Strategies to overcome barriers to the individuals' adherence to their IRPs.* **Findings:** The revised IRP included instructions to staff on the development of the individual's needs list. The manual also included instructions, tip sheets and clinical examples of foci, objectives and interventions. However, the manual did not

			adequately address this recommendation due to the following: 1. Although the Manual (and the revised IRP forms) included instructions to address both treatment and skill building interventions, the outline of foci did not include the social skills of the individual as a focus. 2. The examples of focus statements were inappropriate (they confused focus statement and objectives, were vague and overinclusive). 3. The examples of objectives did not adequately include learning outcomes or ensure that the objectives are attainable and measurable and/or behavioral. 4. The examples of interventions did not adequately specify what staff will do to assist the individual in achieving objectives. 5. The Manual did not adequately address the following: a) Linkages between Mall interventions and IRP objectives; b) Examples of strengths linked to interventions; c) Revision of foci, objectives and interventions in response to the changing needs of the individuals and d) Strategies to overcome lack of individuals' adherence to the IRP. **Recommendations 2-4, March 2009:** • *Develop and implement a training module focused on the development of Foci, Objectives and Interventions. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions.* • Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content. • 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:** SEH's self-report did not address these recommendations. A reference was made to the previously mentioned IRP training, but this training did not include a specific curriculum regarding the development of foci, objectives and interventions. **Recommendations 5-7, March 2009:** • Develop a Clinical Chart Monitoring Form to include complete indicators and operational instructions to adequately address this requirement. • Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** The current clinical chart audit tool contained several indicators that are aligned with this requirement. The facility recently used this audit to review 27 charts as a pilot (July 2009). The compliance data were not properly aggregated and analyzed, but the facility reported a compliance rate of 92% with select indicators that are relevant to this recommendation (individual's needs build upon meaningful strengths for each focus area and

			objectives reflect the individual's needs and level of functioning). **Recommendation 8, March 2009:** *Provide an outline of the following:* *a) Cognitive remediation interventions that are currently provided and plans to increase these interventions.* *b) Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.* **Findings:** SEH's self-report did not provide the requested information. However, during this review period, the facility provided training to its staff on neurocognitive disorders and models and techniques of cognitive remediation. The facility presented data regarding the staff who attended the training, including clinical disciplines and Mall group leaders. **Recommendation 9, March 2009:** *Develop and implement medical care policies and procedures to address the following:* *a) Requirements for preventive health screening of individuals;* *b) Requirements regarding completeness of all sections of initial assessments, including a plan of care that specifies interventions for identified conditions;* *c) Requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format;* *d) Timeliness and documentation requirements regarding periodic reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce*

			the risks; *e) Proper physician-nurse communications to ensure the following:* *i. Timely and properly documented nursing assessments;* *ii. Timely and properly documented physician notification; and* *iii. Physician response within time frames that reflect the urgency of the condition;* f) *Emergency medical response system, including drill practice;* *g) Consultation and laboratory testing to ensure the following:* *i. Communications of needed data to consultants;* *ii. Timely review and filing of consultation and laboratory reports; and* *iii. Follow-up on consultant's recommendations;* *h) Requirements regarding transfer of individuals to outside facilities to ensure the following:* *i. Physician evaluation includes a review of possible contributing factors regarding the individual's status, as clinically appropriate;* *ii. Physician to physician communications upon the transfer regarding the reason for the transfer; and* *iii. Communication of appropriate documents to the outside facility relevant to the reason for the transfer;* *i) Requirements regarding the return transfer of individuals to SEH from outside facilities to ensure that the accepting physician:* *i. Obtains information from the outside facility that is sufficient for continuity of care;* *ii. Documents a review and assessment of the individual's status and the care provided at the outside facility; and* *iii. Documents a plan of care that outlines interventions needed to reduce the future risk for the individuals* *j) Parameters for physician participation in the IRP process to*

			improve integration of medical and mental health care. **Findings:** SEH has made efforts in response to these recommendations. The following is a summary of the facility's efforts and this expert's assessment : 1. Policy #602.1-08: Assessment includes a requirement for completion of a medical assessment within 24 hours of admission and within one hour of an individual's return from outside hospitalization. The content requirements are not specified. 2. The initial IRP form includes a specific focus dedicated to a review of the physical health status (focus II). The revised IRP Manual (membership and responsibilities of the interdisciplinary recovery team) includes instruction for the General Medical Officer to present a summary to the team regarding the physical status of the individual and to identify medical interventions in the IRP. This process adequately addressed the recommendation for better integration of medical and mental health care. 3. The facility is in the process of finalizing a Medical Response Policy. The policy (draft) is intended to address the provision of medical care in emergent, urgent and non-urgent situations. 4. The Medical Response Policy (draft) contains some elements regarding the roles and responsibilities of staff during and after the medical emergency response (code blue) as well as requirements for quarterly emergency drills (one per shift in each building). However, the policy requires significant revision to ensure the following: a. Composition of the medical response team; b. Immediate availability of sufficient number of trained

			and competent staff to be available at the scene of the emergency, including units and Mall areas; c. Requirements for periodic competency-based training of staff; d. Formalized documentation of events during the actual code and code drills utilizing a flow sheet that provides systemic review of the following types of information: i) Staff member(s) who discovered the emergency; ii) Nature of the emergency; iii) Condition of the individual upon discovery; iv) Circumstances of emergency response activation; v) Immediate first aid provided; vi) Personnel and equipment arrival, including timing and roles; vii) Information regarding outside responders; viii) Timing of CPR; ix) Staff performing CPR; x) Information regarding use of airway/oxygen maintenance, intubation, circulation/cardiac interventions and use of AED; xi) Documentation of the individual's vital signs, observations of the individual and medications administered; xii) Outcome of the response; including transport; and xiii)Family notification. e. Documentation of the physician's and nurse's evaluations upon the transport of the individual to an outside facility; f. Timely and appropriate evaluation of the performance of staff, equipment and other systems during the actual emergency and the emergency response drill, including, but not limited to, the following: i) Timeliness of the response; ii) Adequacy of the numbers of team members present;

			iii) Adequacy, timeliness, appropriateness, and functionality of equipment and supplies; iv) Quality of the assessment of the individual; v) Appropriateness of interventions; vi) Any complications that the individual may have suffered during the actual emergency response; and vii) Team members' performance of their assigned functions, including leadership of the response team. g. Requirement that procedures for managing equipments and supplies related to the medical emergency response are continuously updated, including, but not limited to, the following: i) Automatic External Defibrillator (AED), including inventory sheet; ii) Guidelines for competing the AED Inventory Sheet; iii) Emergency kit and equipment/supplies procedure, including Emergency Kit inventory sheet and Emergency Kit and equipment security, checks and documentation of the checks; iv) Nasopharyngeal pathway; v) Oropharyngeal pathway; vi) Oral pharyngeal suctioning; and vii) Oxygen therapy. h. Medical emergency code drills are performed unannounced; i. Medical emergency drills utilize scenarios that adequately cover the range of possible emergencies; j. The oversight function regarding the medical emergency response (actual and drills) includes an inter-disciplinary review, including, but not limited to, both the Medical Director and the Nurse Executive; and k. Reports of the above-mentioned review of the actual emergencies and the emergency drills are submitted for

			regular review by the Medical Executive Committee and that the committee provides recommendations for any systemic corrective actions required at that level, as indicated. 5. The Medical Response Policy (draft) includes mechanisms for physician nurse communications to ensure timely medical attention in urgent and non-urgent situations. However, more work is needed to ensure that the procedures adequately address the following: a. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format; and b. Timeliness and documentation requirements regarding periodic routine reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks. 6. The facility developed Policy #207-09: Hand-Off Communication Guidelines to provide standards that facilitate change of shift communications, physician nurse communications and communications among medical staff to ensure continuity of care in situations that involve planned absences as well as on-call-periods. 7. The facility revised Policy #111.2-08: Patient Transfers. The revised procedures include adequate mechanisms regarding the transfer of individuals from SEH for outside hospitalization. However, regarding return transfers, the policy requires further revision to provide parameters for documentation by the accepting physician of the following: a. A review and assessment of the individual's status and the care provided at the outside facility; and b. A plan of care that outlines interventions needed to

			reduce the future risk for the individuals. 8. The facility's self-report did not address the recommendation regarding the development of a process regarding Consultation and laboratory testing to ensure the following: a. Communications of needed data to consultants; b. Timely review and filing of consultation and laboratory reports; and c. Follow-up on consultant's recommendations. **Other findings:** Chart reviews by this consultant found that the facility has consistently implemented the new format of the IRP as specified in the IRP Manual. This format has improved the organization of information regarding the foci of hospitalization and corresponding needs of the individuals. However, the following deficiencies were noted: 1. Most of the foci statements were generic, vague, overinclusive and simply reiterated the individual's history or overlapped with the objectives and interventions in a diffuse manner. The revised IRP Manual included inappropriate examples of focus statements. Consequently, the teams' implementation of foci statements was problematic. These statements did not really provide a focus for treatment/ rehabilitation. 2. The foci were mostly limited to symptom resolution/ reduction and did not properly address the individual's needs in the other domains. As mentioned earlier, the IRP instructions emphasize the importance of skill-building interventions in all aspects of the IRP; however, a dedicated focus to address social skills of the individual is necessary to ensure proper attention to this area.

			3. In general, the foci statements did not provide adequate linkage to the objectives, interventions and reports of the individual's progress/lack thereof. The following are chart examples: 1. "Will be capable of managing her feelings in such a way as to avoid behaviors that may put her or others in harm's way" (LW). 2. "Will need psychiatric stabilization because Ms. A presented to SEH with complaint of loose association, reports of wandering away from her group home in risqué attire and walking the street, general cognitive decline secondary to Dementia. She currently [recitation of recent history]" (MA). 3. "Will be under medical control, and consumer will be medically compliant with (anticonvulsant) medication and other medications prescribed for his medical conditions" (TVN). 4. "Will report any delusions in which he feels unsafe or bring on aggressive feelings to staff and accept identified "comfort" coping skills. Nursing will work with him on this [identifying a positive diversion] as will social work. He will continue to comply with his current medication regimen, testing, or vitals as needed and supportive activities that enhance the quality of his life" (RP). 5. "Will have a decrease in delusional thinking, as evidenced by identifying realistic goals and no longer verbalizing paranoid or grandiose delusions, exhibit a slowing of her symptoms of Dementia" (BC). 6. "Will demonstrate prosocial behavior, clarity of thought, calmer mood, her cognitive functioning will be assessed and her cognitive abilities will be maximized to improve her

			functioning" (GS). 7. "Mr. M will participate in the management of his seizure disorder, meningioma, weight gain secondary to medication with compliance with meds and remain seizure free, adhere to recommended diet and comply with all recommended diagnostics" (SK). This expert consultant also reviewed the charts of individuals diagnosed with seizure, cognitive and substance use disorders. The purpose of the review was to assess whether foci, objectives and interventions addressed the individuals' identified needs. These reviews found that the facility has maintained some progress in the following areas: 1. Documentation of foci, objectives and interventions with corresponding strengths and stage of change for some individuals diagnosed with seizure disorders (SK and AS). 2. Documentation of some objectives that utilized learning outcomes in individuals with seizure disorders (AK and GH). 3. Documentation of interventions that were appropriately tailored to the individual's level of cognitive functioning in some individuals diagnosed with a cognitive disorder (GH and RJ). 4. Documentation of interventions that were aligned with the stage of change for some individuals diagnosed with substance use disorders (MJ and JL). However, the review found a pattern of persistent deficiencies the must be corrected to achieve compliance with requirements of the Agreement in V.D.1 to V.D.6. The following are examples: 1. Individuals diagnosed with seizure disorders (AK, AS, GH, JL, JN, MJ, RM, SK and TVN) :

			a. The IRP did not document foci, objectives and interventions to address seizure disorder (RM). b. The focus statement, objectives and interventions were generic in most charts, were focused on participation in the management of the disorder and medication compliance and did not appear to address the actual needs of the individuals (SK and TVN). c. There was no evidence of neurological consultation for the past two years for an individual who was diagnosed with seizure disorder and receiving anticonvulsant regimen with clonazepam (SK). d. The objectives were generic and not attainable for some individuals (AS). e. There was no evidence of neurological consultation for the past two years for an individual who was diagnosed with seizure disorder and receiving anticonvulsant regimen with clonazepam (SK). f. No chart included the morphological diagnosis of the seizure disorder. This information is important to determine the proper selection of the anticonvulsant medications. g. The IRPs did not include an update of the present status of seizure activity in any of the charts reviewed (SK). h. Although some objectives were appropriately based on learning to identify triggers of the seizure disorder, the interventions were generic and focused on monitoring the individual without addressing the corresponding objective (AK and GH). i. The objectives did not utilize learning outcomes for the individuals in most of the charts reviewed. j. The IRPs did not include focus, objectives and/or interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize its impact on

			the individual's behavior and cognitive status. Examples include individuals were receiving phenytoin (AS and GH), and/or phenobarbital (RM and MJ). Some of these individuals were at increased risk for adverse effects of treatment due to the presence of cognitive impairments including Dementia Due to Head trauma (GH) and Mild Mental Retardation (MJ). 2. Individuals diagnosed with cognitive disorders (BC, BW, CL, FW, GH, GS, MA, MJ, NL, RB, RH, RP and TJ). a. There was no documentation of a focus or objectives or interventions to address diagnoses of Vascular Dementia with Delusions (NL), Alcohol-Induced Persisting Dementia (RH), Dementia Due to Multiple Etiologies (FW), Dementia NOS (CL), Dementia (small Vessel Disease (MA) and Dementia NOS (RP). This deficiency was noted even in some individuals whose cognitive disorder was the only axis I diagnosis listed on the IRP (Dementia NOS in BC) b. The focus statement related to a diagnosis of Dementia Due to Head Trauma was overinclusive and vague (GH). c. The objective related to a diagnosis of Vascular Dementia with Delusions and Behavioral Disturbance was unattainable (RB). d. An intervention was stated as "continue to assess cognitive status." However, there was no documentation in the subsequent three monthly psychiatric reassessments that the cognitive status was assessed (NL). e. The psychiatric progress notes did not provide justification for the diagnosis of Dementia in some individuals (RH and FW). f. The IRP did not include an update of the present status of the individuals regarding cognitive functioning in any of the charts reviewed.

			g. Some IRPs did not properly address or reconcile the presence of several simultaneous diagnoses of Cognitive Dysfunction, including Cognitive Disorder NOS and Mild Mental Retardation (MJ) and Dementia NOS and Moderate Mental Retardation (RP). h. In general, the stated objectives and prescribed interventions were not appropriately tailored to the level of functioning of individuals who have been diagnosed with cognitive disorders of different levels of severity. i. In general, the facility did not document evidence of cognitive remediation interventions for individuals in need. j. There was general evidence of excessive delay in completing neuropsychological testing for many individuals with questionable and/or unspecified cognitive dysfunction. 3. Individuals diagnosed with substance use disorders (CL, DJ, GS, KL, MJ, RB, RJ and TJ): a. There was no documentation of focus, objective or intervention to address diagnoses of Alcohol Abuse (CL), Alcohol and Cannabis Abuse (RJ) and Alcohol, Marijuana and Cocaine Dependence (KL). b. The objective for the substance use disorder was not aligned with the stated stage of change (TJ, DJ and GS). c. The objective for substance use disorder was unattainable given the individual's stage of change (KL). This expert consultant reviewed the charts of several individuals who were transferred to an outside facility for medical care during this reporting period. The review focused on procedures that facilitate the delivery of medical care that meets the individual's physical needs. The following outlines these reviews:

Initials	Date and time of evaluation	Date of transfer	Reason for transfer
DM	6/5/09 12:40	6/5/09	Electrolyte imbalance, new onset Diabetes Mellitus
GH	4/15/09 06:28	4/15/09	R/O Stroke
RB	2/15/09	2/15/09	Dehydration/Anemia
RG	4/4/09 20:20	4/4/09	Chest pain
TD	7/30/09 08:00	7/30/09	Seizure Disorder
VE	5/18/09 07:30	5/18/09	Recurrent seizure activity

In general, the reviews found medical care to be timely and adequate, including timely and appropriate consultations as follow up on unresolved issues following outside hospitalization (e.g. TD). However, the reviews also found a pattern of process deficiencies with nursing and medical care that preclude compliance with this requirement at this time. The following are examples:

1. There was general evidence of inconsistent utilization of the current transition from documentation of medical notes in the charts to documentation of these notes in the AVATAR system.
2. The nursing assessment of an individual who was experiencing an apparent seizure activity did not adequately document the individual's condition (GH).
3. The medical evaluation of an individual who was described as having jerky movements and alteration of consciousness did

			not include an adequate assessment of the apparent convulsive activity (GH). 4. The medical/transfer assessment of an individual who was newly admitted to the facility and was found to have a critical laboratory value (serious elevation in blood glucose level and other abnormalities) did not provide information to the receiving facility about prior records of laboratory abnormalities or lack thereof (these records were available to SEH). This information was necessary to inform the work-up and management at the outside hospital (the facility reported that corrective actions are underway as part of the facility's new transfer policy). 5. The medical assessment of an individual who had reportedly suffered two successive seizure episodes did not include an assessment of the individual's status relevant to the seizure activity at the time of the medical assessment (VE). 6. The nursing assessment of an individual who suffered an apparent (recurrent) grand mal seizure on June 29 did not include an adequate description of the individual's status (VE). 7. In general, there was no documentation of behavioral guidelines to address non-adherence to anticonvulsant medications in individuals who experienced seizure recurrences due to noncompliance with medications. 8. The transfer assessment of an individual who suffered chest pain did not include some necessary information to ensure continuity of care (RG). The new transfer policy has provided guidance that, if properly implemented, can correct this deficiency. **Compliance:** Partial.

			Current recommendations: 1. *Revise the IRP Manual to ensure the following:* a. *An IRP focus to address social skills/functional impairments;* b. *Operational guidance, including adequate clinical examples, are provided to facilitate the following:* i) *Development of foci, objectives and interventions based on learning outcomes;* ii) *Linkages within the IRP (assessments to case formulation to foci to objectives to interventions);* iii) *Linkage between Mall interventions and IRP objectives;* iv) *Strength formulation for IRP purposes;* v) *Revisions of Foci, objectives and interventions to reflect the individual's changing needs; and* vi) *Strategies to overcome barriers to the individual's adherence.* 2. *Develop and implement a training module focused on the development of Foci, Objectives and Interventions. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions.* 3. *Ensure that IRP training/mentoring addresses the findings of deficiency outlined in this section.* 4. *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* 5. *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.* 6. *Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least 20% sample during the*

			review period. 7. *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 8. *Ensure that the self-report contains a summary outline of the following:* a. *Cognitive remediation interventions that are currently provided and plans to increase these interventions and* b. *Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.* 9. *Finalize and implement an Emergency Medical Response Procedure. In addition to the current elements in the procedure, include standards to ensure the following:* a. *Composition of the response team;* b. *Immediate availability of sufficient number of trained and competent staff to be available at the scene of the emergency, including units and Mall areas;* c. *Requirements for periodic competency-based training of staff;* d. *Formalized documentation of events during the actual code and code drills utilizing a flow sheet that provides systemic review of the following types of information:* i) *Staff member who discovered the emergency;* ii) *Nature of the emergency;* iii) *Condition of the individual upon discovery;* iv) *Circumstances of emergency response activation;* v) *Immediate first aid provided;* vi) *Personnel and equipment arrival, including timing and*

			roles; vii) *Information regarding outside responders;* viii) *Timing of CPR;* ix) *Staff performing CPR;* x) *Information regarding use of airway/oxygen maintenance, intubation, circulation/cardiac interventions and use of AED;* xi) *Documentation of the individual's vital signs, observations of the individual and medications administered;* xii) *Outcome of the response, including transport; and* xiii)*Family notification.* e. *Documentation of the physician's and nurse's evaluations upon the transport of the individual to an outside facility;* f. *Timely and appropriate evaluation of the performance of staff, equipment and other systems during the actual emergency and the emergency response drill, including, but not limited to, the following:* i) *Timeliness of the response;* ii) *Adequacy of the numbers of team members present;* iii) *Adequacy, timeliness, appropriateness, and functionality of equipment and supplies;* iv) *Quality of the assessment of the individual;* v) *Appropriateness of interventions;* vi) *Any complications that the individual may have suffered during the actual emergency response; and* vii) *Team members' performance of their assigned functions, including leadership of the response team.* g. *Requirement that procedures for managing equipments and supplies related to the medical emergency response are continuously updated, including, but not limited to, the following:* i) *Automatic External Defibrillator (AED), including*

			inventory sheet and ii) *Guidelines for competing the AED Inventory Sheet;* iii) *Emergency kit and equipment/supplies procedure, including Emergency Kit inventory sheet and Emergency Kit and equipment security, checks and documentation of the checks;* iv) *Nasopharyngeal pathway;* v) *Oropharyngeal pathway;* vi) *Oropharyngeal suctioning; and* vii) *Oxygen therapy.* h. *Medical emergency code drills are performed unannounced.* i. *Medical emergency drills utilize scenarios that adequately cover the range of possible emergencies.* j. *The oversight function regarding the medical emergency response (actual and drills) includes an inter-disciplinary review, including, but not limited to, both the Medical Director and the Nurse Executive.* k. *Reports of the above-mentioned review of the actual emergencies and the emergency drills are submitted for regular review by the Medical Executive Committee and that the committee provides recommendations for any systemic corrective actions required at that level, as indicated.* 10. *Finalize a policy and procedure regarding the provision of medical care to individuals in urgent and non-urgent situations. In addition to the current elements in the procedure, include standards to ensure the following:* a. *Timeliness and documentation requirements regarding medical attention to changes in the status of individuals to include documentation using a SOAP format; and* b. *Timeliness and documentation requirements regarding periodic routine reassessments of the individuals,*

			including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks; 11. *Revise Policy #111.2-08: Patient Transfers, regarding return transfers. Include parameters for documentation by the accepting physician of the following:* a. *A review and assessment of the individual's status and the care provided at the outside facility; and* b. *A plan of care that outlines interventions needed to reduce the future risk for the individuals.* 12. *Develop and implement a procedure regarding consultations and laboratory testing to provide standards regarding the following:* a. *Communications of needed data to consultants;* b. *Timely review and filing of consultation and laboratory reports; and* c. *Follow-up on consultant's recommendations.*
MES	V.D.2	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Other findings:** The facility did not present data to address this requirement. **Compliance:** Noncompliance.

			Current recommendations: *Same as above.*
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Other findings:** The current clinical chart audit tool contained an indicator that addressed this requirement. As mentioned earlier, the facility used this audit to review 27 charts as a pilot (July 2009). The compliance rate for this requirement was reported at 92%. However, the facility acknowledged that more work is needed on this tool because the high compliance rate was not consistent with the IRP observations. Chart reviews by this expert consultant found limited progress in the formulation of treatment/rehabilitation objectives since the last review as follows: 1. Some improvement in the organization of objectives with some behavioral outcomes (SK, RH, MA and GS); 2. Improved alignment of objectives, foci and diagnosis in some charts (SK, RH and GS); and 3. Establishment of the stages of change in effort to ensure that stated objectives and interventions are properly matched to the individual's level of readiness for change (in all charts reviewed); and 4. Proper alignment of some objectives with the stated stage of

			change in a few charts (SK). The reviews found that the objectives were not always based on the identified needs of the individual. They were often vague and/or overinclusive, did not utilize learning outcomes, were not written in behavioral, observable and/or measurable terms and did not consistently align with the foci statements and the stated interventions. At times, the objectives were not attainable for the individual. The following are some chart examples: 1. "Will be capable of managing her mood and behavior as evidenced by taking all prescribed meds, discussing feelings and worries with staff, and learning about causes of her frustrations and finding learning healthy ways of managing stress" (LW). 2. "Will demonstrate improved compliance as evidenced by staying with staff" (MJ). 3. "Will continue to engage in all recommended treatment, refrain from threatening/intrusive behaviors, develop an awareness of his impulsivity and intrusive behavior as evidenced by [blank]" (FW). 4. "Will maintain stable mood without high levels of anxiety as evidenced by continuing to participate in enrichment and skill building activities, cultivating relationships and returning to community living with wrap around supports" (SK). 5. "Will attain mood stabilization and decrease in paranoia and disinhibition as evidenced by lessening of expressing delusions and flight of ideas, less irritable, calmer, accepting assistance from others" (CC). 6. "Will develop increased insight into her mental illness and the need for treatment as evidenced by accepting her medication and verbalizing an understanding of the effects of the

			medication and understanding the need for supportive living in the community" (BC). 7. "Will maintain medication and diet as prescribed daily as evidenced by freedom from seizures, manage weight" (SK). 8. "Will report if he is experiencing any unusual body tremors and unexplained alterations in level of consciousness" (AS) [for an individual suffering from seizure disorder]. 9. "Will be under medical control and consumer will be medically compliant with (anticonvulsant) medication and other medications prescribed for his medical conditions as evidenced by (cooperation) with necessary medical treatment and (expressing) an awareness of his medical conditions, symptoms, effects and required treatment" (TVN). 10. "Will not abuse drugs and know the risk factors and treatment for nicotine dependence [individual was also diagnosed with alcohol, marijuana and cocaine dependence, but these were not addressed]" (KL)." 11. "Will take medications, comply with treatment, attend groups, work towards a community-based activity and living arrangement, not ingest objects and exhibit self-control as evidenced by xxxx" (DJ). In addition, the objectives were often not aligned with the stated stage of change. **Compliance:** Noncompliance. **Current recommendations:** *Same as above.*
MES and	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and	**Current findings on previous recommendations:**

RB (PSR/ Mall)		within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Recommendation 1, March 2009:** Same as above. **Findings:** The revised format of the IRP included information regarding interventions that align with each objective, the type of intervention, its frequency and duration and responsible staff as well as delineation of treatment and skill building interventions. The facility reported that the IRP format has been in use since June 2009 and that the IRP training has emphasized this requirement. The facility has revised its therapeutic monthly progress notes in an effort to ensure that interventions are linked to the objectives. In July 2009, SEH developed a self-audit tool to assess proper completion of the therapeutic progress notes. **Recommendation 2, March 2009:** *Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Ensure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box.* **Findings:** The current audit tool meets this requirement but auditing was not scheduled to begin until 09/09 so no data was able to be presented. Records reviewed by this consultant found that, in about 70% of charts, the patient's progress toward the objective was adequately addressed by the mall group provider. **Recommendation 3, March 2009:**

			Make data available both at the individual level, so that progress toward discharge can be appropriately tracked, and at the aggregate level so that performance improvement can be maintained. **Findings:** Auditing data is not yet available. **Other findings:** Chart reviews by this expert consultant found that the alignment of some interventions with stated objectives has improved in a few charts (MA). However, most charts contained a pattern of persistent deficiencies regarding this requirement. The following are chart examples of interventions that were generic, did not specify who will do what within what time frames to assist the individual in achieving observable, measurable and/or behavioral objectives and did not align with the stated foci and/or objectives: 1. "Monitor mental status and prescribe and adjust medications as needed" (TJ). 2. "Continue to evaluate symptoms of mental illness, assess, monitor, treat, provide therapy and adjust meds, as necessary" (RH). 3. "Asses, evaluate and treat symptoms of mental illness with medication and therapy, monitor response, adjust as needed, refer to the treatment mall" (FW). 4. "Administer medications, teach side effects and assist him with reporting side effects. Review negatives of negative behavior and encourage self exploration of behaviors" (HR). 5. "Health education from nursing and ward staff regarding activities of daily living, medication compliance, reporting of

			side effects, somatic complaints and supportive psychiatric support" (RP). 6. "Health education with a focus on identifying behaviors that led to hospitalization and the necessity of continued treatment" (BC). 7. "Medical management, assess, evaluate and monitor seizure activity and response to meds, refer for neurological consultation" (SK). 8. "Monitoring by nursing staff" (AK). These statements appeared to be brief summaries of each discipline's job description rather than individualized interventions to address the assessed needs of the individuals. In addition, some interventions were not implemented as written (e.g. SK was not referred for a neurological consultation as the intervention written on July 14, 09 had indicated and neuropsychological testing referral was not documented despite an intervention to that effect (RB). As mentioned earlier, there was general evidence that Mall interventions were not properly linked to the IRP objectives. **Compliance:** Noncompliance. **Current recommendations:** 1. *Same as above.* 2. *Provide additional data using the therapeutic progress notes self-audit based on least 20% sample during the review period.* 3. *Ensure that the self-report includes an aggregated monitoring data regarding the therapeutic monthly progress*

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<tr><td></td><td></td><td></td><td>notes, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
4. Develop procedures to assure that interventions are appropriately aligned with treatment objectives.
5. Conduct audit monthly and present results as trended data.</td></tr>
<tr><td>MES</td><td>V.D.5</td><td>design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and</td><td>Current findings on previous recommendations:

Recommendations 1-4, March 20092:
• Develop and implement a system to track active treatment hours scheduled per week.
• Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours.
• Provide data regarding the number of active treatment hours per week for all individuals at the facility during the review period.
• Identify barriers to individual’s attendance at scheduled activities.

Findings:
SEH acknowledged that it does not yet have reliable data regarding active treatment hours provided to the individuals. However, the previously mentioned pilot of the Clinical Chart Audit reviewed the number of hours scheduled in the IRP. The following is a summary of the results:

<table><tr><td>0 hr</td><td>19%</td></tr><tr><td>1-9 hrs</td><td>19%</td></tr></table></td></tr>
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			<table><tr><td>10-19 hrs</td><td>37%</td></tr><tr><td>20+ hrs</td><td>26%</td></tr></table> The facility reported that it has made progress in hiring staff to provide needed hours, but that key shortages in rehabilitation and nursing staff have persisted, which continues to have negative impact on the provision of required active treatment hours. **Recommendations 5-7, March 2209:** • *Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.* • Monitor Mall alignment based on at least 20% sample (October 2007 to March 2009). • Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH has yet to implement these recommendations. The facility reported that plans are underway for development and implementation of a tool. **Other findings:** This consultant reviewed the charts of six individuals to determine the number of weekly active treatment hours that were scheduled by the team and documented in the IRP. The following table outlines the initials of the individuals and the

number of intervention hours that were documented in the IRP reviews:

Initials	Number of hours
DC	14.7
DT	13.3
GL	12.6
KE	12.5
SC	14.2
YL	13.3

The review found overall improvement in the number of scheduled hours since the last tour. However, the facility has yet to make progress to ensure the following:

1. An adequate system to track the number of active treatment hours per week (scheduled and attended);
2. Information regarding the participation of individuals in scheduled activities and
3. Proper Linkage between active treatment hours provided at the Mall and the objectives specified in the IRPs.

The facility has initiated adequate corrective action to address items 2 and 3 (adequate implementation of the facility's new version of the Therapeutic Note should provide needed correction).

Compliance:
Partial.

Current recommendations:
1. *Develop and implement a system to track active treatment hours scheduled per week.*

			2. *Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours.* 3. *Provide data regarding the number of active treatment hours per week for all individuals at the facility during the review period.* 4. *Identify and resolve barriers to individual's attendance at scheduled activities.* 5. *Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives.* 6. *Monitor Mall alignment based on at least 20% sample.* 7. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.D.6	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in V.D.1 through V.D.5. **Findings:** Same as in V.D.1 through V.D.5. **Compliance:** Noncompliance. **Current recommendations:** Same as in V.D.1 through V.D.5.

	E. Outcome-Driven Treatment Planning		
		By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:	Please see sub-cells for findings and compliance.
MES	V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals.* **Findings:** The facility's report did not adequately address this recommendation. **Recommendation 2, March 2009:** *Develop a Clinical Chart Monitoring Forms to include complete indicators and operational instructions to adequately address this requirement.* **Findings:** The Clinical Chart Audit tool includes an indicator to assess whether the IRP team modifies the objectives or interventions based upon the individual's progress or due to use of PRN/Stat medications, seclusion nor restraint. **Recommendations 3 and 4, March 2009:** • Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at

least 20% sample during the review period.

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

Findings:
The facility reported process observation data regarding this requirement (March to June 2009). Although the data addressed processes that are relevant to this requirement, the facility did not information regarding the actual revision of the IRP to reflect the changing needs of the individual.

Results of the Clinical Chart Audit pilot indicated 100% compliance with this indicator. In its self-report, the facility acknowledged that this compliance rate may be too high suggesting that modifications to the monitoring process may be needed.

Other findings:
This consultant reviewed the charts of eight individuals to assess the process of revising the IRPs as clinically indicated.

Initials	IRP reviews
AFB	6/17/09 and 9/16/09
DM	6/18/09 and 8/24/09
MM	7/8/09
RAM	6/8/09 and 8/3/09
RB	6/3/09 and 8/28/09
SC	7/8/09 and 9/9/09

WHM	7/10/09 and 9/2/09
WW	5/21/09 and 7/20/09

There was evidence, in most charts, that the treatment teams have revised some aspects of the IRP (case formulation, stages of change, goals/foci, objectives and/or interventions) in an effort to address the changing needs of the individuals. However, the chart of MM did not include evidence of timely review of the IRP. In the chart of DM, the last two treatment plan reviews were identical except for the dates of the reviews.

To achieve compliance with this requirement, the facility must also adequately address the pattern of deficiencies in the content of foci/objectives/interventions (initial and revised) outlined in sections V.D.1 through V.D.4.

Compliance:
Partial.

Current recommendations:
1. *Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals.*
2. *Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least 20% sample during the review period.*
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.E.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in V.E.1. **Findings:** Same as in V.E.1 **Recommendation 2, March 2009:** Implement the schedule of IRP reviews as specified in the revised policy. **Findings:** The revised Policy #602.2-04: IRP contained a requirement that IRP reviews are conducted by days 7, 14, 30, 60 and every 60 days thereafter. The self-report did not address the status of implementation of this requirement. The facility presented data regarding implementation of the monthly disciplinary progress notes not the IRP reviews. **Recommendations 3 and 4, March 2009:** • Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines. • Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions. **Findings:** SEH did not address these recommendations.

			Other findings: Chart reviews by this monitor showed that the facility has yet to implement this requirement. **Compliance:** Noncompliance. **Current recommendations:** 1. *Same as in V.E.1* 2. *Implement the schedule of IRP reviews as specified in the revised policy.* 3. *Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines.* 4. *Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.*
MES	V.E.3	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in V.E.1. **Findings:** Same as in V.E.1. **Other findings:** The revised IRP policy, the revised IRP Manual, the clinical formulation update and the psychiatric update template include requirements that should facilitate implementation of this requirement. The facility presented data regarding this requirement based on the Restraint/Seclusion Event Review Audit (February to June 2009) and the Clinical Chart Audit pilot. The facility recognized the need to refine monitoring for this

requirement because of the disparate results from these two tools.

This expert consultant reviewed the charts of five individuals who have 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 intervention 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 and subsequent reviews of the IRPs:

Initials	**S/R**	**IRP reviews**
AH	5/5/09	5/14/09
EW	6/24/09	6/25/09 and 7/2/09
KL	5/8/09	5/13/09 and 7/10/09
RJ	5/16/09	6/14/09
RW	6/26/09	7/13/09

In the charts reviewed, the present status section was either not completed or did not address the occurrence of the seclusion/restraints, the circumstances leading to their use or modifications of objectives and/or interventions to decrease future risk for the individuals. In addition, there was some discrepancy between the information documented in the present status section of the case formulation and the recent use of the restrictive interventions during the interval (e.g. EW was described as having no risk to self one week after experiencing seclusion/restraints for hitting another individual and being described as "very aggressive and unpredictable").

			Compliance: Partial. **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	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure that the policy regarding IRP provides instruction to individualize the discharge criteria.* **Findings:** SEH has implemented this recommendation. **Recommendation 2, March 2009:** *Revise the IRP manual to provide operational guidance with clinical examples to facilitate the individualization of discharge criteria.* **Findings:** The revised IRP Manual includes guidance to develop observable, behavioral or measurable criteria for discharge planning. However, the manual did not include clinical examples to facilitate implementation. **Recommendation 3, March 2009:** *Revise the IRP manual to include strategies to increase the motivation of individuals to participate in their IRPs.* **Findings:** The IRP training has included some information about

			motivational techniques. However, further work is needed to ensure full implementation of this recommendation. **Recommendations 4-6, March 2009:** • *Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions.* • Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content. • Provide aggregated data regarding results of competency-based training of all core members of the treatment team. **Findings:** The facility developed an IRP training module dedicated to discharge planning. The module includes adequate guidance regarding the development of individualized discharge criteria, documentation of progress towards criteria, recommendations for next setting and review and revision of objectives and interventions to support transition to the community. Training on this module was provided as part of IRP training (four units completed this training and training is ongoing for the remaining 13 units). The facility presented data regarding disciplines that attended the training. However, there was no documentation that training was competency-based. **Recommendations 7-9, March 2009:**

			• Develop Clinical Chart Monitoring form including complete and adequate indicators and operational instructions to address requirements of this Agreement regarding discharge planning. • Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** The facility presented process observation data (May through June 2009). The data were incomplete and not properly aggregated. However, month to month data showed compliance rates ranging from 92 to 100% regarding the team's review of barriers to discharge and 25 to 91% regarding the team's performance in providing the individual with opportunity to participate in discharge planning. **Other findings:** As mentioned earlier, chart reviews by this expert consultant found that the present status sections of the clinical formulation did not adequately document individualized discharge criteria and/or discussion by the team of the individual's progress towards these criteria. Most of the criteria were generic and did not utilize appropriate learning outcomes. The revised IRP Manual and training curriculum have yet to

			provide adequate clinical examples to facilitate the individualization of discharge criteria or include adequate cognitive and behavioral strategies to enhance the motivation of individuals to participate in their IRPs. **Compliance:** Partial. **Current recommendations:** 1. *Ensure that the IRP Manual provides adequate clinical examples to facilitate the individualization of discharge criteria.* 2. *Ensure that the IRP Manual/training includes strategies to increase the motivation of individuals to participate in their IRPs.* 3. *Implement the training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions* 4. *Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content.* 5. *Provide aggregated data regarding results of competency-based training of all core members of the treatment team.* 6. *Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample during the review period.* 7. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S),*

			indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in Section V.A.1 to V.A.1.5. **Findings:** Same as in Section V.A.1 to V.A.1.5. **Recommendation 2, March 2009:** Same as in V.B.1. **Findings:** Same as in V.B.1. **Recommendation 3, March 2009:** Same as V.E.4. **Findings:** Same as V.E.4. **Recommendation 4, March 2009:** Fully implement the new template for the Monthly Therapy Progress Note. **Findings:** SEH has revised its template for the Therapeutic (Progress) Note and developed operational instructions to ensure proper alignment of the Mall interventions and IRP objectives. As

			mentioned earlier, the facility developed an audit tool to assess implementation of this mechanism. Plans are reportedly underway to begin monitoring in September 2009. In addition, the facility developed disciplinary progress note templates, with operational instructions to ensure that the progress notes (psychiatry, social work and nursing) provide data to inform progress reviews and revision recommendations. Regarding the psychiatric notes, the new template has improved the structure and content of the reviews. **Other findings:** Observations by this expert consultant of the treatment team meetings indicated that the teams did not conduct a data-based review of the individual's progress in active treatment provided at the Mall. Other process deficiencies (see other findings in V.B.1) also contributed to inadequate implementation of this requirement. **Compliance:** Partial. **Current recommendations:** 1. Same as in Section V.A.1 to V.A.1.5. 2. Same as in V.B.1. 3. Same as V.E.4.

	VI. Mental Health Assessments		
MES and RB		By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	**Summary of Progress:** 1. The facility's Medical Director has taken the initiative to survey certain diagnostic practices in an effort to improve compliance with requirements of this Agreement. 2. SEH has improved its practice in the finalization of provisional diagnoses. 3. Although significant refinements are needed, SEH has implemented adequate templates for the comprehensive initial psychiatric assessment and psychiatric update (reassessment) and developed guidelines for the use of these templates. 4. Although refinements are needed, the facility has finalized self-audit tools and operational instructions regarding the comprehensive initial psychiatric assessments and updates (reassessments). 5. The facility has initiated the process of self-auditing of the content of the comprehensive initial psychiatric assessment. 6. SEH conducted a follow-up self-assessment that offered a candid assessment of current status and some corrective measures needed towards compliance with requirements of the Agreement. 7. The initial assessments conducted by Psychology, Social Work and Rehabilitative Services are designed to appropriately meet the requirements of the Agreement. Auditing data has revealed areas where continued supervision is necessary so that appropriate compliance rates are met and maintained.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Sumit Anand, MD, Medical Director, Civil Service 3. Feng Dong, MD, Staff Psychiatrist 4. Tyler Jones, Staff Psychiatrist Reviewed: 1. Charts of the following 38 individuals: AK, BC, BW, CB, CC, DA, DJ, DS, EW, FF, FP, GS-1, GS-2, JA, JN, JR, JW, KE, KW, LJ, LN, LW, MA, MK, ML, MLH, ND, PJJ, PS, RJ, RJB, RP, RW, TJ-1, TJ-2, TT, WC and WW 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (September 1, 2009) 3. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians 4. SEH Policy #602.1-08: Assessments, revised August 13, 2009 5. SEH Policy #601-02: Medical Records, revised July 21, 2009 6. SEH template for the Psychiatric Update, revised July 07, 2009 7. SEH Policy #111.2-08: Patient Transfers, revised August 13, 2009 8. SEH Description of Monitoring System, Draft (not dated) 9. SEH Clinical Chart Audit tool and operational instructions, July 2, 2009 10. SEH Process Observation Tool and Operational Instructions, revised July 13, 2009 11. SEH IRP Process Observation data summary (February to June 2009) 12. SEH Comprehensive Initial Psychiatric Assessment Self-

			Audit Tool and operational instructions (August 18, 2009) 13. SEH Comprehensive Initial Psychiatric Assessment Self-Audit summary data (April to June 2009) 14. SEH Psychiatric update Self-Audit tool and operational instructions (not dated) 15. SEH Patient Transfer Monitoring Tool (revised June 02, 2009) 16. SEH Patient transfer monitoring summary data (March to June 2009) 17. Outline of orientation sessions for all trainees, including students and residents related to patient abuse/neglect (6/1/09. 6/29/09 and 7/1/09) 18. Outline of grand rounds on Neurocognitive Disorders and Remediation/Accommodation, March 2009 19. SEH data regarding current psychiatric staffing, including trainees <u>Observed</u>: 1. Team meeting at JHP-1 for IRP review of MM 2. Team meeting at JHP-6 for IRP review of CB 3. Team meeting at JHP-6 for IRP review of CS 4. Team meeting at JHP-8 for IRP review of CD 5. Team meeting at JHP-8 for IRP review of VA 6. Team meeting at RMB-1 for IRP review of BS 7. Team meeting at RMB-4 for IRP review of RN 8. Team meeting at RMB-7 for IRP review of SD 9. Team meeting at RMB-8 for IRP review of AH
MES	VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Ensure consistency between the revised policy, Assessments and the revised policy, Medical Records regarding the required*

		outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	*frequency for completion of psychiatric updates (reassessments).* **Findings:** SEH reported that the revised policies #602.1-08: Assessments and #601-02: Medical Records contain consistent time frames for completion of the psychiatric updates (reassessments). However, the time frames in the Assessments policy ("at least two business days prior to the scheduled IRP meeting") are still inconsistent with the time frames in the medical records policy ("at least weekly until the 6oth admission day then monthly thereafter"). At this time, only the Medical Records policy contains a frequency requirement that reflects current generally accepted standards in this area. **Recommendation 2, March 2009:** *Develop guidelines for completion of the psychiatric update and self-auditing of these updates.* **Findings:** SEH has implemented this recommendation. **Recommendation 3, March 2009:** *Ensure the integration of additional information that becomes available following admission to the facility to permit a more complete review/assessment. This information should include, but not be limited to, psychosocial history, substance abuse history, psychiatric risk factors, strengths, diagnostic formulation, differential diagnosis, and management of identified additional risks.* **Findings:** SEH did not address this recommendation.

			Recommendation 4, March 2009: *Ensure consistent and full implementation of the new templates for initial comprehensive assessments and psychiatric update.* **Findings:** SEH reported that it has begun to implement both templates. The template for the comprehensive initial psychiatric assessment (CIPA) was activated in the facility's electronic system (AVATAR) in July 2009. Implementation of the template for the psychiatric update began in August 2009 (this template has yet to be entered into AVATAR). As mentioned above, the facility has developed adequate guidelines for its staff regarding the proper completion of the current templates for comprehensive initial psychiatric assessment and psychiatric update (reassessment). **Recommendations 5 and 6, March 2009:** • Provide monitoring data regarding the timeliness and content of psychiatric assessments and reassessments based on at least 20% sample during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures. • Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** As mentioned earlier, SEH has finalized its Comprehensive

			Initial Psychiatric Assessment Self-Audit Tool and operational instructions (August 18, 2009). In June and July 2009, the facility conducted an audit using the previous version of this tool. This audit was based on a sample size of 20%. The facility has yet to refine the process of data aggregation and presentation of compliance data per each specific quality indicator. Overall, however, the current self-assessment data showed improvement in the psychiatric assessments in several quality indicators. In addition, the facility has finalized a Psychiatric Update Self-Audit tool and operational instructions (not dated) and has a plan to begin auditing in September 2009. The facility reported that data regarding the timeliness of all disciplinary assessments and reassessments will be obtained through AVATAR when all corresponding templates are entered into this system. **Other findings:** Chart reviews by this monitor indicated that, in general, the structure and content of the comprehensive initial psychiatric assessments and the psychiatric updates (reassessments) have improved since the last review. However, the assessments and reassessments still fell short of compliance with the requirements of the Agreement as illustrated by findings of deficiencies in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. These deficiencies must be corrected to achieve substantial compliance with the Agreement. **Compliance:** Partial.

			Current recommendations: 1. *Ensure the revised policy regarding, Assessments contain the same time frames for completion of psychiatric updates (reassessments) that are outlined in the policy regarding Medical Records.* 2. *Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.* 3. *Provide monitoring data regarding both timeliness and content of psychiatric assessments and reassessments based on at least 20% sample during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures.* 4. *Ensure that the progress report includes a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VI.A.2	By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as VI.A.1. **Findings:** Same as VI.A.1. **Recommendation 2, March 2009:** *Ensure an integrated system of admission risk assessment (psychiatric and psychological).* **Findings:**

			The facility's report reiterated previously submitted information regarding the current processes of psychiatric and psychological risk assessments that are completed within different time frames. However, the report did not address this recommendation. The current psychiatric and psychological risk assessment processes have the potential to produce different ratings in the same or similar categories of risk, which can confound clinical determinations by the teams and the proper establishment of high-risk situations by the facility's risk management system. **Recommendations 3 and 4, March 2009:** • Monitor risk assessment as part of the initial psychiatric assessment, based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** The facility presented data based on the CIPA audit (April to June 2009) showing that the risk assessment was completed in 87% of the cases and precautions identified in 77% of the cases. The sample was 18% of admissions. More work is needed to improve data aggregation and presentation per specific quality indicators. **Compliance:** Partial.

			Current recommendations: 1. *Same as VI.A.1.* 2. *Ensure an integrated system of admission risk assessment (psychiatric and psychological).* 3. *Monitor risk assessment as part of the comprehensive initial psychiatric assessment, based on at least 20% sample during the review period.* 4. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VI.A.3	By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in VI.A.1 and VI.A.6. **Findings:** Same as in VI.A.1 and VI.A.6. **Recommendation 2, March 2009:** *Develop and implement monitoring indicators regarding diagnostic accuracy in the psychiatric reassessments.* **Findings:** The psychiatric update (reassessment) audit includes some adequate indicators regarding diagnostic accuracy. However, this audit has yet to in include an indicator to assess if diagnosis is properly updated in response to a review of current clinical

			data. **Recommendations 3 and 4, March 2009:** • Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** In its self-report, SEH reported a completion rate of 83% for the diagnostic sections in the comprehensive initial psychiatric assessments. However, no data were presented regarding the quality of diagnostic accuracy due an error in the auditing process that has reportedly been corrected of late. More work is needed to refine data aggregation and presentation of compliance rates per specific indicators. **Other findings:** The facility reported that its Medical Director is leading a survey of individuals receiving deferred Axis I diagnosis and diagnosis of Psychotic Disorder NOS to assess proper justification and practitioner patterns that require corrective action. In its self-report, SEH reported plans to improve the capacity of its AVATAR system to track diagnostic information of each individual for certain periods of time. If properly implemented,

this process can facilitate efforts to determine practitioner trends and patterns related to this requirement and implementation targeted corrective actions.

Review of the facility's database found a significant decrease in the number of individuals receiving certain unspecified diagnosis compared to the last review. The following table shows the current number of individuals who have received these diagnoses continuously for the past three or more months:

Diagnosis	Number of individuals
Psychotic Disorder NOS	14
Impulse Control Disorder NOS	3
Depressive Disorder NOS	8
Mood Disorder NOS	2

This expert consultant reviewed the charts of 14 individuals who have received diagnoses listed as NOS or R/O during this reportable period. The review found improved practice in the following areas:

1. Documentation of adequate metabolic and neurological work-up for some individuals diagnosed with Dementia NOS (BW);
2. Finalization, as clinically appropriate, of diagnoses of Dementia NOS in some cases (LN);
3. Finalization, as clinically appropriate, of diagnoses of Psychotic Disorder NOS in most charts reviewed:
4. Appropriate justification for the diagnosis of Depressive Disorder NOS in some individuals who were also diagnosed with chronic schizophrenic illnesses (e.g. JW); and
5. Performance of the mini mental status examination (MMSE) for some individuals suffering from cognitive disorders (RJ,

TJ and BW). This tool can provide an adequate basis for monitoring of changes in the status of the individual (BC).

However, the review found deficiencies in several charts (CC, MA, RP, GS, DS, DJ and WW) regarding the documentation of efforts to finalize the diagnosis, as indicated, the assessment of the cognitive impairments, as indicated and/or alignment of the diagnostic information in the current IRP with the corresponding psychiatric progress notes. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the chart reviews:

Initials	**Diagnosis**
LW	Psychotic Disorder, NOS (updated to Schizoaffective Disorder, Bipolar Type)
EW	Psychotic Disorder, NOS (updated to Paranoid Schizophrenia)
RJ	Impulse Control Disorder, NOS and Cognitive Disorder NOS
CC	R/O Dementia
BW	Dementia, NOS
MA	Dementia, NOS
LN	Dementia, NOS (Updated to Vascular Dementia with Delusions)
RP	Dementia, NOS
BC	Dementia, NOS
GS	Cognitive Disorder, NOS and Mood Disorder NOS
JW	Depressive Disorder, NOS
DS	Depressive Disorder, NOS
DJ	Impulse Control Disorder, NOS
WW	Impulse Control Disorder, NOS

			Compliance: Partial. **Current recommendations:** 1. *Same as in VI.A.1 and VI.A.6.* 2. *Develop and implement an indicator in the psychiatric update (reassessments) audit to assess if diagnosis was properly updated in response to a review of new clinical data.* 3. *Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments during the review period.* 4. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 5. *Provide a summary of findings by the facility's Medical Director regarding internal survey of diagnosis listed as deferred and/or not otherwise specified, including any corrective actions.*
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;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:**

			Partial. **Current recommendations:** Same as above.
MES	VI.A.5	By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.1 and VI.A.2. **Findings:** Same as in VI.A.1 and VI.A.2. **Other findings:** This expert consultant reviewed the charts of 10 individuals (AK, CB, DA, GS, JA, JW, KE, MLA, PJJ and RW) who were admitted during this review period (June and July 2009). The reviews found that the facility has implemented the comprehensive initial psychiatric assessment in all the cases reviewed. In general, implementation of this template appeared to have improved the content of the assessments, However, the following deficiencies were noted: 1. In general, the history of present illness, psychosocial history and risk assessment were based on incomplete information upon admission. There was no documentation or integration of additional information that became available following admission. 2. The psychosocial history did not address relationship/sexual, military or legal history (CB and DA). 3. In all the charts reviewed, the substance use section was inconsistently completed and excessively redundant. In general, this section did not meaningfully inform the

			assessment. 4. The mental status examination did not provide information to specify the nature of current symptoms, e.g. command hallucinations in the chart of CB. 5. The mental status examination did not address the individual's speech (CB and DA), mood (CB and DA) or thought content (GS). 6. The mental status examination did not include a comment on current suicidal and homicidal ideations, intent or plan (CB, DA, GS, JW, KE and MLA). 7. Memory was described as "poor" (MLA) or "seemed limited" (RW) with no specifics. 8. The risk assessment for sexual aggression included contradictory information regarding the history (KE). 9. The risk assessment for elopement included a statement that did not address the risk (KE). 10. The risk assessment was incomplete (DA). 11. The assessment of impulse control, insight and judgment was generic and nonspecific (listed as impaired, grossly impaired, fair or poor) in almost all the charts reviewed. 12. No diagnosis of substance use disorder was established despite information in the assessment that supports this diagnosis (RW). **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.1 to VI.A.3.* 2. *Develop and implemented corrective actions to address the deficiencies outlined in findings 1-12 above. Ensure that these corrections focus on the following main areas:* a) *Consolidation and reorganization of information*

			regarding substance use history to better the inform the assessment; b) *An update of the assessment by the seventh hospital day following admission to integrate additional information that became available regarding the history of present illness, psychosocial history and risk assessment as well as any additional relevant clinical data; and* c) *Provision of specific data to address findings in the mental status, including disturbances of thought content, cognitive examination, current suicidal and homicidal ideations/intent/plan and insight/judgment.*
	VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
MES	VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.1, VI.A.3, and VI.A.6. **Findings:** Same as in VI.A.1, VI.A.3, and VI.A.6. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.1, VI.A.3 and VI.A.6.*
MES	VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments	**Current findings on previous recommendations:** **Recommendation 1 March 2009:** *Provide information to specify how all trainees, including*

		and write a note to accompany these assessments;	*students and residents have been oriented to the facility's policy and procedure regarding the recognition and reporting of patient abuse and neglect.* **Findings:** SEH provided an outline of adequate orientation training to trainees, including students and residents. However, the facility did not provide documentation to verify attendance and competency-based training. **Recommendations 2 and 3, March 2009:** • *Implement corrective actions to ensure attending physicians provided follow up.* • Provide self-assessment data regarding implementation of this requirement. **Findings:** SEH provided data based on the CIPA audit, which included an operational instruction that aligns with the facility's policy. The data (April to June 2009) was based on an 18% sample and showed an 83% compliance rate. Further, a review of a small sample of notes by the medical students or externs found that 75% of the notes were accompanied by a note by the attending physician addressing the student/extern's note. However, in its self-report, the facility acknowledged that the attending physicians' merely countersigning notes by trainees continues to be too common a practice. **Other findings:** During this review period, SEH has maintained its facility-based residency training program in Psychiatry and continued to serve as a training site for forensic psychiatry fellows from Georgetown University and residents. In addition, SEH has

			continued to serve as a training site for psychiatry residents from Howard University and the Uniformed Services University Schools of Medicine as well as medical students from Georgetown University, George Washington University, Uniformed Services University, Ross University, Howard University and the American University of Antigua. Chart reviews confirmed the facility's findings regarding the practice of the attending physicians countersigning the notes by trainees without providing additional documentation to ensure that diagnostic and treatment questions are adequately addressed by the supervising physician. **Compliance:** Partial. **Current recommendations:** 1. *Provide documentation of competency-based training of all trainees, including students and residents regarding issues of patient abuse/neglect.* 2. *Implement corrective actions to ensure attending physicians provided follow up.* 3. *Provide self-assessment data regarding implementation of this requirement.*
MES	VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4.

			Recommendations 2 and 3, March 2009: • *Provide CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.* • *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.* **Findings:** SEH provided grand rounds to its psychiatry and psychology staff (in March 2009) regarding Neurocognitive Disorders and models and techniques of cognitive remediation for individuals suffering from these disorders. The facility's report did not specify the affiliation of the speakers. **Recommendation 4, March 2009:** Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS. **Findings:** Same as in VI.A.3. **Other findings:** Same as in VI.A.3. In addition, during one IRP team meeting (JHP-6), this expert consultant learned that the psychiatrist and the psychologist assigned to this team were unaware that the facility had provided the above-mentioned training regarding cognitive remediation. **Compliance:**

			Partial. **Current recommendations:** 1. *Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.* 2. *Provide further CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.* 3. *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.*
MES	VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.1 through VI.A.6.a and VI.6.c **Findings:** Same as in VI.A.1 through VI.A.6.a and VI.6.c **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.1 through VI.A.6.a and VI.6.c*
MES	VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	**Current findings on previous recommendations:** **Recommendation 1 and 2, March 2009:** • *Ensure consistent implementation of the new template for the psychiatric update.* • *Implement corrective actions to ensure that the content of the psychiatric updates meets all requirements of this Agreement.*

			Findings: As mentioned earlier, the facility developed a template for the psychiatric update (reassessment) and developed instructions to staff regarding proper completion of this template. The template provides information on each of the following areas: 1. Legal status; 2. Subjective findings; 3. Objective findings and mental status examination; 4. Clinical history/course; 5. Current target symptoms; 6. Use of Stat medications, seclusion and/or restraints, including triggers for this use; 7. Use of involuntary medications; 8. Side effects of new generation antipsychotic medications (if applicable); 9. Rationale for polypharmacy if applicable); 10. Risk assessment for violence/suicide; 11. Results of rating scales used; 12. Assessment of individual's progress; 13. Review of specific behavioral and/or psychodynamic issues affecting lack of progress (if applicable); 14. Diagnoses (five axes); 15. Justification for continued deferral of diagnosis and NOS diagnosis (if applicable); 16. Current medication regimen; 17. Abnormal laboratory results; 18. Plan of care (pharmacological and behavioral, with attention to high risk medication uses) and 19. Certification of necessity of inpatient level of care. If properly implemented, this template can improve the facility's

			compliance with this requirement (the facility should refine this template to address PRN medication use during the interval). SEH recently began implementation of this template and plans to enter the template in the AVATAR system. The facility recently developed a psychiatric update (reassessment) self-audit tool with operational instructions and expects to begin auditing in September 2009. **Recommendation 3, March 2009:** *Same as in VI.A.1.* **Findings:** Same as in VI.A.1. **Other findings:** This consultant reviewed the charts of 24 individuals (BC, BW, CC, EW, FF, FP, GS-1, GS-2, JN, JR, KW, LJ, MA, MK, ML, ND, PS, RJB, RP, TJ, TJ-2, TT, WC and WW). The reviews found that the facility has implemented the new template for the Psychiatric Update (reassessment) since July 2009. In general, this template has improved both the content and the organization of information in the reassessments. However, the facility must address the following deficiencies in order to achieve substantial compliance with this requirement: 1. None of the charts included an adequate review of the use of PRN medications during the interval or evidence of adjustment of regular treatment based on this review. 2. Some psychiatric updates skipped the requirement for review of the individual's interval history/course since the

			last update (BC, BW and TJ). In on reassessment, the interval history was described as "stable" without any other information that addresses treatment/rehabilitation targets and justifies need for further hospitalization (WW). 3. The mental status examinations (cognitive status assessment) often did not support the established diagnoses of Dementia (BC, BW, MK and RP). Conversely, a few reassessments appeared to suggest a diagnosis of Dementia, but the diagnosis was not addressed or listed as an R/O (JR). 4. The cognitive examination was incomplete (no memory testing was done/attempted) for an individual who was diagnosed (as per the IRP) with borderline intellectual functioning and was receiving high-risk treatment (ML). 5. Some reassessments did not provide specific information regarding significant abnormalities of thought content e.g. persecutory and religious delusions (CC). 6. The psychiatric reassessments for some individuals who required the use of seclusion/restraints (e.g. EW) did not document the circumstances of the restrictive interventions or modifications of treatment to lower the risk for the individual. 7. During hospitalization, an individual (TJ-2) was diagnosed with Major Depression with Psychotic features in addition to the known diagnosis of Borderline Personality Disorder. The individual had a serious suicide attempt on July 25, 2009. The psychiatric reassessments did not adequately address the new diagnosis, including optimization of antidepressant and antipsychotic medication trails prior to the decision to send the individual to court on July 28, 2009. Review of the case and staff interviews found that the root cause was a breakdown in the process of diagnostic update, particularly regarding the roles of the attending psychiatric and the on-call psychiatrist in this process.

			8. The psychiatric reassessment of some individuals (GS and MK) who were diagnosed with substance use disorder and/or possible (GS) or definite (MK) cognitive impairment included inaccurate information about current treatment with a high risk agent (lorazepam). 9. Some reassessments did not address the risks of continued treatment with anticholinergic agents in presence of cognitive impairment (FF, JN, KW and RJB). Two of these reassessments (KW and RJB) inaccurately stated that this practice did not occur. 10. The psychiatric reassessment of an individual who was diagnosed with cognitive impairment, tardive dyskinesia and substance use disorder did not address the risk of current treatment with a combination of anticholinergic medications and a benzodiazepine agent (LJ). 11. Some psychiatric reassessments did not address the status of individuals diagnosed with tardive dyskinesia (FP, ND, PS and WC). 12. In one individual, there was no evidence of psychiatric reassessments in May or June 2009 that would meet minimum requirements of the Agreement (the individual, LW, was admitted in April 2009). 13. There was no evidence of integration of pharmacological and behavioral modalities in any of the charts of individuals who appeared to be candidates for behavioral interventions. **Compliance:** Partial. **Current recommendations:** 1. *Refine the template for the psychiatric update to address PRN medication use;* 2. *Ensure consistent implementation of the new template for*

			the psychiatric update. 3. *Develop and implemented corrective actions to address the deficiencies outlined in findings 1-13 above. Ensure that these corrections focus on the following main areas:* a) *Interval history is consistently addressed;* b) *PRN medications are reviewed and regular treatment is adjusted, as clinically appropriate, based on this review;* c) *The sections regarding special risks of treatment (benzodiazepines, anticholinergics, antipsychotics and polypharmacy) as well as use of restrictive interventions are properly completed.* d) *The assessment section adequately addresses current risk factors as well as risks/benefits of treatment.* e) *There is timely and appropriate referral for behavioral interventions when indicated and integration of pharmacological and behavioral interventions as applicable.* 4. *Same as in VI.A.1.*

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Richard Gontang, PhD, Chief, Psychology Department Reviewed Records of the following 15 individuals: AB, AK, CJ, II, JW, KH, KP, LD, MH, PJ, RG, RP, SD, SW and WT Observed: 1. IRP Conference: BS 921351 09/22/09 2. IRP Conference: AH 151124 09/22/09 3. IRP Conference: CS 923352 09/23/09 4. IRP Conference: VA 121396 09/24/09
RB	VI.B.1	By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools)* ***according to the planned roll out schedule*** *that address the psychological assessment process. At a minimum, monitor:* a. *Timeliness of the assessment process as per yet to be established policy guidelines;* b. *The quality of each section of the evaluation;* c. *The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record; and* d. *The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation.*

			Findings: Auditing has only begun for Initial Psychological Assessment (IPA). A roll out plan was presented that indicated that the remainder of the audit tools will be developed by 10/30/09. Results of IPA audit from April through July 2009 indicated that most indicators were being reported at about 80%. Problem areas include: summary of patient strengths and history of previous psychological assessments. These findings correspond with those of this consultant. **Recommendation 2, April 2009:** Present the above as trended data. **Findings:** Data is not being presented in trended format. **Recommendation 3, April 2009:** *Revise the IPA to include prompts for history of head/brain injury and dates and results of past psychological assessment.* **Findings:** Completed. **Recommendation 4, April 2009:** *Develop a FTE for neuropsychology that assures full time coverage of this service.* **Findings:** Not done. **Compliance:** Partial.

			Current recommendations: 1. Present all auditing data in trended fashion and not as 6-month summaries. 2. Develop a FTE for neuropsychology. 3. Complete the roll out for additional audit tools.
	VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments shall:	Please see sub-cells for findings and compliance.
RB	VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice. **Findings:** Current practice remains consistent. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
RB	VI.B.2.b	be based on current and accurate data;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice. **Findings:** Current practice remains consistent. **Compliance:**

			Substantial. **Current recommendation:** Continue current practice.
RB	VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Maintain current level of practice. **Findings:** Current practice remains consistent. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Develop clear guidelines for the Conclusions and Recommendations sections of the IPA.* **Findings:** Guidelines have been developed but need to be modified to include recommendation of specific groups from the Mall Catalogue. **Compliance:** Partial.

			Current recommendation: Revise guidelines for Recommendations section of IPA to include recommendation of specific groups from the Mall Catalogue.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current level of practice. **Findings:** Current practice level has been maintained. **Compliance:** Substantial. **Current recommendation:** Continue current level of practice.
RB	VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Implement developed timeline*. **Findings:** It was reported that team psychologists have been asked to determine for these individuals the need for further assessment at the time of each IRP conference. However, there is no documentation process for this and hence, no auditing. Moreover, the lack of a more clearly delineated process may have played a role in the fact that some individuals implicated in a behavioral incident on RMB 3 in July 2009 did not have a current psychological assessment data in their charts. The hospital's self-assessment indicated that there was a plan to complete IPAs on all individuals by 01/15/2010

			Recommendation 2, April 2009: *Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment.* **Findings:** Not yet done. **Compliance:** Partial. **Current recommendations:** 1. Implement timeline. 2. Begin auditing process.
RB	VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current level of practice. **Findings:** Current level of practice has been maintained. **Compliance:** Substantial. **Current recommendation:** Continue current level of practice.
RB	VI.B.5	By 24 months from the Effective Date hereof,	**Current findings on previous recommendations:**

		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.	**Recommendation 1, April 2009:** *Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations*. **Findings:** An acceptable process was developed but has not yet been implemented. **Recommendation 2, April 2009:** Monitor through chart auditing process that treatment teams document their response to the results of psychological assessments other than the IPA. **Findings:** Not yet begun. **Compliance:** Partial. **Current recommendations:** 1. Implement process for assuring the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations. 2. Begin auditing process. 3. Present all results as trended data.

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: 1. Michelle Coleman, Chief, Rehabilitation Services – Civil Division 2. Crystal Robinson, Chief, Rehabilitation Services – forensic Division 3. Dr. Clo Vidani-Clark.; Chief of Civil Division Reviewed: Medical records of the following 15 individuals: AB, AK, CJ, II, JW, KH, KP, LD, MH, PJ, RG, RP, SD, SW and WT Observed: 1. IRP Conference: BS 921351 09/22/09 2. IRP Conference: AH 151124 09/22/09 3. IRP Conference: CS 923352 09/23/09 4. IRP Conference: VA 121396 09/24/09
RB	VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop a staffing and recruitment plan to assure that an adequate number of RS staff are hired and retained to enable timely completion of SRAs*. **Findings:** The Approved Positions List supplied by the hospital indicated that 3 Rehabilitative Services (RS) positions have been approved, but information provided on the tour suggests an additional need for several categories of staff including recreation therapists, music and art therapists, occupational therapists and vocational

			and educational specialists. It was also reported that RS staff routinely have a caseload of approximately 50 individuals, which helps to explain why they are frequently not present at IRP conferences (RS staff not present at 50% of the IRP conferences attended by this consultant). Additionally, the hospital's self-assessment indicated that only 50% of SRAs are being completed in a timely fashion, which is similar to the rate found by this consultant in reviewed records. **Recommendation 2, April 2009:** Audit and present data from forensic charts as well. **Findings:** Data is being presented for both civil and forensic patients, but no breakdown was provided. **Recommendation 3, April 2009:** *Develop policies so that all clinical disciplines are providing a required number of mall groups and so that treatment planning is scheduled at times that permit all treatment team members to attend.* **Findings:** Not done. **Compliance:** Partial. **Current recommendations:** 1. Complete a Needs Assessment for RS staffing and provide a staffing plan specific to the RS Department with indications of when outstanding positions will be filled. 2. Present SRA audit data both for all patients and broken

			down by division. 3. Present all auditing results as trended data. 4. Develop guidelines for all clinical disciplines concerning the minimum number of mall treatment groups that must be provided by each discipline per week.
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;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.* **Findings:** See Cell VI.C.1 **Recommendation 2, April 2009:** *Audit and provide data for forensic as well as civil units.* **Findings:** See Cell VI.C.1 **Compliance:** Partial. **Current recommendation:** See Cell VI.C.1
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or	**Current findings on previous recommendations:**

		disorder;	**Recommendation 1, April 2009:** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.* **Findings:** See Cell VI.C.1 **Recommendation 2, April 2009:** *Audit and provide data for forensic as well as civil units.* **Findings:** See Cell VI.C.1 **Compliance:** Partial. **Current recommendation:** See Cell VI.C.1
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.* **Findings:** See Cell VI.C.1 **Recommendation 2, April 2009:** *Audit and provide data for forensic as well as civil units.*

			Findings: See Cell VI.C.1 **Compliance:** Partial. **Current recommendation:** See Cell VI.C.1
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.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop a staffing and recruitment plan to assure that an adequate number of RT staff are hired and retained to enable timely completion of SRAs.* **Findings:** See Cell VI.C.1 **Recommendation 2, April 2009:** *Revise that section of the instructions for the SRA to indicate the need for recommendations to include specific and individualized strategies.* **Findings:** Guidelines have been developed but need to be modified to include recommendation of specific groups from the Mall Catalogue. **Recommendation 3, April 2009:** *Audit and provide data for forensic as well as civil units.* **Findings:**

			See Cell VI.C.1 **Compliance:** Partial. **Current recommendations:** 1. See Cell VI.C.1 2. Revise instructions for Recommendations section of SRA to include recommendations for specific groups from the Mall Catalogue.
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.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Continue to implement timeline for providing an SRA for all individuals previously admitted to the Hospital.* **Findings:** The hospital's self-assessment report indicated that a process is in place to complete this and the process has begun; however, no timeline for completion was given. **Recommendation 2, April 2009:** *Continue to implement timeline for development of forensic mall services.* **Findings:** Mall services are now provided for all post-trial forensic patients and on unit groups are provided for pre-trial patients. Mall services for this latter group will be developed when space is available in the new hospital. **Compliance:**

			Partial. **Current recommendations:** 1. Continue current practice for mall services for post-trial patients and on-unit services for pre-trial patients. 2. Provide a date by which SRAs will be completed on all previously admitted patients.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Daisy Wilhoit, LCSW; Chief, Social Work Department – Civil Division 2. Harriette Moore, LCSW; Chief, Social Work Department – Forensic Division Reviewed: Medical records of the following 15 individuals: AB, AK, CJ, II, JW, KH, KP, LD, MH, PJ, RG, RP, SD, SW and WT Observed: 1. IRP Conference: BS 921351 09/22/09 2. IRP Conference: AH 151124 09/22/09 3. IRP Conference: CS 923352 09/23/09 4. IRP Conference: VA 121396 09/24/09
RB	VI.D	By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Begin to audit a 20% sample of all newly admitted individuals using the new audit tool.* **Findings:** Auditing with appropriate sample size appears to have begun in April 2009, but other data provided in the self-assessment suggests less than a 20% sample size was audited each month. Data indicated that most indicators were at or above 80% with the exception of a discussion of the patient's goals (65%) and identification of skills needed for discharge (75%). SW chiefs indicated that deficiencies in this area were being handled in

			individual supervision. **Recommendation 2, April 2009:** Present trended data analysis as part of an overall performance improvement initiative. **Findings:** Audit results were presented as trended data. **Compliance:** Partial. **Current recommendation:** Demonstrate that a proper sample size was used for each audit.

	VII. Discharge Planning and Community Integration		
RB		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The hospital has successfully reduced the number of individuals on the resistive to discharge list and has implemented weekly meetings to review these cases. Further refinement of the documentation requirements for these meetings must be developed. 2. A lack of conceptual clarity exists among IRP team members about the proper flow from individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions.
			Methodology: <u>Interviewed</u>: 1. Sue Sepheri, Director of Community Integration and Social Services 2. Daisy Wilhoit, LCSW, SW Chief, Civil Division 3. Harriette Moore, LCSW, SW Chief Forensic Division <u>Reviewed</u>: Medical records for the following 55 individuals: AA, AH-1, AH-2, AP, BC, BS, CE, CH, CL, CM, CW-1, CW-2, DC, DD, DH, DJ, DT, EC, ED, FW, GM, JA, JJ, JL, JM, JT, KEK, KP, LC, LK, LM-1, LM-2, MA, MC, MH, MJ, MS, ND, OM, PN, PT, RB-1, RB-2, RE, RG-1, RG-2, RH, RM, RP, SW, TJ, TK, TT, VA and WC
RB	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of*

			treatment to discharge criteria, and how to document this in the IRP. **Findings:** This consultant was told that training had emphasized that discharge criteria would primarily be embedded in the Focus Statement for Focus 1. However, a lack of conceptual clarity was still evident in the IRP Manual and clear discharge criteria were found in none of the reviewed records. **Compliance:** Partial. **Current recommendations:** 1. Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. 2. Assure that training includes how to clearly document these processes in the IRP.
RB	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Modify treatment team training to clearly identify how to develop discharge criteria and foci of hospitalization that utilize an individual's strengths and preferences in discharge planning.* **Findings:** This consultant was told that training had emphasized that discharge criteria would primarily be embedded in the Focus Statement for Focus 1. However, a lack of conceptual clarity was

			still evident in the IRP Manual and clear discharge criteria were found in none of the reviewed records. **Recommendation 2, April 2009:** *Once training is completed, develop appropriate audit to monitor the implementation of this integration in both the IRP conference and the written IRP.* **Findings:** While the current IRP process and content are being audited, the audit tool will need to change as a result of the training recommended below. **Compliance:** Partial. **Current recommendations:** 1. Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. 2. Assure that training includes how to clearly document these processes in the IRP. 3. Modify audit tools to reflect this training.
RB	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.*

			Findings: See VII.A.1 **Compliance:** Partial. **Current recommendation:** See VII.A.1
RB	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria, and how to document this in the IRP.* **Findings:** See VII.A.1 **Compliance:** Partial. **Current recommendation:** See VII.A.1
RB	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Current findings on previous recommendations:** **Recommendation, April 2009:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to discharge criteria and the skills necessary for*

			successful community tenure, and how to document this in the IRP. **Findings:** See VII.A.1 **Compliance:** Partial. **Current recommendation:** See VII.A.1
RB	VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Modify treatment team training to clearly identify the conceptual and practical flow from assessment to foci of treatment to specific treatment objectives, and how to document this in the IRP.* **Findings:** See VII.A.1 **Compliance:** Partial. **Current recommendation:** See VII.A.1
RB	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Revise IRP to include a section specifically on Discharge Criteria.*

			Findings: See VII.A.1 **Compliance:** Partial. **Current recommendation:** See VII.A.1
RB	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Revise IRP training module as needed to assure that this item is routinely addressed by all treatment teams.* **Findings:** While interventions are now measureable, it is frequently unclear how they are related to discharge criteria, when the latter are not clearly specified. **Compliance:** Partial. **Current recommendation:** Clarify how discharge criteria are to be presented in the IRP.
RB	VII.C.2	the persons responsible for accomplishing the interventions; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Include this item as part of the clinical chart audit of the IRP.* **Findings:**

			The audit includes this item but hospital data indicated that compliance is only achieved 46% of the time. **Compliance:** Partial. **Current recommendations:** 1. Continue audit process. 2. If compliance rate does not increase, determine and address barriers to successful completion of this item.
RB	VII.C.3	the time frames for completion of the interventions.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Modify IRP training to assure that this item is covered.* **Findings:** Same as VII.C.3 **Recommendation 2, April 2009:** *Develop separate process and content audits for the IRP.* **Findings:** Completed. **Compliance:** Partial. **Current recommendation:** Same as VII.C.3
RB	VII.D	By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall	**Current findings on previous recommendations:**

		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.	**Recommendation 1, April 2009:** Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. **Findings:** While admirable work has been done in providing more community transition services to several of the hospital's patients, meetings have apparently only begun to address identifying the needed skills and no target date was indicated for the completion of this process. **Recommendation 2, April 2009:** Train auditors to acceptable levels of reliability. **Findings:** Not begun. **Recommendation 3, April 2009:** Provide operational definitions of all terms in a written format to aid in data reliability and validity. **Findings:** Not begun. **Recommendation 4, April 2009:** Report as trended data analysis. **Findings:** Not begun. **Compliance:** Noncompliance.

			Current recommendations: 1. Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. 2. Train auditors to acceptable levels of reliability. 3. Provide operational definitions of all terms in a written format to aid in data reliability and validity. 4. Report as trended data analysis. 5. Provide target dates for all above recommendations.
RB	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop a method for auditing the social work documentation of follow up meetings on systemic discharge barriers*. **Findings:** A form has been developed that is to be filled out by the social worker after each meeting for patients resistive to discharge, but there is not clarity as to whether or not a SW note is also required. The form was found in only one record and, by itself, the form does not give enough information. **Recommendation 2, April 2009:** *Institute a regular clinical case review for those individuals who are ready for but resisting discharge that assures that interdisciplinary collaboration occurs in determining how best to help these individuals transition to a less restrictive level of care*. **Findings:** This process has begun and one week (07/29/09-08/05/09) of

			auditing data was provided in the hospital's self-assessment. That data indicated that only 50% of cases were reviewed and also indicated very low compliance rates for a variety of indicators. **Recommendation 3, April 2009:** Develop a method to document the recommendations and follow up to these reviews in the individual's record. **Findings:** This has not been done and should take place in the SW progress note indicated in the recommendation above. **Recommendation 4, April 2009:** Develop a method for auditing the above documentation. **Findings:** An audit for the form has been developed. **Compliance:** Partial. **Current recommendations:** 1. Develop requirements for a SW progress note to follow each of these meetings regarding patients resistive to discharge. 2. Expand the auditing tool for the form to include an audit of the SW progress note.
RB	VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Present an overview of the completed monitoring system including audit instruments and key indicators.*

			Findings: System was presented and ongoing developments are in place. **Recommendation 2, April 2009:** Develop a plan to train auditors to reliability. **Findings:** All current auditors have been trained and new hire of 08/09 is to undergo training. **Recommendation 3, April 2009:** When system is implemented, assure distribution of audit findings to key stakeholders. **Findings:** Completed. **Compliance:** Partial. **Current recommendations:** 1. Complete training of auditors. 2. Update tracking system as appropriate.
RB	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** *As part of the overall quality improvement monitoring system referenced in VII.F (above), the Hospital must determine how it is going to effectively monitor this portion of the Agreement.* **Findings:**

			This has been partially completed. **Compliance:** Partial. **Current recommendations:** 1. Work with MHA to revise audit so that all aspects of the Agreement relative to discharge and follow-up of discharged patients is included in the audit tool. 2. Provide target dates and timelines for completion of this process as it was supposed to have been completed within 12 months of the signing of the Agreement.
RB	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Utilize staff from the Division of Integrated Care to provide audit data for the quality improvement instruments developed in conjunction with VII.F (above [in previous report]). **Findings:** There is a vacant Care Manager position that impedes completion of this item. **Compliance:** Noncompliance. **Current recommendation:** Hire the necessary staff to ensure that this item can be accomplished.

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Progress:** 1. SEH has achieved substantial compliance with the requirement regarding psychiatric staffing levels. 2. SEH has improved the content of most of its individualized medication guidelines. 3. Although SEH has yet to improve reporting of ADRs, the facility has improved its data collection system regarding reporting and analysis of ADRs. 4. SEH has conducted a Drug Evaluation Utilization that met requirements of the Agreement. 5. Although serious deficiencies exist in the actual reporting of medication variances, SEH has made process improvements in the tools used for reporting, presenting and analyzing medication. 6. SEH conducted a self-assessment to serve as a follow-up evaluation of the status of implementation of this agreement. The facility's report included a candid assessment of current status and some corrective measures needed to move towards compliance. 7. The hospital failed to make significant progress in the area of behavioral treatment interventions due to the lapse of contracted services with the consultant who was providing training in this area and due to the fact that a standalone PBS psychology position was not filled until July 2009. 8. A new CNE was appointed in May 2009. In the short period of time that he has been in the position, he has revised all of the policies identified for revision during the last review. In addition, he also has developed multiple documents and reports that will support efficient and effective deployment of nursing staff. He has begun a framework for organizing nursing competency measurement, and has described the linkages between annual competencies and annual

			performance evaluations. 9. The CNE has developed and provided oversight for the implementation of a pilot program on RMB 3 that has enhanced nursing staff engagement with patients. The program is being enthusiastically embraced by the staff. A distinguishing facet of the program (that may be contributing to its success) is the fact that it affirms *both* staff and patients. The planned extension of this program to other units should support nursing staff throughout SEH to increase engagement with patients. 10. The Infection Control Program has been substantially revised and is now fully aligned with generally accepted practice standards. The Infection Control Coordinator, who has been in place under six months, is providing creative, contemporary leadership to program implementation. He is keenly focused on exchanging data and information to and from the staff at the point of service.

	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. John Stiller, MD, Neurologist and Chair of the Pharmacy and Therapeutics Committee 3. Ermias Zerilassie, Chief Pharmacist 4. Michael Hartley, Nurse Administrator 5. Martha Pontes, RN, Director of Nursing Reviewed: 1. Charts of the following 36 individuals: AFB, BW, CH, DM, EG, FF, FP, FW, GS, JD, JN, LF, LJ, LM, MK, ML, MM-1, MM-2, MT, ND, PG, PS, RAM, RB, RJ, RJB, RM, SC, SD, TT, WC, WHM, WK, WLL, WW-1 and WW-2 2. SEH Self-Assessment Report (September 1, 2009) 3. SEH database regarding individuals receiving benzodiazepines 4. SEH database regarding individuals receiving anticholinergic treatments 5. SEH database regarding individuals receiving polypharmacy 6. SEH database regarding individuals receiving treatment with New Generation Antipsychotic medications 7. SEH Comprehensive Initial Psychiatric Assessment Self-Audit Tool and operational instructions (August 18, 2009) 8. SEH Comprehensive Initial Psychiatric Assessment Self-Audit summary data (April to June 2009) **9.** SEH Psychiatric update Self-Audit tool and operational instructions (not dated) 10. SEH Medication Monitoring Review Form and operational instructions (February 11, 2009) 11. SEH Medication Monitoring summary data (March to July

			2009) 12. SEH Medication Guideline regarding Clozaril (clozapine), revised August 13, 2009 13. SEH Medication Guidelines regarding other antipsychotic medications, revised July 22, 2009 14. SEH Medication Guidelines regarding benzodiazepines, July 22, 2009 15. SEH Medication Guideline regarding anticholinergic medications (not dated). 16. SEH Adverse Drug Reaction (ADR) Incident Report, revised August 29, 2009 17. SEH Instructions for Completing the ADR Report Form and Assessment (not dated) 18. SEH data regarding ADRs (October 2008 to July 2009) 19. SEH tracking log including description of all ADRs and actions taken to address the reactions (February to July 2009) 20. SEH ten completed ADR Incident reports 21. SEH Policy #202-05: Medication Variance Reporting and Assessment, revised August 13, 2009 22. SEH data regarding Medication Variances (October 2008 to July 2009) 23. SEH Medication Variance Incident Report, revised, June 30, 2009 24. SEH Instructions for Completing the Medication Variance Incident Report Form and Assessment (not dated) 25. SEH ten completed Medication Variance Incident reports (using the revised template) 26. SEH Intensive Case Analysis regarding Medication variance Event/Major Unusual Incident of March 2009 27. SEH Pharmacy and Medication Monthly Report, August 11, 2009 28. Medical Director's letter regarding the facility's proposal for

			monitoring individuals receiving divalproex treatment (not dated) 29. SEH Mortality reviews completed during this review period (IW, HME, MLS and WW-3) 30. SEH list of all current psychiatrists at SEH with their case loads and FTE status 31. SEH Tardive Dyskinesia (TD) Peer Review summary data, June and July 2009 32. SEH Minutes of the P&T Committee meetings (March 11, April 8, May 13, June 17 and July 8, 2009) 33. SEH Pharmacy Drug Interventions and Recommendations, March to August 2009 34. SEH Pharmacy Drug Alerts, February 22 to August 4, 2009 <u>Observed</u>: 1. Team meeting at JHP-1 for IRP review of MM 2. Team meeting at JHP-6 for IRP review of CB 3. Team meeting at JHP-6 for IRP review of CS 4. Team meeting at JHP-8 for IRP review of CD 5. Team meeting at JHP-8 for IRP review of VA 6. Team meeting at RMB-1 for IRP review of BS 7. Team meeting at RMB-4 for IRP review of RN 8. Team meeting at RMB-7 for IRP review of SD 9. Team meeting at RMB-8 for IRP review of AH
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;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:**

			Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. **Findings:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. **Recommendation 2, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments. Same as in VI.A.7 regarding psychiatric updates (reassessments). **Current recommendations:** 1. *Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c xxx* 2. *Same as in VI.A.7.*
MES	VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Partial.

			Current recommendations: *Same as in VI.A.7.*
MES	VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.7.*
MES	VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.7.*
MES	VIII.A.	assessment of, and attention to, high-risk	**Current findings on previous recommendation:**

	1.e	behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Recommendation, March 2009:** Same as in VI.A.7.and VI.A.2. **Findings:** Same as in VI.A.7.and VI.A.2. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.7.and VI.A.2*
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. In addition, the facility reported that the CIPA audit (April to June 2009) showed that the documentation of the risks of treatment occurred in 59% of the cases reviewed. As mentioned earlier, more work is needed to streamline and better specify the indicators used in auditing and to improve data presentation relevant to each corresponding requirement. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.7.*

MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7. **Findings:** Same as in VI.A.7. In addition, the facility's self-report presented some data that were tangential to this requirement. However, the facility also presented data based on the Medication Monitoring Form (items that addressed the use of polypharmacy) that were relevant to this requirement. This audit was conducted March to July 2009. The audit showed compliance rates of 85% and 100% with the documented justification of the use of three or more medications of the same class (11 cases) and four or more medications of different classes (one case), respectively. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.7.* 2. *Provide monitoring data based on the Medication Monitoring Form (items related to intra and interclass polypharmacy) based on at least 20% sample during the review period.* 3. *Ensure that the progress report includes a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of*

			correction. Supporting documents should be provided.
MES	VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in VI.A.7 **Findings:** Same as in VI.A.7 **Recommendations 2 and 3, March 2009:** • *Implement corrective actions to ensure compliance with the requirements regarding the use of PRN/Stat medications.* • Develop and implement a clinical chart audit tool to assess compliance with the new template for the psychiatric update. The tool must include indicators to assess the following: o Face-to-face assessment of the individual following the administration of Stat medications; o The prescription of PRN medications for specified behavioral indications; o Critical review by practitioners of the use of PRN/Stat medications during the interval, including the circumstances leading to the use, the individual's response and the appropriateness of the medication order; o The adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval. **Findings:** The facility's corrective actions and response to these recommendations included the following:

			1. The use of the AVATAR system for medication ordering, which requires the practitioner to specify the reason for the prescription of PRN medications. This was an effort to address the use of PRN medications for generic indications. 2. The revised IRP Manual includes a requirement for the IRP team to review the use of PRN and Stat medications as well as restrictive interventions (seclusion and/or restraint) as part of the team's review of the present status of the individuals. 3. The psychiatric update audit (yet to be implemented) includes an indicator to assess the documentation of an adequate explanation for the use of Stat medications. 4. The Medication monitoring audit includes indicators to track the number of PRN/Stat medication administrations. Although the above mentioned actions can enhance compliance with this requirement, none of these actions included the recommended indicators. **Recommendations 4 and 5, March 2009:** • Provide monitoring data based on 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** The facility presented data based on the Medication Monitoring Form (March to July 2009). The data was based on a sample of

			26% and focused on the number of individuals receiving a certain number of PRN/Stat medication. In addition, SEH reported that the conversion of medication ordering system to AVATAR has apparently eliminated the practice of ordering these medications for generic indications (e.g. agitation). The facility's data did not address the intent of this requirement, i.e. the adjustment of regular treatment based on a review of the PRN/Stat medication use. As mentioned earlier, more work is needed to streamline the monitoring indicators and improve data presentation relative to each corresponding requirement of the Agreement. **Other findings:** Chart reviews by this expert consultant (see other findings in V.E.3 regarding review of IRP goals/objectives/interventions and VI.A.7 regarding psychiatric reassessments) found no evidence of significant progress in this requirement. The facility has yet to adequately address the previously reported deficiencies in the following areas: 1. The occasional prescription of PRN medications for generic behavioral indications; 2. Inconsistent face-to-face evaluation of the individuals by the treating psychiatrists following the administration of Stat medications; 3. Inadequate documentation in the psychiatric progress notes of a review of the use of PRN/Stat medications and the use of this information in the update of diagnosis and regular treatment, as clinically indicated; and 4. Inconsistent documentation by nursing of the circumstances of the use of PRN/Stat medications and the individuals' response to the administration.

			Compliance: Partial. **Current recommendations:** 1. *Same as in VI.A.7.* 2. *Ensure that corrective actions include monitoring indicators to assess the following:* a. *Face-to-face assessment of the individual following the administration of Stat medications;* b. *The prescription of PRN medications for specified behavioral indications;* c. *Critical review by practitioners of the use of PRN/Stat medications during the interval, including the circumstances leading to the use, the individual's response and the appropriateness of the medication order;* d. *The adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval.* 3. *Provide monitoring data based on 20% sample during the review period and ensure that the data address this requirement.* 4. *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or	Please see sub-cells for findings and compliance.

		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:	
MES	VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a.i	clinically justified;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).* **Findings:** Same as in VI.A.2.b.i and VI.A.2.b.iv. **Recommendation 2:** *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* **Findings:** Same as in VI.A.2.b.i and VI.A.2.b.iv. **Recommendations 3-5, March 2009:** • *Develop and implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications).* • Provide monitoring data regarding high risk medication uses,

			based on at least 20% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH has revised its Medication Monitoring tool audit and developed operational instructions to address this recommendation. The facility plans to begin auditing in September 2009. In general, the revised indicators are adequate to address this requirement. However, some refinements are needed to ensure that self-monitoring yields clinically useful data that aligns clearly with the main purpose of monitoring (i.e. proper justification for the use of these medications in individuals at various types of risk). Using the older auditing tool (March to July 2009), the facility presented some useful data that has relevance to this requirement. The following is a summary of the compliance data (based on a sample of 26%): 1. Geriatric individuals were prescribed medication(s) that can cause a delirium in 29% of cases; 2. Benzodiazepines were administered continuously for more than 90 days in 21% of the cases; 3. Of all individuals taking benzodiazepines, 19% were diagnosed with substance use disorder and 37% with a cognitive disorder; 4. Anticholinergic medications were administered for more than

			90 days continuously in 38% of the cases; 5. Of all individuals taking anticholinergic medications, 16% were diagnosed with a cognitive disorder; and 6. Of all individuals taking new generation antipsychotic medications, 14% were diagnosed with Diabetes Mellitus (there was documented evidence that the prescribing physician evaluated the risk in 12% of these cases and that body mass index was assessed in 2% of the cases). **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; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. This expert consultant also reviewed the charts of 22 individuals receiving the above types of medication uses. The reviews found that the facility has yet to decrease the overall number of individuals receiving long-term treatment with benzodiazepines and/or anticholinergic medications for individuals at risk. Adequate justification of this practice, including an assessment of the risk and benefits was documented in several charts (e.g. PG, MT and MM-2). However, most of the charts reviewed included examples of long-term treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or

diphenhydramine) and/or polypharmacy without documented diagnostic justification and/or assessment of the individuals for the risks associated with this practice. These practices must be corrected in order to achieve substantial compliance with this requirement.

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

Benzodiazepine use

Individual	Medication(s)	Diagnosis
BW	Lorazepam	R/O Dementia NOS
EG	Clonazepam and zolpidem	Cognitive Disorder NOS
FW	Clonazepam and zolpidem	Dementia Due to Multiple Etiologies
GS	Lorazepam	Polysubstance Dependence (alcohol, PCP, cannabis and heroin) and R/O Cognitive Deficits
JD	Zolpidem	Vascular Dementia with Depressed Mood
LM	Lorazepam	Cocaine dependence and Mild Mental Retardation
MK	Lorazepam	Dementia NOS
PG	Clonazepam	Cannabis Dependence
RJ	Lorazepam and zolpidem	Alcohol Abuse, Cognitive Disorder NOS and Cannabis Abuse

Anticholinergic use

Individual	Medication(s)	Diagnosis
FF	Benztropine and amantadine	Borderline Intellectual Functioning
JN	Benztropine	Dementia NOS
LJ	Benztropine (and clonazepam)	Borderline Intellectual Functioning, tardive dyskinesia and alcohol abuse
ML	Benztropine	Borderline Intellectual Functioning
RJB	Benztropine (and clonazepam)	Mild Mental Retardation
WK	Benztropine and diphenhydramine	Borderline Intellectual Functioning

Polypharmacy use

Individual	Medication(s)	Diagnosis
CH	Clozapine, quetiapine and lithium	
LF	Quetiapine, risperidone, aripiprazole, chloimipramine, trazodone and benztropine	
MM-2	Clozapine, risperidone and sertraline	
MT	Olanzapine, ziprasidone, trazodone, divalproex and zolpidem	
SC	Quetiapine, chlorpromazine, ziprasidone and buspirone,	
WLL	Thioridazine, paliperidone, quetiapine, doxepin, divalproex and benztropine	Borderline Intellectual Functioning

WW-2	Clozapine, ziprasidone, clonazepam and topiramate	

This expert consultant reviewed the charts of 12 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**
AFB	Risperidone and chlorpromazine	Diabetes Mellitus and Hypertension
DM	Quetiapine	Diabetes Mellitus
MM	Olanzapine	None documented
MT	Olanzapine and ziprasidone	Diabetes Mellitus and Hypertension
RAM	Risperidone	Diabetes Mellitus and Hypercholesterolemia
RB	Clozapine	Diabetes Mellitus and Hypertension
SC	Quetiapine, ziprasidone and chlorpromazine	Diabetes Mellitus
SD	Risperidone and haloperidol	Diabetes Mellitus, Obesity and Hypertension
TT	Clozapine	None documented
WHM	Olanzapine and risperidone	Diabetes Mellitus
WW	Clozapine and ziprasidone	Diabetes Mellitus and Hypercholesterolemia

This review found the following:

			1. In general, the facility has maintained adequate laboratory monitoring of the blood counts and vital signs in individuals at risk. 2. In general, the facility has maintained adequate frequency of laboratory monitoring of serum lipids and glucose as well as monitoring of weight for individuals receiving high risk medications. 3. In general, the psychiatric updates (reassessments) have improved the documentation of specific risks associated with high risk treatment. However, there were several deficiencies that must be corrected in order to achieve substantial compliance. The following are examples: 1. There was no evidence that serum prolactin and lipase/amylase were being monitored in several individuals receiving treatment with quetiapine (SC), olanzapine and/risperidone (MT, MM and WHM). 2. Some individual were receiving treatment with lipid lowering agents, but their IRPs did not address dyslipidemia (WHM, RAM and DM). 3. The laboratory testing for the metabolic risks of treatment with clozapine was not completed in a timely manner (WW and RB). 4. There was no evidence of periodic assessment of the cognitive risks associated with the long-term use of benztropine (combined with clozapine) for an individual who was diagnosed with Mild Mental Retardation (RB). 5. The psychiatric progress notes included inaccurate information about the number of antipsychotic medications used for an individual (SD). 6. There was general evidence of inadequate clinical and/or

			laboratory monitoring for the endocrine risks associated with risperidone treatment in female individuals (SD and RM). 7. There was no evidence of adequate interventions to address the refusal of an individual of any laboratory testing during the past year. The individual, a female was diagnosed with Diabetes Mellitus and Obesity (SD). 8. The IRP did not include objectives to address a diagnosis of Obesity in one individual (SD). 9. In general, there was evidence of inadequate documentation of attempts to utilize safer antipsychotic treatment alternatives for individuals diagnosed with a variety of metabolic disorders and receiving high risk treatments. **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).* 2. *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* 3. *Implement monitoring tools wit indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications). The indicators must address the justification of high-risk medication, including the proper assessment of risks and benefits and attempts to utilize safer treatment alternatives.* 4. *Provide monitoring data regarding high risk medication uses,*

			based on at least 20% sample during the review period. 5. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VIII.A.2.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	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • *Finalize and implement individualized psychotropic medication guidelines that address findings 1-4 by this consultant above.*

		in the formulary;	• *Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.* **Findings:** Since the last review, the facility has revised its medication guidelines for clozapine and other antipsychotic medications, including new generation antipsychotics (NGAs) and anticholinergic medications and developed new guideline for the use of benzodiazepines. **Other findings:** Reviews by this consultant found that the facility has improved the content of the guidelines and addressed some of the findings in the previous report, including the following areas: 1. The indications for clozapine use in suicidal individuals; 2. Clinical monitoring/interventions to address the risk of myocarditis associated with clozapine therapy; 3. Individualization of the guidelines regarding the new generation antipsychotic medications; 4. The risk of endocrine dysfunction in individuals receiving NGAs; 5. The risks of long-term use of benzodiazepines; and 6. The risks of long-term use of anticholinergic medications for individuals suffering from tardive dyskinesia. However, further refinements are needed to address the following: 1. The use of clozapine for individuals suffering from severe forms of tardive dyskinesia; 2. Further guidance regarding clozapine use (interpretation of

			blood levels, monitoring for the metabolic risks, interactions with diet and tobacco and strategies for use in individuals who fail to respond satisfactorily); and 3. Individualized monitoring guidelines regarding the metabolic risks associated with various NGAs. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. *Fully implement the revised guidelines.* 2. *Finalize the individualized psychotropic medication guidelines to address findings 1-3 by this expert consultant above.* 3. *Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.*
MES	VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VIII.A.1.h. **Findings:** Same as in VIII.A.1.h. **Compliance:** Partial. **Current recommendations:** *Same as in VIII.A.1.h.*
MES	VIII.A.2.b.iii	establish a system for the pharmacist to communicate to the medical staff; and	**Current findings on previous recommendations:**

			Recommendations 1 and 2, March 2009: • Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the prescribing practitioners. • Present documentation of review by the P&T Committee of drug alerts. **Findings:** SEH has implemented these recommendations. The facility reported that 22 drug alerts were communicated by the Pharmacy Department to the prescribing physicians between February 22 and August 4, 2009. These alerts were reviewed by the Pharmacy and Therapeutics Committee. **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 by the P&T Committee of drug alerts.*
MES	VIII.A. 2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Adverse Drug Reactions (ADRs): Present summary information to address the following:* a) *Development of written instructions to guide staff in the proper use of the data collection tool;* b) *Number of ADRs reported during the review period compared with the number during the previous period;*

			c) *Classification of ADRs by outcome category compared with the number during the previous period.* d) *Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;* e) *Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:* i. *Date of the ADR;* ii. *Description of the ADR;* iii. *Outline of ICA recommendations; and* iv. *Outline of actions taken in response to the recommendations.* f) *Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.* **Findings:** SEH adequately addressed recommendation a). The facility improved its ADR Incident Report from in an effort to address findings from the previous report and developed adequate instructions to assist staff in the proper completion of the form. The facility anticipates implementation of this form to begin in September 2009. To address recommendations b) and c), the facility reported that a total of 43 ADRS were reported during this the period of February to July 2009 (only one reaction resulted in outside hospitalization of an individual for less than five days and no reaction was rated as more severe). The facility acknowledged that underreporting of ADRs continues to be a challenge.

			Regarding recommendations d) and e), the facility reported a brief description of the ADR that resulted in the outside hospitalization of an individual. However, no intensive case analysis was performed to address this development and the only documented action taken was the completion of an ADR report. The facility has yet to address recommendation f). **Recommendation 2, March 2009:** *Drug Utilization Evaluation (DUE):* a) *Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.* b) *Perform DUEs and present a summary outline of the following:* i. *Date of each DUE;* ii. *Description of each DUE including methods used;* iii. *Outline of each DUE's recommendations; and* iv. *Outline of actions taken in response to the recommendations.* c) *Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends and provide a summary of corrective/educational actions taken to address these trends/patterns.* **Findings:** SEH has begun implementation of these recommendations. During this review period, the facility conducted a DUE to assess the use of anticholinergic medications for individuals diagnosed with Cognitive Disorders (not otherwise specified), Amnestic Disorders, Dementias and Tardive Dyskinesia. The DUE utilized

			appropriate methodology and resulted in appropriate recommendations for performance improvement. In addition, the facility has initiated a proposal for a protocol regarding the clinical and laboratory monitoring of individuals receiving divalproex for the risk of pancreatitis. While further research is needed prior to finalization, the protocol is aligned with current literature. **Recommendation 3, March 2009:** *Medication Variance Reporting (MVR): Present summary information to address the following:* *a) Revisions of the data collection tool to ensure:* *i. Reporting of all possible categories of variances: prescribing, transcribing, ordering/procurement, dispensing/storage, administration, documentation, medication security;* *ii. Assessment of critical breakdown points; and* *iii. Assessment of contributing factors.* *b) Development of written instructions to assist staff in the proper use of data collection tool;* *c) Total number of actual and potential variances during the review period compared with numbers reported during the previous period;* *d) Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;* *e) Clinical information regarding each variance (category E or above) and the outcome to the individual involved;* *f) Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and* *g) Outline of ICAs, including description of variance, recommendations and actions taken.*

			Findings: SEH has made significant revisions in its Policy #202-05: Medication Variance Reporting and Assessment (August 13, 2009), and the process of gathering and analyzing variances. The facility also developed written instructions to assist staff in the proper completion of medication variance reporting forms. These changes are being phased in and plans are underway for hospital wide implementation in September 2009. The changes adequately addressed recommendations a) and b). The facility presented medication variance data in response to recommendations c) and d). Although these data were obtained prior to full implementation of the improved system, the facility improved the process of data presentation. The data showed that a total of 369 variances were reported between October 2008 and July 2009 (316 were potential and 53 were actual variances). Prescription variances were the most common type reported (56%) followed by administration (17%) and transcription/documentation variances (17%). The facility did not aggregate the data for this review period or compare to previous period as requested. The facility's data was based on medication variances that were captured using the old tools, the limitations of which were highlighted in previous reports. Review of the data found that 85% of the variances were reported by the Pharmacy Department (mostly based on retrospective reviews), 7% by nursing and 4% by the medical staff. The data represented very serious underreporting by nursing staff of actual/potential variances. The facility's report did not provide an analysis or corrective actions to address this matter. During personal interviews, SEH Director of Nursing reported that contributing

			factors included inadequate practice by some nursing staff and inconsistent leadership at the unit level (to supervise and/or monitor). The Director of Nursing and Assistant Director of Nursing reported that the facility has initiated corrective actions including significant revisions of the performance competency statements for all nurse managers and a plan to make changes in all nurse manager positions, including having all current nurse managers reapply for these positions and ensure an on-site nurse administrator at all times. The facility also provided training (in four units) to address the coordination of the roles of nursing staff, clinical manager and psychiatry staff in the provision of unit care. A performance improvement initiative to address nursing underreporting of variances is expected to result from this effort. The facility presented data to address recommendation e), f) and g). Only one variance met severity criterion E (resulting in temporary harm to the individual and requiring intervention). No variance had more severe outcome. The facility provided adequate details about this variance and presented adequate intensive case analysis. No variance had more severe outcome. The minutes of the Pharmacy and Therapeutics Committee showed that the committee adequately addressed medication variance reports. The variances were aggregated and analyzed by the Pharmacy Department and presented to the committee for its review on a quarterly basis. **Recommendation 4, March 2009:** *Mortality reviews: Ensure that the revised policies/procedures regarding mortality reviews address the following:* *a) The integration of the special investigator's report regarding possible abuse/neglect by staff as a contributing factor in*

			the first level review. *b) The performance of an independent external medical mortality review and the integration of information form this review in the final level interdisciplinary review.* *c) Tracking mechanisms to ensure that interdisciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate.* **Findings:** SEH revised its Policy #302.3-05: Patient Death Review (August 11, 2009). The revised policy adequately addressed items 1 and 3. Although the facility's self-report indicated that external reviews will be conducted by the Department of Mental health or specific contractors, the policy regarding Patient Death review was silent on this matter. During this review period, the facility conducted four reviews on four mortalities. Reviews by this expert consultant confirmed that all four mortalities were anticipated due to medical causes. None of these mortalities was reviewed based on requirements of the revised policy. **Compliance:** Partial. **Current recommendations:** 1. *Adverse Drug Reactions (ADRs): Ensure that the self-report contains summary information to address the following:* a) *Full implementation of the revised ADR data collection system;* b) *Number of ADRs reported during the review period compared with the number during the previous period;*

			c) *Classification of ADRs by outcome category compared with the number during the previous period.* d) *Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;* e) *Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:* i) *Date of the ADR;* ii) *Description of the ADR;* iii) *Outline of ICA recommendations; and* iv) *Outline of actions taken in response to the recommendations.* f) *Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.* 2. *Drug Utilization Evaluation (DUE): Ensure that the self-report contains summary information about the following:* 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) *Completed DUEs, with a summary outline of the following:* i) *Date of each DUE;* ii) *Description of each DUE including methods used;* iii) *Outline of each DUE's recommendations; and* iv) *Outline of actions taken in response to the recommendations.* c) *Analysis of DUE data to determine practitioner and*

			group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns. 3. *Medication Variance Reporting (MVR): Ensure that the self-report includes a summary information of the following:* a) *Full implementation of the revised data collection system;* b) *Total number of actual and potential variances during the review period compared with numbers reported during the previous period;* c) *Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;* d) *Number of variances by critical breakdown point;* e) *Clinical information regarding each variance (category E or above) and the outcome to the individual involved;* f) *Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and* g) *Outline of ICAs, including description of variance, recommendations and actions taken.* h) *Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances;* i) *Evidence of corrective actions to address patterns and trends identified in medication variances.* 4. *Mortality review: Ensure that the revised policy regarding mortality review address the performance of an independent external medical mortality review and the integration of information form this review in the final level interdisciplinary review.*
MES	VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric	**Current findings on previous recommendations:**

		staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.	**Recommendation, March 2009:** *Ensure compliance with this requirement in all acute care and long-term care units in the facility.* **Findings:** SEH has made further progress in recruiting psychiatrists to ensure that staffing levels meet this requirement. The following is a summary of the current status of psychiatric staffing at the facility: 1. Civil programs have average case loads of one FTE psychiatrist per 10.5 individuals (acute care units) and one FTE psychiatrist per 17 individuals (long-term units). 2. Forensic programs have average case loads of one FTE psychiatrist per 10 individuals (acute care units) and one FTE psychiatrist per 20.3 individuals (long-term units). 3. Each program has a full-time Medical Director. 4. In addition, 1.8 FTE psychiatrists are assigned to the Treatment Mall and 3.1 FTE psychiatrists are assigned to night and weekend coverage. 5. The facility has a full-time Medical Director. **Compliance:** Substantial. **Current recommendation:** *Maintain compliance with this requirement in all acute care and long-term care units in the facility.*
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in V.A.2.e and VI.A.7.

			Findings: Same as in V.A.2.e and VI.A.7. The facility's self-assessment report acknowledged minimal progress in this area. **Compliance:** Same as in V.A.2.e and VI.A.7. **Current recommendations:** Same as in V.A.2.e and VI.A.7.
MES	VIII.A.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 of the medication treatment.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Findings:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Compliance:**

			Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **Current recommendations:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.
MES	VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Ensure implementation of substance recovery services consistent with the transtheoretical model of change. **Findings:** The facility has addressed this recommendation as follows: 1. The new template for the comprehensive initial psychiatric assessment contains a section for screening of substance use history. As mentioned earlier (see VI.A.5). 2. The new IRP format includes a dedicated focus to address substance use disorders. This format is adequate to address substance use issues. 3. The revised IRP manual contains instructions and examples regarding the development of foci, objectives and interventions related to substance use. 4. The new IRP format requires the establishment of the stages of change relevant to objectives and interventions that address substance use disorders. As mentioned earlier (see V.D.1), the objectives and interventions listed in most charts did not align with the established stage of change. **Recommendation 2, March 2009:** Ensure that substance abuse self-assessment indicators also address the following:

			1. There is at least one objective related to the individual's stage of change; 2. The interventions are appropriately linked to the objective and are aligned with the Mall schedule; 3. The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms. **Findings:** The facility did not address this recommendation. Instead, the self-report made reference to the comprehensive initial psychiatric assessment audit that includes indicators to assess if substance use history was completed as part of the assessment. **Recommendations 3 and 4, March 2009:** • Provide monitoring data based on at least 20% sample during this review period. The data should include and initial screening and the IRP management of substance use disorders. • Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. **Findings:** SEH presented data based on the comprehensive initial psychiatric assessment audit (June and July 2009). The data addressed the completion of the substance use history and the alignment of this information with the stage of change. The compliance rates were 82% and 75%, respectively. However, the

			data did not address the proper evaluation of the substance use disorder, as part of the IRP (see Recommendation 2 above) and the operational instruction regarding the second indicator was inappropriate. **Other findings:** See this monitor's findings in V.D.1 regarding the evaluation and management of substance use disorders at SEH. **Compliance:** Partial. **Current recommendations:** 1. *Same as in V.D.1 and VI.A.5.* 2. *Ensure implementation of substance recovery services consistent with the transtheoretical model of change.* 3. *Ensure that substance abuse self-assessment indicators also address the following:* *a) There is at least one objective related to the individual's stage of change;* *b) The interventions are appropriately linked to the objective and are aligned with the Mall schedule;* *c) The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.* 4. *Provide monitoring data (to address the above mentioned indicators) based on at least 20% sample during this review period. The data should include and initial screening and the IRP management of substance use disorders.* 5. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance*

<table>
<tr><td></td><td></td><td></td><td>rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.</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>Current findings on previous recommendations:

Recommendations 1-4, March 2009:
• Develop and implement corrective actions to correct the deficiencies outlined by this consultant regarding the monitoring and management of individuals suffering from TD.
• Implement the self-auditing tool for TD.
• Provide monitoring data based on a review of a 100% 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 and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

Findings:
SEH has developed a database that tracks individuals diagnosed with Tardive Dyskinesia (TD); 34 individuals at the facility were identified as having this diagnosis.

The facility has implemented the TD Peer Review (Monitoring) tool (June and July 2009) based on a sample of 19 individuals diagnosed with TD. The following is a summary of compliance data:

<table>
<tr><td>Indicator</td><td>Compliance</td></tr>
<tr><td>Individuals receiving AIMS upon admission or</td><td>74%</td></tr>
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annually			
Individuals receiving AIMS twice a year	36%		
Evidence of neurology consultation	57%		
Consideration of (safe) medication choices	50%		
Presence of IRP interventions related to TD	43%		
Justification of use of first generation antipsychotic agent	57%		

Other findings:
This monitor reviewed the charts of six individuals (FP, ND, PS, RM, TT and WC) who had current diagnoses of tardive dyskinesia (TD). This review found that SEH has maintained some progress as evidenced by the following:

1. The admission AIMS tests were completed in all the charts reviewed;
2. The periodic AIMS tests were completed in most charts at least every six months (but only the chart of RM included quarterly testing as required by facility policy);
3. The IRP documented a diagnosis of TD in all the charts reviewed; and
4. There was no evidence of unjustified long-term use of anticholinergic medications in most charts reviewed (FP, PS, RM and TT).

However, the review also showed a number of deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples:

1. The psychiatric progress notes did not address the status of TD in several individuals (FP, ND, PS, RM and WC);
2. The IRP did not include diagnosis, focus or interventions to address the diagnosis of TD in any of the charts reviewed;

			3. The AIMS tests were not documented quarterly as required in any of the charts reviewed; and 4. There was no documented justification for the long-term use of anticholinergic medications for some individuals (ND and WC). **Compliance:** Partial. **Current recommendations:** 1. *Develop and implement corrective actions to correct the deficiencies outlined by this consultant regarding the monitoring and management of individuals suffering from TD.* 2. *Provide monitoring data based on a review of a 100% sample during the review period.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

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, PhD, Chief of Psychology 2. Michelle Marsh, PsyD, Acting PBS Lead Reviewed: 1. Medical records for the following 38 individuals: AB, AK, BC, BP, CJ, CK, CM, DA, DH, DJ, DS, EH, FF, GS, GS-Q, II, JD, JJ, JN-1, JN-2, JW, KH, KP, KR, LD, LM, MH, MK, PJ, PM, RD, RG, RP, SD, SH, SW, TS and WT 2. Patient Roster for RMB 3 for 03/31/09 and for 09/22/09 3. Current schedules for TLC 1, TLC 2 and TLC 3 Observed: 1. Unit RMB 3 2. Treatment Malls for TLC 1, TLC 2, TLC 3
RB	VIII.B.1	By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	Please see sub-cells for findings and compliance.
RB	VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals,	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Discontinue the process of transferring to RMB 3 those individuals in need of PBS plans and provide that service on the ward on which the individual currently resides.*

		and individuals on multiple medications;	**Findings:** The hospital completed this on 06/18/09. **Recommendation 2, April 2009:** *Free the PBS psychologist from unit/ward/treatment team duties as the first step in developing a stand-alone PBS service. Fill out the PBS team with the addition of at least one RN and two PNAs.* **Findings:** An Acting Lead psychologist for the PBS team was put in place in July 2009 and freed from all other clinical duties. No other members of the PBS team were yet in place. **Recommendation 3, April 2009:** *Within the next 6 months, transfer at least 50% of those individuals on RMB 3 due to the need for more intensive behavioral treatment to other units and provide the behavioral treatment on those units.* **Findings:** Census records indicated that, as of 09/22/09, only 7 of the 19 residents of RMB 3 on the last tour continued to be residents of RMB 3. **Recommendation 4, April 2009:** *Within the next 6 months, develop PBS plans for at least 50% of the remaining individuals on RMB 3 who are in need of intensive behavioral treatment.* **Findings:** Six of the current RMB 3 caseload has been referred for a PBS

			plan. One plan has been developed and is operational and two additional plans were in the development phase with targeted completion dates by mid-October 2009. **Compliance:** Partial. **Current recommendations:** 1. Complete the staffing of the PBS team with at least one RN and two PNAs, although it is likely that more plans could be more efficiently developed if the staff also includes two data entry personnel. 2. Complete the two PBS plans that are currently in development.
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 system for earning reinforcement;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Continue training with consultant*. **Findings:** Training was discontinued. **Recommendation 2, April 2009:** *Implement a significant number of Behavior Guidelines and PBS plans*. **Findings:** Only 1 PBS plan and 2 Behavioral Guidelines were completed. Reviewed records indicated that a number of individuals could have benefitted from these interventions. **Recommendation 3, April 2009:**

			Present quantifiable and trended data on all auditing of behavioral interventions. **Findings:** No data. **Compliance:** Noncompliance. **Current recommendations:** 1. Re-start training with consultant. 2. Implement 6-10 PBS plans and at least 10 Behavioral Guidelines by 05/01/09.
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;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Continue training with consultant.* **Findings:** Training was discontinued. **Recommendation 2, April 2009:** *Refine token economy process so that it is in line with current best practices.* **Findings:** With the closing of RMB 3 as a behavioral unit, the Token Economy on that unit was discontinued. **Recommendation 3, April 2009:** Present quantifiable and trended data on all auditing of behavioral interventions.

			Findings: No data presented. **Compliance:** Partial. **Current recommendation:** Re-start training with consultant.
RB	VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	This cell repeats cell VIII.B.1.a
RB	VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Include monitoring data about progress notes in auditing data discussed in Cell VIII.B.1.c (above [in previous report]). **Findings:** No auditing has begun. The one progress note on the one existent PBS plan was well done. **Recommendation 2, April 2009:** *Implement training of unit staff on any unit that has an individual receiving intensive behavioral treatment interventions.* **Findings:**

			Some training appears to have been provided as the one existent PBS plan appeared to be adequately implemented and producing effective clinical outcomes, but no systematic presentation of training data was provided. **Recommendation 3, April 2009:** *Implement the BCC in consultation with training/consultation provided by Angela Adkins*. **Findings:** Work with the consultant was discontinued and the BCC was not implemented. **Compliance:** Noncompliance. **Current recommendations:** 1. Re-start work with consultant. 2. Implement BCC. 3. Develop all necessary audits for PBS plans and Behavioral Guidelines. 4. Present audit results as trended data.
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.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Assure that the PBS service is a stand-alone service, whose psychologist does not also have unit/ward/treatment team responsibilities*. **Findings:** A stand-alone position for the PBS psychologist was established in July 2009 and is currently being filled in an acting capacity.

			Recommendation 2, April 2009: *Continue to recruit and hire psychologists so that there is at least one psychologist per ward/treatment team.* **Findings:** There are currently four vacancies in the Psychology Department. **Compliance:** Partial. **Current recommendation:** Fill current psychology department vacancies.
RB	VIII.B.2	By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop guidelines for the completion of the Comprehensive Nursing Assessment that give clear direction on how to complete Section VIII: Interventions for Recovery.* **Findings:** Guidelines were developed and implemented and now need to be refined to include recommendations for specific groups from the Mall Catalogue. **Recommendation 2, April 2009:** *Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3.* **Findings:** This process has continued and has been expanded to include

			TCL4. **Compliance:** Partial. **Current recommendations:** 1. Revise guidelines for Nursing Assessment to include recommendations for specific groups from the Mall Catalogue. 2. Continue current practice of developing and using manual-based treatments.
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.	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Continue the use of manual-based and empirically validated curricula for TLC2 and TLC3.* **Findings:** This process has continued and has been expanded to include TCL4. Additionally, an impressive array of group treatments is offered during all mall hours. A review of the malls for TLC 1, TLC 2 and TLC 3 found that over 90% of the assigned patients were present in their assigned groups. Since TLC 4 was only recently established, it will be reviewed in more detail on the next tour, as will the treatment services provided to pre-trial forensic patients in their new mall to be developed after the move to the new hospital. **Compliance:** Partial. **Current recommendation:**

			Development treatment mall for pre-trial forensic patients.
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;	**Current findings on previous recommendation:** **Recommendation, April 2009:** See cell VIII.B.1.c. **Findings:** See cell VIII.B.1.c. **Compliance:** Partial. **Current recommendation:** See cell VIII.B.1.c.
RB	VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Implement treatment mall realignment project.* **Findings:** Treatment mall realignment process has been implemented and currently consists of 4 programs, TLC 1 – 4, with substance abuse treatment provided. Services for pre-trial forensic patients must also include substance abuse services where individuals present with the appropriate diagnoses. **Recommendation 2, April 2009:** Develop substance abuse treatment options based on the

			individual's stage of change. **Findings:** Completed. **Compliance:** Partial. **Current recommendations:** 1. Maintain current level of practice on existing treatment malls. 2. Ensure that substance abuse treatment is available to pre-trial forensic patients.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Complete a survey of community supports for individuals with cognitive impairment.* **Findings:** Not completed. **Recommendation 2, April 2009:** *Audit the integration of neuropsychological findings with the IRP diagnosis, objectives and interventions.* **Findings:** 10 medical records for which neuropsychological evaluations (NE) were completed were reviewed. In none of the records was the completed NE found, but two of the records reflected diagnostic changes recommended by the NE. No specific audit addresses these questions directly at this time, as it is rolled into an item

			on consultations in general. A new form that needs to be completed by the team psychologist for other psychological evaluations should be used (if not already planned) for NEs to be certain that the results and recommendations from NEs are integrated into the IRP. Psychology Service audits will then capture this item more specifically. **Compliance:** Noncompliance. **Current recommendations:** 1. Ensure that the form developed to document the integration of psychological assessments into the IRP is used for neuropsychological evaluations as well. 2. Present audit results as trended data.
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;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Maintain current level of practice. **Findings:** The current level of practice has been maintained. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VIII.B. 4.e	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant	**Current findings on previous recommendations:** **Recommendation 1, April 2009:**

		developments, and the individual's progress, or the lack thereof;	*Revise training program to ensure that it contains conceptual clarity regarding how to best integrate all of the essential elements of person centered planning, and add additional training modules as necessary to achieve this goal.* **Findings:** While training program revisions have been completed, conceptual clarity still does not exist among treatment team members of for how to move from individually developed discharge criteria to foci of hospitalization and objectives and interventions. **Recommendation 2, April 2009:** Ensure that this item is audited on both the IRP conference process auditing tool and the IRP chart review tool. **Findings:** This item is audited in both the observational audit and the clinical chart audit. **Compliance:** Partial. **Current recommendation:** Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions.
RB	VIII.B. 4.f	clinically relevant information remains readily accessible; and	**Current findings on previous recommendation:** **Recommendation, April 2009:**

			Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Assure that the tool monitors for clinically meaningful responses from the treating clinician regarding progress or its lack rather than merely checking a box. **Findings:** This process has been completed and is now reflected in both the IRP observational audit and the clinical chart audit. **Compliance:** Substantial. **Current recommendation:** Continue to audit and present results as trended data.
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.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Continue work with consultant.* **Findings:** Work with consultant was discontinued. **Recommendation 2, April 2009:** *Continue providing overview training in PBS for all clinicians.* **Findings:** Not done. **Recommendation 3, April 2009:** *Implement, monitor and audit several PBS plans in the next 6 months.*

			Findings: Not done. **Recommendation 4, April 2009:** *Train nursing staff in the implementation of specific behavioral plans and guidelines*. **Findings:** Not done. **Compliance:** Noncompliance. **Current recommendations:** 1. Re-start work with consultant. 2. Continue providing overview training in PBS for all clinicians. 3. Develop and implement auditing process for PBS plans and Behavior Guidelines. 4. Train nursing staff in the implementation of specific behavioral plans and guidelines, and include this item in audit. 5. Present audit results as trended data.

	C. Pharmacy Services		
MES		By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:	**Methodology:** Interviewed: 1. Ermias Zerilassie, Chief Pharmacist 2. Bernard Arons, Medical Director Reviewed: SEH data regarding recommendations made by the pharmacists based on drug regimen reviews (March to August 2009).
MES	VIII.C.1	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department. The recommendations should include, but not limited to, the following categories:* *a) Drug-drug interactions;* *b) Side effects;* *c) Need for laboratory testing;* *d) Indications;* *e) Contraindications;* *f) Drug allergy;* *g) Dosage issues;* *h) Polypharmacy;* *i) Drug-food interactions;* *j) Incomplete orders; and* *k) Orders that need clarification.* **Findings:** During this review period, the Pharmacy Department at SEH provided 205 recommendations to the medical staff based on

reviews of drug regimens. The facility's data presentation was not aligned with the recommendation. However, at the request of this expert consultant, the facility made an effort to improve its data presentation. The following is an outline of the categories of these recommendations based on the facility's data:

Type of recommendation	% of total recommendations
Drug allergy	7%
Interaction (not defined)	2%
Dosage issues	12%
Drug information (not clearly defined)	22%
Order clarification	27%
Order entry	9%
Patient monitoring	1%
Polypharmacy	4%
Indications	2%
Side effects	0%
Others	14%

Recommendation 2, March 2009:
Provide operational definitions and an explanation of the significance of pharmacists' recommendations in the categories of ""activities, drug information, pharmacist clinical counseling and therapeutic consultation and no change."

Findings:
The facility's report did not address this recommendation.

Recommendation 2, March 2009:

			Develop tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews. **Findings:** The facility's report did not address this recommendation. **Recommendation 2, March 2009:** Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2. **Findings:** The facility's presented data in response to this recommendation. However, more work is needed to improve data presentation, aggregation and to initiate data analysis. Reviews by this expert consultant found that the prescribing physicians did not respond to recommendations by the pharmacists in 20% of these recommendations. **Compliance:** Partial. **Current recommendations:** 1. *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department. The recommendations should include, but not limited to, the following categories:* a) *Drug-drug interactions;* b) *Side effects;* c) *Need for laboratory testing;* d) *Indications;* e) *Contraindications;*

			f) Drug allergy; *g) Dosage issues;* *h) Polypharmacy;* *i) Drug-food interactions;* *j) Incomplete orders; and* *k) Orders that need clarification.* *2. Provide clear operational definitions for all categories of the recommendations.* *3. Develop and implement tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews.* *4. Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2.*
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as above. **Findings:** Same as above. **Compliance:** Same as above. **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:	**Methodology:** <u>Interviewed</u>: 1. Brenda Lateef, RN, Nurse Educator 2. Paul Perrin, RN 3. Mark Bean, RN NUM RMB 3 4. Robert Johnson, RN NUM JHP 6 5. Mildred Kromah, RN 6. Allan Johnson, FPT 7. Adoracion Punio, RN 8. Deana Alice Oswosu, LPN 9. Kwason Newton, LPN 10. Olivia Hamilton, RN 11. Grace Agbaw, RN 12. Dr. Zaidi 13. Christianah Fayomi, RN 14. Ozaree Lee, PPN 15. Felix Alozie, PPN 16. Enyioma Anyatonwu, RN 17. Gloria Alford, PT 18. Regina Ogsuegbu, RN 19. Gwendolyn Chappelle, LPN 20. Althea Wright, RN 21. Beatric Fomundian, RN 22. Ann Marshall, PNA 23. Amma Pokuaab, RN 24. Gladys Nabafu, RN 25. Cheryl Moore, PNA 26. Denise Young, PNA 27. Philo Amaechi, RN 28. Josephine Ogochukwu, RN NUM, JHP 9 29. Carol Hogan, RN

			30. Faye Stewart, Dining Room Supervisor (Dietary Staff) 31. Laverne Plater, RN, Nurse Educator 32. Malcolm Cook, RN, Infection Control Chief 33. Mamerta Benzon, RN, NUM RMB 1 34. Reba Brothers, RN, NUM RMB 6 35. Rosylin Yesudian, RN 36. Shirley Quarles, RN, Director of Nursing Education and Research 37. Yi-Ling Tu, RN, NUM RMB 2 38. Michael Hartley, CNE <u>Reviewed</u>: 1. Medical records of the following 44 individuals: AF, AH, AK, AP, AS, AW-B, CB-1, CB-2, CB, CJ, CM, DA, DJ, EC, FH, GE, GR, JP, JS, JW, KH, LE, LR, LS, MA, MO, MT, NJ, PM, RD, RG-1, RG-2, RH-1, RH-2, RJ, RW-1, RW-2, SA, SF, SR-1, SR-2, SS, TC and YS 2. SEH DOJ Compliance Office Report, September 1, 2009 3. SEH PRISM Report, August 2009 4. Environmental Survey Report, 2nd Quarter, 2009, Final, March 2009 5. Environmental Survey Report, 3rd Quarter, 2009, August 28, 2009 6. SEH, Annual Training, Department of Training and Professional Development, revised 8/0/2009 7. "Feedback Loop for those who fail Training," not dated, not signed 8. Nursing Staff Education (as of 9/15/2009), (summary report of percent of staff trained in seven topics 9. SEH, Department of Nursing, Course Outlines and Competency measures for RNs, LPNs, FPTs and PNAs for: Type 1 and Type 2 Diabetes and Diabetes Insipidus 10. Department of Nursing Course Outlines for: Schizoaffective

			Disorder (two outlines, one for RN/LPN, one for FPT and PT); Choking/Swallowing Assessment and Prevention; Diabetes Insipidus (RN and LPN); Diabetes (two outlines, one for RN /LPN; one for FPT/PNA); Stages of Change; Schizophrenia (two outlines, one for RN/LPN; one for FPT and PNA) , The General Survey; Vital Signs (FPT/PNA); Group Process Training for Para-Professional Nursing Staff 11. Therapeutic Learning Center (TLC) and Civil Side Unit Program Schedules 12. SEH, Nursing Reference Manual, Nursing Competency Structure, new issuance; signed 8/24/09 13. SEH, Nursing Reference Manual, Change of Shift Report, not numbered, revised 8/2009 14. SEH, Nursing Reference Manual, Nursing Intake and Output Procedure, no number, revised 8/2009 15. 24 Hour Intake and Output Form, not numbered or dated 16. SEH, Nursing Reference Manual: Insulin Administration, not numbered; revised 8/2009 17. SEH, Nursing Reference Manual: Physical Observation, not numbered; revised 8/2009 18. Clinical Record, Physical Observation Form (not numbered); revised 8/14/09 19. SEH, Nursing Reference Manual: Guidelines for Choking/Swallowing Assessment and Prevention; not numbered, revised 8/2009 20. Clinical Record, Choking/Swallowing Assessment Form; revised February 5, 2009 21. SEH, Draft Policy: Medical Response, Emergent/Urgent/Non Urgent 22. SEH, Hand Off Communication Guidelines, number 207-09, new issuance, effective August 13, 2009 23. Medical Director memo, Clarification of Use of Terms "STAT" and "PRN" at Saint Elizabeth's Hospital, July 22,

			2009 24. SEH Infection Control Policy and Procedure Manual, 7/28/09 25. SEH Infection Control Report, June 2009 26. Infection Control Meeting Minutes April 22, - July 22, 2009 27. Government of the District of Columbia, Department of Mental Health, St. Elizabeth's Hospital Pandemic Influenza Plan 28. Draft Form, PPD/Chest X-Ray Refusal Tracking Form 29. SEH Policy: Restraint and Seclusion for Behavioral Reasons, 101.1-04; revised August 11, 2009 30. SEH, Nursing Reference Manual: Restraint and Seclusion 31. SEH Seclusion and Restraint Audit Results, June, 2009 32. SEH Restraint/Seclusion Review Tool, 9/14/09 33. SEH Operational Instructions, Restraint/Seclusion Review Tool, revised 9-1-2009 34. SEH, Nursing Reference Manual: Restraint and Seclusion, no number; revised 5/2009; signed 8/25/09 35. SEH, Nursing Reference Manual: Protective , PSS 400.7; revised 8/2009 36. Training curriculum for *Restraint and Seclusion for Behavioral Reasons (August 27, 2009)* 37. SEH IRP Chart Review and Process Observation Results, February through July, 2009 38. Comprehensive Initial Nursing Assessment; SEH Form 300.01.09; revised 5/12/09. 39. Comprehensive Initial Nursing Assessment Operational Instructions (undated) 40. SEH, Clinical Record, Nursing Update, Form 300.02.09; 6/30/09 41. SEH, Nursing Assessment Update Operational Instructions, not dated 42. Nursing Update Audit Tool, revised 6/30/09 43. "Instructions" accompanying Nursing Update Audit Tool,

			revised 6/30/09; may still be draft 44. Nursing Assessment Update Audit Results, 8/24/09 45. Initial Interdisciplinary Recovery Plan; SEH Form 350.01.09; revised 5/7/09 46. Operational Instructions for Initial Interdisciplinary Recovery Plan, and the Interdisciplinary Recovery Plan; both undated 47. SEH Nursing Assessment Audit Questions. undated 48. SEH Policy: Medication Variance Reporting, 202-05; revised August 13, 2009 49. SEH Policy: Medication Ordering and Administration, 206-09; revised July 13, 2009. 50. SEH Policy: Involuntary Medication Administration, 201-05; revised August 11, 2009 51. Medication Monitoring and Chart Review Results, February, 2009; March – July, 2009 52. Pharmacy and Therapeutics Committee Minutes, February 11, 2009 - July 8, 2009 53. Pharmacy and Medication Monthly Report, June 16, 2009 and July 7, 2009 54. SEH Nursing Reference Manual: Using eMAR for Medication Administration; no number; revised August, 2009 55. Advanced Instructions/Personal Comfort Planning (Form 302.01.08; revised February 11, 2009) 56. Levels of Observation Flow SEHet (no number or revision date on the form that is an attachment to the policy) 57. Doctor's Order for Restraint and Seclusion (Form 402.508.08; revised February 13, 2009 58. List of Patients given PRN/STAT Medications between 3/1/2009 and 8/26/2009 59. List of Patients give 5 or more PRN/STAT Medications between 7/1/2009 and 7/31/2009 60. Department of Nursing, SEH, Resource – Staffing

			Assessment and Action Plan Nurse Training – FY 09 to Date (undated) 61. SEH, Plan for Provision of Care, Nursing Department, Draft 62. List of vacant nursing positions 63. SEH Nursing Department NCHPPD August 1 – 16, 2009 Observed: 1. IRP Conference: CD JHP 6; MM JHP 1 2. Meal Observations: RMB 4, 7 (Dining Room) 3. Change of shift report: RMB 2, 3, 8 4. Med pass: RMB 3, 5, 6, 7, 8;
LDL	VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review and staff interviews, I concur. **Recommendation 1, April 2009:** *Review the course outlines/content of hospital-wide orientation and nursing department orientation. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine competency.* **Findings:** A beginning structure for ascertaining nursing staff competency has been developed. The topics have not been listed to clearly differentiate orientation that occurs at the hospital-wide level, from that which occurs in the nursing department. However, some topics for competencies have been identified and are imbedded in performance criteria. The Nursing Competency Structure (NCS) is described as having two components. Part A, new employee orientation, is conducted

			by the SEH Department of Training and Professional Development (DTPD). There is no additional program description/topic(s) conducted by Nursing Education during the orientation period. There is also no description of "on the unit" orientation. Part B involves the annual determination of competency. This is done by the Nursing Manager (NM), with minimal involvement of Nursing Education. The nurse educators do not directly organize and conduct regular programs/activities related to annual competency. The description of orientation in the NCS is very general e.g. "…newly hired nursing staff members receive an orientation of sufficient scope and duration…." This is a fine generic/opening statement. However, it needs to be operationalized. SEH must determine, and describe, the scope and duration of orientation at SEH. This should be based on the qualifications for/roles of the service providers, and the nature of the services provided. The current organization of orientation topics is difficult to follow. It appears that there are four primary "focus areas:" performance description (job description), critical thinking/judgment; medication competency test - medication administration; physical assessment. Other focus areas are in a separate section of Part A, although the implication of the second section isn't clear, and the selection of topics for each section isn't clear. Most hospitals have fairly typical orientation content, some of which is not included in SEH's NCS. Because of the lack of clarity in the current draft, it is difficult to determine if the topic, and curriculum content, is well aligned with the role e.g. licensed and unlicensed nursing staff. It is also difficult to determine if the content areas required in this

			agreement are sufficiently specified. The current program description offers seven excellent potential ways to validate competencies. However, which method is used for which area of practice is not specified. In fact, there is some indication that each NM is expected to determine the validation method. This is not appropriate. One standard for validating competency must be established across the hospital. Although the NMs should have input into the method, it would seem that the nurse educators would be the most qualified to specify validation methods. The NCS needs to be refined to explicitly state the methods used to determine/validate competency for each designated topic/practice area. **Recommendation 2, April 2009:** *Review the course outlines/content of hospital-wide annual update training and nursing department annual update training. Develop a list of topics covered in each area. Determine if these topics cover required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine if competency has been maintained*. **Findings:** See findings from Recommendation 1 above. These also apply to annual update. The training topics listed in the SEH Annual Training, (DTPD, revised 8/1/2009) do not correspond to the focus areas and performance criteria described in the Nursing Competency Structure, Part B. **Recommendation 3, April 2009:** Review all competency assessment tools to determine if competency measures meet the requirements of this agreement and generally accepted practice standards, and if the measures

			are currently applicable. Assure that RN competencies address RN judgment as it relates to physician order transcription, medication administration, seclusion and restraint use, and notifying a physician when a patient's physical status changes. **Findings:** The NCS has beginning potential to address most of the requirements in this agreement, as well as generally accepted practice standards. There needs to be much greater clarity and specificity in all areas, but especially in areas associated with physical status changes, and medication administration. **Recommendation 4, April 2009:** *Develop a nursing policy and procedure template that will assure that each policy/procedure (p/p) is in the same format and that it addresses: the purpose of the p/p; the policy statement that expresses the standard; definitions as needed; general information as needed to address context and integration with other p/p; and procedures. The procedures should be step-by-step directions addressing: who does what; when or at what intervals; where as applicable; how as applicable; and documentation requirements. Align forms and p/p as each of these are developed.* **Findings:** There was some evidence that a systematic template has been initiated. **Recommendation 5, April 2009:** *Develop a policy that describes 1 – 3 above and specifies actions taken when a staff member does not achieve or maintain competency.*

			Findings: Some aspects of 1-3 above cannot be adequately evaluated until the NCS is refined. Actions taken when a staff member does not achieve or maintain competency have not yet been comprehensively addressed. SEH provided an undated document "Feedback Loop for Those who Fail Training" pending policy revision by the DTSD. It adequately describes linkages between the training department and supervisor. It also adequately describes linkages with the SEH performance evaluation system. It does not address how the staff member's job functions will be temporarily adjusted pending competency achievement. It also puts considerable responsibility on the supervisor and/or ADON. A model that uses designated instructors for each topic (as used in some topical areas that offer immediate test review and re-test), and/or that integrates nurse educators and uses the nursing skills lab, would most likely be helpful to NMs. **Recommendation 6, April 2009:** Implement the policy. **Findings:** The policy needs further refinement. **Recommendation 7, April 2009:** *Report aggregate percentages of staff who attended training.* **Findings:** SEH reported aggregate percentages of nursing staff who attended training. As of 9-15-09, the following percentages of nursing staff

			attended these trainings: Non-Confrontational Techniques – Therapeutic Communication 76%; Mental Health Diagnosis: Schizophrenia 76.8%; Physical Assessment – Diabetes Mellitus: 53%; Stage of Change 37.8%; Physical Assessment, Choking/Swallowing – 31.8%; Phys Assessment/Gen'l Survey Assessment (Critical Thinking) 47.6%; Physical Assessment – Vital Signs Assessment – 49.4%; Restraint and Seclusion – 31.8%. The goal for completing all trainings is reportedly early December 2009. **Recommendation 8, April 2009:** Report aggregate percentages of staff who achieved or maintained competency. **Findings:** SEH reports that a data-base has been developed to track training attendance and post-test grades. Conversations regarding reporting nursing staff competency achievement/maintenance are reportedly pending. **Recommendation 9, April 2009:** *Develop and implement Nursing IRP training.* **Findings:** SEH reported that 89.4% of Nursing staff attended IRP Overview and Mock training. **Recommendation 10, April 2009:**

			Add content to the physical assessment curricula related to GI issues (bleeding, bowel obstruction), infection, delirium, and diabetes. **Findings:** The course outline, supporting materials, and competency measures provided for diabetes (Type 1, Type 2, and Diabetes Insipidus) were comprehensive. The physical assessment curriculum does not contain information related to the other conditions specified. **Recommendation 11, April 2009:** Review and consider addressing other comments in the findings above. **Findings:** SEH indicated that these would be considered upon completion of prioritized recommendations. This is a reasonable approach. **Recommendation 12, April 2009:** At this time, consider using the requirements in this agreement as a nursing strategic plan rather than spend time developing/revising the draft plan. **Findings:** SEH reports that this is under consideration. **Other findings:** The Restraint and Seclusion for Behavioral Reasons training slides are well organized, focused on priorities, integrate SEH specific information, and contain valuable and practical "tips." This approach could be helpful when conceptualizing other training, especially physical assessment.

			Compliance: Partial. **Current recommendations:** 1. *Review the course outlines/content of hospital-wide orientation and nursing department orientation. Develop a list of topics covered in each area and specify this list in the NCS. Determine if these topics address required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine competency.* 2. *Review the course outlines/content of hospital-wide annual update training and nursing department annual update training. Develop a list of topics covered in each area and specify this list in the NCS. Determine if these topics address required annual competencies, including those required in this agreement. For each topic, explicitly state the process used to determine if competency has been maintained.* 3. *Review all competency assessment tools to determine if competency measures meet the requirements of this agreement and generally accepted practice standards, and if the measures are currently applicable. Assure that RN competencies address RN judgment as it relates to physician order transcription, medication administration, seclusion and restraint use, and notifying a physician when a patient's physical status changes.* 4. *Develop a policy that describes 1 – 3 above and specifies actions taken when a staff member does not achieve or maintain competency. Actions must specify methods to assure that a staff member does provide the related service pending competency achievement.*

			5. Implement the policy. *6. Identify and resolve barriers to nursing staff attendance at required training to ensure that required training is accomplished by February 1, 2010.* *7. Report aggregate percentages of staff who attended training.* *8. Report aggregate percentages of staff who achieved or maintained competency.* *9. Add content to the physical assessment curricula related to GI issues (bleeding, bowel obstruction), infection, and delirium.* 10. Review and consider addressing other comments in the findings above, especially those related to more effective use of and integration of nurse educators. *11. Consider accessing assistance to quickly develop/write necessary policies so that refinements can be quickly accomplished and implementation proceed at an increased pace.*
LDL	VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *Clarify expectations/align the Comprehensive Nursing Assessment with the content and timeline expectations reflected in the hospital policy.* **Findings:** A new initial nursing assessment has been developed, along with instructions. The assessment is to be completed within eight hours. This aligns with hospital policy.

			Recommendation 2, April 2009: *Using the nursing p/p template, develop a nursing p/p that provides step-by-step guidance to conduct and document the comprehensive assessment. Assure that the policy addresses: the process for linking the assessment to the initial IRP, the process for using "screens," and the process for evaluating/updating information that emerges during the time interval between admission and the IRP.* **Findings:** A Comprehensive Initial Nursing Assessment Procedure (Revised 8/2009) has been developed. Exhibit A, Procedure for Completing the Comprehensive Initial Nursing Assessment, is detailed and provides some excellent examples to elicit and document information provided by the patient. Greater clarity is needed on instructions for "Integumentary System." BMI and waist circumference should be a required component of Metabolic Syndrome evaluation Several "screens" are included in the Comprehensive Initial Nursing Assessment (INA). If positive findings are revealed, immediate action needs to be specified for some screens e.g. suicide and violence risk assessment screens, Choking/Nutritional Risk Screen. Nursing interventions are documented on the INA. The Initial Interdisciplinary Recovery Plan (IIRP) also has an area for Focus Area objectives and interventions. The psychiatrist is responsible for completing the IIRP in consultation with an RN. This is required to assure inclusion of the appropriate nursing interventions. The process for assuring this and/or links between the INA and this document need to be specified in order to assure an interdisciplinary approach to services. This

			was not consistently evident in the records, may need greater clarification for implementation, and will need to be monitored. **Recommendation 3, April 2009:** *Implement the policy and the Comprehensive Nursing Assessment*. **Findings:** The policy and new ICN have been implemented. **Recommendation 4, April 2009:** Finalize the monitoring tool, begin audits, act to resolve trends and monitor the effectiveness of actions. **Findings:** The audit tool was developed, however SEH reported that initial data suggests that the tool needs modification. I agree. **Recommendation 5, April 2009:** Develop a template for nursing progress notes that includes prompts to meet documentation requirements in this agreement. **Findings:** A Nursing Update Form (SEH 300.02.09; Nursing Update, 6/30/09) along with form instructions were developed. It is not clear if this is toke the place of narrative nursing progress notes. **Recommendation 6, April 2009:** Develop a policy for nursing progress notes that meets the documentation requirements in this agreement. **Findings:**

			No policy was presented that describes the content and frequency of nursing progress notes. Duplicative content was evident in progress notes in the patient records. Often the PNA and RN made entries at the same time, with virtually the same content. Although notes were sometimes frequent, and duplicative, not all relevant content was consistently present. **Other findings:** Nursing policies and procedures use four different terms to describe the service recipient: consumer, client, individual, and patient. It would be useful for the hospital to determine which term will be utilized in order to assure clarity in the policies/procedures and in documents such as progress notes that reference the recipient of services. Nursing admission assessments varied in terms of completion and adequacy of content. Most forms contained some blanks (RH, AK, JP, FH, RW, SH, SR), boxes were checked that required further information, yet none was provided,(RH, JP, FH,AK). More consistent use of the new form, with accompanying comprehensive instructions, should support greater adherence to the requirements. There are rarely IIRP or IRP objectives and interventions that relate to nursing care, even though the patient's behavior reflects that these are necessary (SR.JP, FH, RW, SR,AK, RG). This is one influence on the quality of information that nursing shares with the team. Some of the documentation in the records was specific and reflected implementation of the IRP e.g. attendance at groups. There were several occasions, when there was evidence that "comfort plan" was implemented. In the IRP conferences that I attended, nursing staff were

			unprepared or none attended (MM), (despite the fact that the IRP was held on the Mall to enable staff to attend). The prompts on the Nursing Update Note are primarily deficit/problem/barrier based with few prompts that are consistent with a recovery informed system of care. The areas of evaluation (although they are called re-assessments, which is not correct terminology) do not contain all areas relevant to nursing practice. There is no evidence of the patient's perspective of progress. **Compliance:** Partial. **Current recommendations:** 1. *Assure that the nursing assessment policy/procedure addresses: the process for linking the assessment to the initial IRP, the process for using "screens," and the process for evaluating/updating information that emerges during the time interval between admission and the IRP.* 2. *Finalize the monitoring tool, begin audits, act to resolve trends and monitor the effectiveness of actions.* 3. *Develop a policy and template for nursing progress notes that meets the documentation requirements in this agreement.*
LDL	VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	**Current findings on previous recommendations:** SEH reports partial compliance in this area. Based on document and record review, and staff interviews, I concur. **Recommendation 1, April 2009:** *Revise the Physical Observations form and the Intake and Output form. Use the nursing p/p template to develop a p/p to*

			accompany each form. **Findings:** The SEH, Nursing Reference Manual; Physical Observation (not numbered, revised 8/2009) is not well organized, contains uneven levels of procedural detail, and needs further refinement. The policy also references "unit specific standards, protocols and procedures" that "…may further define the physical assessment." There are numerous potential problems with additional unit specific standards. The problems range from the burden of developing and keeping them updated to challenges with assuring that all nursing staff maintain competency in both department wide and unit specific standards. No unit specific standards were provided for review. My recommendation is that SEH reconsider this idea. The policy requires minimum monthly measures for temperature, heart rate, blood pressure, respiratory rate, pain, pulses, neurological assessment, menses, bowel movement, and edema. Skin is assessed "per skin care protocol" (not provided). Weight is measured on admission, transfer, and as ordered. In light of the impact that medications can have on a weight, it would be prudent for nursing to at least do routine monthly weights. The policy references the need to document using an "SBAR" format when situations are urgent and/or emergent, but this format is not described. The policy states: "The RN must conduct a thorough physical assessment when patients' physical status changes and/or prior to or return from transfer to another care setting" and" Focus shall pertain only on the area(s) which the patient has voiced as the chief complaint." This is not adequate and could be dangerous. The patient's chief complaint is only one of the

			considerations that should inform the assessment. The Physical Observation form, revised 8-14-09 does not contain space to document all of the monthly measures. In addition, it has space for other measures e.g. "oxy sat." The content relative to measuring oxygen saturation illustrates the uneven level of detail in the procedure. There are detailed step-by-step instructions describing how to obtain the measure, but there is no information about potential indicators that the measurement should be taken and no information about levels that would require MD notification. There is also an area for "physician assessment" on the nursing form, but there is no direction relative to who or what is documented in this area. The SEH Nursing Reference Manual, Nursing Intake and Output Procedure (no number; revised 8/2009) was generally comprehensive and specific. The 24-hour Intake and Output form (no number or date) is clear. The name of the GMO notified should be included. **Recommendation 2, April 2009:** *Implement the forms and policies/procedures*. **Findings:** The records reviewed contained a mix of old and new/revised forms. However, there was more complete documentation of measures ordered by the physician e.g. vital signs, BS. **Recommendation 3, April 2009:** *Develop a joint medical nursing policy that at a minimum addresses: assessment data that the RN will provide to the MD; joint determination of the level of urgency of a physical status change; expected response times based on the level of urgency*

			(emergent, urgent, and non-urgent); RN and MD follow up actions; assessments and documentation prior to transfer to an ED or acute care hospital; assessments, notifications, and documentation upon return from an ED or acute care hospitalization. **Findings:** The policy does not adequately address this issue. **Recommendation 4, April 2009:** Resolve barriers to using the draft Change of Shift Report template as designed; revise the form as necessary; finalize the procedure; implement the form and procedure. **Findings:** SEH Nursing Reference Manual, Change of Shift Report (Revised 8/2009), is detailed and contains many requirements. As implementation proceeds, SEH will need to closely monitor if it is possible/necessary to include all of these activities/information as designated and/or if some consolidation could occur without compromising the quality of the necessary functions. The RMB 3 day to evening change of shift report was excellent. It included relevant information on the patients' physical and psychiatric/behavioral status, indicated effective interventions, implications for on-coming shift, and was completed in the designated time. The RMB 8 night to day change of shift report contained relevant information from evening shift as well as night shift. **Recommendation 5, April 2009:** Consider developing templates to document nursing assessments for physical status change, and transfers to and from EDs or

			acute care hospitalizations. **Findings:** This has not been completed. The policy needs to be addressed first. **Recommendation 6, April 2009:** Develop a monitoring instrument; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. **Findings:** This has not been completed. The policy needs to be addressed first. **Other findings:** Record reviews revealed some improvement in the documentation of the nursing assessment prior to and upon return from transfer. For the most part, however, a thorough and relevant physical assessment was not documented (SA, LE, RG, RD, EC). Physician notification was timely and documented in most instances. **Compliance:** Partial. **Current recommendations:** 1. *Refine the Physical Observations nursing policy.* 2. *Implement the forms and policies/procedures.* 3. *Revise the SEH, Draft Policy: Medical Response, Emergent/Urgent/Non Urgent to at a minimum address: assessment data that the RN will provide to the MD; joint*

			determination of the level of urgency of a physical status change; expected response times based on the level of urgency (emergent, urgent, and non-urgent); RN and MD follow up actions; assessments and documentation prior to transfer to an ED or acute care hospital; assessments, notifications, and documentation upon return from an ED or acute care hospitalization. *4. Consider developing templates to document nursing assessments for physical status change, and transfers to and from EDs or acute care hospitalizations.* 5. Develop a monitoring instrument; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. *6. Monitor change of shift report to assure that all of the current requirements are necessary and can be accomplished in the designated time period.*
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *Same as in VIII.A.2.b.iv.* **Findings:** The AVATAR eMar system contains some safeguards that enable the nurse administering medication to quickly find medications that might have been missed. **Recommendation 2, April 2009:** *The P&T Committee should analyze aggregate data, identify trends, take action to address improvement opportunities, and*

			monitor the effectiveness of actions taken. **Findings:** See VIII.A.2.b.iv. **Recommendation 3, April 2009:** *Revise the Medication Variance Reporting and Assessment policy to direct coding for undocumented medications*. **Findings:** This has been revised. **Recommendation 4, April 2009:** Consider potential to eliminate duplicative reporting. **Findings:** It is not clear if this has been addressed. **Recommendation 5, April 2009:** Finalize the policy on monitoring patient response to first dose of medication. **Findings:** No action has been taken. **Recommendation 6, April 2009:** Continue to develop processes to analyze and act on medication variances. **Findings:** Processes are being developed and refined. **Other findings:**

			See VIII.D.5. In addition, Section VIII.A.2.b.iv contains further discussion of the status of reporting and analyzing medication variances at SEH. **Compliance:** Partial. **Current recommendations:** *1. See VIII.A.2.b.iv.* *2. See VIII.D.5.* 3. Monitor the patient response to the first dose of medication.
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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews and unit observations, I concur. **Recommendation 1, April 2009:** *See recommendations for VIII.D.1, items 1-3, 5, 7 and 8.* **Findings:** See VIII.D.1. **Recommendation 2, April 2009:** *Review practice and p/p for change of shift narcotic count.* **Findings:** Unit observations revealed that narcotics continue to be opened and counted in non-locked areas. This is likely a result of significant space limitations in the current medication room. However, an interim method to assure that narcotics are counted in a locked area needs to be developed pending the move to the new facility.

			Recommendation 3, April 2009: *Using the nursing p/p template, finalize the "Using eMAR for Medication Administration" (MED 501, Revised 2-18-09), assuring integration of requirements specified in this agreement.* **Findings:** The policy has been substantially revised to include much more information about the actual med administration process. Refinements will support greater clarity regarding the steps for checking medication prior to administering. **Recommendation 4, April 2009:** The P&T committee should drill down the top three causes of medication variances to determine actions needed to reduce medication variances. **Findings:** Pharmacy and Therapeutics Committee minutes reflect review of medication variances. However, as mentioned in Section VIII.A.2.b.iv, the facility has yet to fully implement the newly revised data collection tools to ensure valid and reliable reporting of variances. **Other findings:** Observations of medication administration showed inconsistent knowledge of/adherence to established steps for identifying the patient, and for checking the medication packet against the eMAR in order to assure the complete accuracy of the medication being administered. The SEH, Nursing Reference Manual, Using E-MAR for Medication Administration (unnumbered, revised 8-2009) does not specify the number of checks or the order in which they must be performed prior to administering the medication; no staff member was observed to

			fully and consistently perform even one check. When asked about the action of specific medications, a nursing staff member responded accurately. Documentation that the medication was administered, or refused, sometimes occurred after all medications were administered to all patients, rather than immediately after each individual received his/her medications. Staff members were relying on their memories, an unacceptable practice. One identified barrier to documenting immediately after each individual received his/her medication was the report that AVATAR can "go down" as many as four times in the middle of medication administration. The definition of medication variance in the nursing policy differs from that of the hospital policy on medication variance reporting. The virtual absence of medication variance reports from nursing is of significant concern. Although it will be important to ascertain whether or not nursing staff know what constitutes a variance, it is even more important to consider whether or not staff feel "safe" in reporting their own, or their colleague's, variances. While it is apparent that the new medication administration policy provides considerably increased process clarity, it still needs refinement. Until SEH can assure that there is consistent system and process clarification/direction to support staff to safely administer medication, it will be difficult to ascertain the degree to which individual staff performance requires attention. When the policy is finalized, all nursing staff who administer medications need to be re-trained and competency documented.

			Following this, NMs should make spot checks to provide additional coaching so that the policy is fully implemented. The SEH policy for Medication Ordering and Administration (SEH 206-09, Revised July 13, 2009) continues to have statements/direction inconsistent with safe practice e.g. item 3 page 9. **Compliance:** Partial. **Current recommendations:** 1. *Refine medication administration policy to assure it fully aligns with hospital policy, and provides clear direction regarding steps, and the order of the steps, that must be followed to support accurate medication administration.* 2. *Re-train all nursing staff who administer medication. Measure and document competency. Include a review of medication variance reporting during this training.* 3. *Resolve continuing issues in the Medication Ordering and Administration policy.* 4. *Explore barriers to nursing reporting medication variances.*
LDL	VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *Resolve differences between SEH policy and Draft Nursing policy relative to who can administer medications and relative to the different definitions for medication variances.* **Findings:**

			The two policies continue to have different definitions for medication variances. The term "Certified Medication Givers" is still utilized. If this must be referenced, SEH should specify which roles are in this category, and orientation/annual competencies for all of these roles must be accomplished. **Recommendation 2, April 2009:** *See VIII.D.4, Recommendation 2.* **Findings:** The Pharmacy and Medication Monthly Report does not report failures to document. The P&T Committee minutes did not reflect a discussion of medication errors/variances associated with failure to document. **Other findings:** The nursing policy on medication administration describes review steps that should enable staff to quickly identify any failures to sign the eMAR. **Compliance:** Partial. **Current recommendations:** See VIII.D.4 and VIII.D.5
LDL	VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, and unit observations, I concur. **Recommendation, April 2009:** *See VIII.D.5, Recommendation 3.*

			Findings: See VIII.D.5. **Other findings:** Although one staff member did ask a patient about side effect, there is no structure to document this. The Nursing Update Form does not include a prompt for this information. Because policies for general nursing documentation were not reviewed, it is not clear if there is an expectation that this would be documented in narrative nursing progress notes. The nursing policy for medication administration assigns this responsibility to staff members who administer medication. Developing a prompt in AVATAR could be helpful to staff to support documentation. **Compliance:** Partial. **Current recommendation:** Develop a mechanism for staff who administer medications to document inquiries relative to side effects and patients' responses.
LDL	VIII.D.8	Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *See D.1, Recommendation 9.* **Findings:** See D.1.

			Recommendation 2, April 2009: *See D.2, Recommendations 1-4 and 7.* **Findings:** See D.2. **Other findings:** See VIII.D.1 and VIII.D.2. **Compliance:** Partial. **Current recommendations:** *See VIII.D.1 and VIII.D.2. and VIII.D.9.*
	VIII.D.9	Ensure that each individual's treatment plan identifies:	Please see sub-cells for findings and compliance.
LDL	VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *See D.1, Recommendation 9.* **Findings:** See VIII.D.1 and VIII.D.2. and VIII.D.10. **Recommendation 2, April 2009:** *See D.2, Recommendations 1-4, 6 and 7.*

			Findings: See VIII.D.1 and VIII.D.2. and VIII.D.10. **Recommendation 3, April 2009:** *Using the nursing p/p template, revise the Guidelines Choking/ Swallowing Assessment (NCP 600.25), re-titling this as Dysphagia Assessment. Provide clear direction for what information/behavior will trigger an assessment, what the assessment will entail, what referrals will be made, and what interventions will be provided.* **Findings:** The guidelines remain non-specific, focusing largely on what to do to relieve, rather than prevent, choking. **Recommendation 4, April 2009:** *Align the Choking/Swallowing Assessment form with the policy. Change the title to Dysphagia Assessment. Review risk factors to assure that all relevant to the population at SEH are included.* **Findings:** This has not been done. **Recommendation 5, April 2009:** Clarify how the RN will be directly involved in developing the IIRP. **Findings:** The process to assure that the Psychiatrists involves the RN in developing the IIRP is not specified and is not monitored. Many IIRPs did not have an RN signature and did not contain necessary nursing interventions.

			Other findings: Observations during meal time revealed that some staff were knowledgeable about patients who were at risk for choking. The patients were not, however, consistently observed by staff. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.1, VIII.D.2 and VIII.D.10.* 2. *Using the nursing p/p template, revise the Guidelines Choking/ Swallowing Assessment (NCP 600.25), re-titling this as Dysphagia Assessment. Provide clear direction for what information/behavior will trigger an assessment, what the assessment will entail, what referrals will be made, and what interventions will be provided.* 3. *Align the Choking/Swallowing Assessment form with the policy. Change the title to Dysphagia Assessment. Review risk factors to assure that all relevant to the population at SEH are included.* 4. *Consider accessing assistance to develop a sound policy/procedure for dysphagia.* 5. *Explore and resolve barriers to RN involvement in developing the IIRP.*
LDL	VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *See VIII.D.1, Recommendation 9.* **Findings:**

			See VIII.D.1. **Recommendation 2, April 2009:** See VIII.D.2, Recommendations 6 and 7. **Findings:** See VIII.D.2. **Recommendation 3, April 2009:** Using the nursing p/p template, revise the nursing documentation policy/procedure. **Findings:** No policy was provided for review. **Other findings:** The Nursing Update form contains prompts for nursing to provide some information relative to each IRP focus. The Change of Shift report also included some information about the IRP. However, other than groups, and medication, there are few to no meaningful or relevant nursing interventions in the IRPs. **Compliance:** Partial. **Current recommendations:** *1. Resolve IRP quality issues.* *2. See VIII.D.1 and VIII.D.2.* *3. Revise the nursing documentation policy/procedure.*
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:**

			Based on the planned dining room hours for each unit, immediately clarify when insulin should be administered. **Findings:** SEH has clarified that insulin will be administered 30 minutes before meals and that a snack will be provided if the meal is not served in that time frame. A policy on insulin administration was developed. It is not clear if the second RN who verifies the proper insulin must be present when it is drawn up, or merely checks the bottle and syringe after it has been drawn up. The policy was not followed during one observation. **Recommendation 2, April 2009:** *Immediately review the signs of hypo- and hyperglycemia with all nursing staff.* **Findings:** The policy includes the signs of hypo and hyperglycemia. Training was planned, but it is not clear if it was accomplished. **Recommendation 3, April 2009:** *Using the nursing p/p template, develop policies that comprehensively address the care of patients with diabetes, including actions to take when meals are delayed.* **Findings:** Actions to take when meals are delayed are described in the insulin administration policy. **Recommendation 4, April 2009:** *See VIII.D.1, Recommendation 10.*

			Findings: See VIIII.D.1. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.1 and VIII.D.2xxx* 2. *Clarify if the second nurse must be present when the insulin is drawn up.*
	VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	Please see sub-cells for findings and compliance.
LDL	VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Current findings on previous recommendations:** SEH is to be commended for taking action on all previously prioritized recommendations as well as others that were not prioritized. SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *The Medical Director should pursue his current plan to review the Infection Control Program. Consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting, mechanisms that are embedded in existing work processes so as not to create additional reporting workload.* **Findings:** The Infection Control Policy and Procedure Manual (ICPPM) was substantially revised. In July, the manual was approved by the

			Chair of the Infection Control Committee, and the Director of Medical Affairs. The ICPPM provides clear direction for staff and appropriately addresses infection control (IC) priorities for an urban psychiatric hospital. Some reporting mechanisms have been established that extract data from the existing computerized database/reporting system e.g. lab reports. The *Infection Prevention and Control Department Report* (May 29, 2009) notes that the IC Coordinator was not informed of all patients placed on isolation precautions. The low numbers of reported infections in the *Monthly Infection Rates by Site Report* also suggest that reporting may be incomplete. Greater policy/program clarity may be needed in order to ensure consistent reporting by relevant SEH staff. As the program develops, data regarding employee infections should be incorporated into the regular review of SEH infections. **Recommendation 2, April 2009:** *Develop a clear structure for the IC Program that includes a description of the ICC responsibilities and that addresses each requirement in VIII.D.10 of this agreement.* **Findings:** A structure for the Infection Control Program (ICP) has been developed. The structure specifies the IC Coordinator's responsibilities as well as those of the IC Committee. These should now be checked against each requirement in VIII.D.10. of the agreement, especially as it relates to taking actions/monitoring effectiveness of actions. Although the requirement associated with VIII.D.10.f is generally addressed, greater specificity will support integration.

			Recommendation 3, April 2009: Develop a TB Control policy/program based on generally accepted standards and CDC guidelines, including those related to risk level. **Findings:** A thorough risk assessment informed the SEH IC Policy (15.0), "Tuberculosis Control Plan." The policy is comprehensive, provides for annual risk assessment as well as employee and patient screening, follow up, and conversion tracking. Based on his observations relative to PPD follow-up, the IC Coordinator has developed a form to provide structure for the tracking and documentation of PPDs. The *PPD/Chest X-ray Refusal Tracking Form* will be used to support the physician to close the clinical loop and document follow up on PPD results and PPD refusals. This form will also provide data for the IC Coordinator to use to monitor adherence to the expected IC procedures. **Recommendation 4, April 2009:** *Develop policies and procedures to identify cluster outbreaks*. **Findings:** The SEH IC Policy (18.0), "Cluster/Outbreak Investigation and Response," provides clear direction to support identification and management of an unusual or rapidly increasing incidence of symptoms/communicable diseases. The methodology/form that details the steps to investigate an outbreak is especially clear, well sequenced, and comprehensive. **Recommendation 5, April 2009:** Develop policies and procedures for food borne illness, flu, and

			norovirus. **Findings:** SEH has a Pandemic Influenza Plan that is a part of the overall DC Government Plan. The SEH IC Policies (16.0 and 17.0) address "Norovirus Outbreak Management" and "Influenza Outbreak Management." The general discussion about food borne illness that is embedded in the Norovirus policy adequately meets requirements. The policy title may need to include the phrase "food borne illness" so that staff can quickly locate the relevant policy in the event that patients or staff develop gastrointestinal symptoms. Prevention of food borne illness is addressed in the SEH IC Policy (8.0), "Safe Food Handling and Drinking Water." Preventative activities are further supported by the active involvement of the Nutritional Services Department in the IC Committee. **Recommendation 6, April 2009:** Identify categories of data to be collected with initial focus on those data that relate to risks for this population. **Findings:** In addition to data associated with Hepatitus B and C, HIV, MRSA and other MRDOs, and TB control, SEH is collecting data on: urinary tract infections; upper and lower respiratory infections; gastrointestinal symptoms; skin infections; eye infections; and generalized infections e.g. primary blood stream infection and unexplained febrile episodes. These data sets are relevant to the service population. Data were not presented relative to employee health. However,

			the IC policies reflect attention to relevant IC matters for employees. **Recommendation 7, April 2009:** Develop a system to monitor the degree to which the IC Program is implemented at the individual patient level and across the hospital. **Findings:** The IC Coordinator conducted hand hygiene surveillance throughout the hospital in May. Some Environmental Survey findings that are associated with IC surveillance have been reviewed and addressed by the IC Committee. **Other findings:** The IC Coordinator's belief in "collaboration, communication, and compliance" is evidenced in the actions he has taken during approximately five months that he has provided leadership for the ICP. The ICPPM has been distributed to all units, is available on the SEH intranet, and inservices have been conducted for staff. The IC Coordinator has provided consultation on the units, described utilizing "just-in-time teaching," and has a keen sensitivity for creatively adapting IC processes to a mobile patient population in a psychiatric hospital. He is also sensitive to maintaining a therapeutic milieu and has suggested appropriate modifications that maintain the milieu as well as prevent/control infection transmission. He is actively working with the Nursing Department to implement the program. He used an extensive number of professional resources when developing the ICP, has attended important IC conferences, and collaborated with regional colleagues.

			Since April, the IC Committee has met on a monthly basis. Minutes reflect that the Committee has responded to priority IC issues, received regular reports from the IC Coordinator, and has begun to review trends in data. Two matters have been discussed in several IC meetings that require immediate attention from hospital leadership. First, the minutes reflect that although N-95 masks for nursing units have been ordered, only the small size has been provided. Other sizes are on back-order. More importantly, these masks must be fit-tested before use, and there is no budget for training SEH staff to conduct the fit-testing. The IC Coordinator is knowledgeable about effective alternatives to the N-95 masks. The alternative masks should be purchased if N-95 masks will not be available for use. Second, the minutes reflect that there are no safety syringes available for use when administering IM medications. This poses significant risk for needle-stick injury. Both of these matters need to be quickly addressed. The IC Coordinator has given thought to strategies that can be used to monitor implementation of the program at both the individual patient and hospital wide levels. He described being invested in strengthening the communication flow to and from unit level staff. He is actively considering strategies to increase staff investment in and enthusiasm for the ICP. **Compliance:** Partial. **Current recommendations:** 1. *Continue to develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload.*

			2. Refine the IC Program description to assure that each requirement in VIII.D.10 is specifically addressed. *3. Monitor reporting to assure that all infections are being reported. Determine if reporting responsibilities need to be further specified and modify policies accordingly.* *4. Include employee health IC data in the IC Committee reviews.* *5. Purchase safety syringes for IM medications.* *6. Resolve issues associated with N-95 sizes and fit testing or purchase recommended masks to provide protection when droplet precautions are required.*
LDL	VIII.D. 10.b	assess these data for trends;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, April 2009:** *See VIII.D.10.a.* **Findings:** See VIII.D.10.a. **Recommendation 2, April 2009:** The IC Committee should review data/data analysis no less than quarterly. **Findings:** The IC Committee reviewed data in June. These data included relevant graphs and infection rates that were prepared by/calculated by the IC Coordinator. **Other findings:** The IC Coordinator indicated that trends were assessed

			/discussed in the IC Committee. However, there was scant evidence of this in the minutes. The IC Coordinator is spending considerable time developing various reports. Dedicated administrative support for these tasks, as well as IT assistance, would enable him to spend time developing this nascent program and working directly with several departments to ensure program implementation. **Compliance:** Partial. **Current recommendations:** *1. Continue no less than quarterly data analysis.* *2. Assure that the IC Committee minutes specify data assessment. Attach all relevant data displays to the meeting minutes.* 3. Consider allocating administrative support time for program functions (e.g. report and minute preparation), so that the IC Coordinator can focus on program development and implementation. 4. Provide IT assistance to develop prioritized IC data sets.
LDL	VIII.D. 10.c	initiate inquiries regarding problematic trends;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, April 2009:** *See VIII.D.10.a.* **Findings:** The IC Committee is in the early stages of data review. There is evidence that inquiries regarding problematic trends have been

			initiated. For example, reference is made to providing handouts to the units and collaborating with Unit Managers following the low findings resulting from hand-hygiene surveillance conducted in May. **Recommendation 2, April 2009:** The Infection Control Committee should determine areas for further "drill down" based on trends in data. **Findings:** See findings from Recommendation 1 above. **Compliance:** Partial. **Current recommendations:** *1. Continue data collection and analysis by the IC Committee.* 2. Based on data trends, "drill down" as necessary.
LDL	VIII.D. 10.d	identify necessary corrective action;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, April 2009:** *See VIII.D.10.a.* **Findings:** There was evidence that necessary corrective actions on identified issues have been taken. For example, the IC Coordinator identified and followed up on unit supply issues e.g. the need for spill kits, as well as disposable medical equipment. He also is assisting the Nursing Department to develop nursing policies and procedures related to IC. He has identified the

			need for physicians to more consistently order transmission-based precautions as required. **Recommendation 2, April 2009:** Differentiate "monthly safety inspections" and "environmental survey", clarifying purpose, method, reporting routes, responsibility for taking and documenting actions as well as evaluating effectiveness of actions taken. Ensure involvement of the ICC and the Infection Control Committee as applicable. **Findings:** The IC Committee minutes (July 22) reflect that the committee reviewed relevant findings from the Environment of Care Report (1st quarter). Corrective actions were identified. **Other findings:** It is not clear how the monthly safety inspections and environmental survey inspections are differentiated. Although the *Environmental Survey Report* (3rd Quarter, 2009) references the involvement of the IC Coordinator, the processes for doing so need to be more clearly specified in the ICPPM. **Compliance:** Partial. **Current recommendation:** In the ICPPM, specify the: reporting routes; review responsibility; and responsibility for taking, documenting, and evaluating effectiveness of actions relative to findings from "monthly safety inspections" and "environmental survey" that have implications for IC.
LDL	VIII.D.	monitor to ensure that appropriate remedies	**Current findings on previous recommendations:**

	10.e	are achieved;	SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, April 2009:** *See VIII.D.10.a.* **Findings:** The ICP was approved on July 31, 2009. Therefore, insufficient time has elapsed to evaluate this requirement. The structure of the program, as well as the IC Committee minutes, provides a framework to perform/document this function. **Recommendation 2, April 2009:** Include in the Infection Control Program/Policy/Procedures how actions will be monitored, and the effectiveness of actions evaluated. **Findings:** Most of the IC policies address monitoring. As the policies are implemented, it will be important to evaluate the need for greater specificity in the monitoring systems and processes. **Recommendation 3, April 2009:** Assure that the Infection Control Officer review Environmental Survey findings that relate to Infection Control. **Findings:** See VIII.10.d. **Compliance:** Partial. **Current recommendation:**

			Continue program implementation. Based on findings, evaluate and refine monitoring systems and processes.
LDL	VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, I concur. **Recommendation, April 2009:** The Director of Performance Improvement and the Infection Control Chief should determine how to achieve integration. This should be described in Infection Control Program/Policies/Procedures. **Findings:** The SEH ICPPM has some embedded information related to performance improvement. In addition, IC Policy (10.0),"Performance Improvement," begins to address this issue. However, the linkages with the hospital level QA/PI reviews are not specified. **Other findings:** The Environmental Survey Report (3rd Quarter) specifies the linkages among IC, Risk Management and Safety, and PI. The IC Coordinator should review the described processes, and if he concurs should integrate a description of the linkages into the ICPPM. Linkages should be evident in the IC Committee minutes. **Compliance:** Partial. **Current recommendation:** Specify the linkages between the IC Committee and hospital-wide Quality Assurance/Performance Improvement. When

			relevant, document the linkages in the IC Committee minutes.
LDL	VIII.D. 10.g	ensure that nursing staff implement the infection control program.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews and unit observations, I concur. **Recommendation 1, April 2009:** *See VIII.D.2 and VIII.D.10.a.* **Findings:** Chart reviews revealed that nursing staff are not consistently documenting implementation of the IC program/policies when patients have a diagnosed infection. While the records sometimes included excellent patient teaching, there was no documentation that necessary precautions were ordered by the physician or documented as implemented by nursing staff (CC). Furthermore, the IRPs did not address the presence of infections, associated health risks for the individual patient, risk of transmission to others, or strategies to address PPD refusals (SR, JR, CC, TS). Because nursing staff progress notes are based on IRP foci, there is no prompt to address infections. In the absence of MD orders, or IRP integration, there is no trigger for nursing to routinely review and document program implementation at the individual patient level. Unit observations revealed some situations when nursing staff were following IC policies/procedures e.g. appropriately wearing gloves, washing hands or using alcohol based gel prior to administering medications. More consistent implementation of IC policies/procedures should become evident now that a framework has been established and communicated. **Recommendation 2, April 2009:**

			Develop a policy that clearly defines precautions, directs steps to implement each type of precaution, and specifies documentation requirements. **Findings:** The SEH ICPPM (6.0) policy, "Standard and Transmission-Based Precautions," details steps associated with defined precautions. Documentation requirements may need to be further specified by both the medical staff and the nursing staff within their respective departmental procedures. **Recommendation 3, April 2009:** Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions. **Findings:** Although some audit criteria can be extracted from the ICPPM, the associated nursing policies/procedures have not yet been finalized. Since criteria from both sets of policies/procedures need to be developed, a monitoring instrument/process is not currently in place. **Other findings:** The SEH DOJ Compliance Office report (September 1, 2009) indicated that a "Supervisory Review" would be used "…to detect and take corrective action for non-compliance with infection control policies and procedures." While supervisory observations/reviews are relevant in terms of determining employee performance vis a vis all hospital policies, these actions do not meet requirements for monitoring and reporting IC program implementation. The IC Coordinator has done some monitoring, and is actively considering multiple additional strategies.

			Chart reviews reflected appropriate follow-up for positive PPD and PPD refusal (GH, YL). However, this was not consistent (KW, TS). **Compliance:** Partial. **Current recommendations:** 1. *Finalize nursing IC policies/procedures.* 2. *Identify and resolve barriers to physicians ordering precautions consistent with IC policy requirements.* 3. *Involve the IC Coordinator to evaluate the degree to which IRP instructions and monitoring address IC issues.* 4. Develop criteria and instructions for monitoring, implement monitoring, report results to the IC Committee, take actions as required, evaluate the effectiveness of actions taken. 5. Consider monitoring options that would minimize duplication and could build on existing systems.
LDL	VIII.D. 11	Ensure sufficient nursing staff to provide nursing care and services.	**Current findings on previous recommendations:** SEH reported partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation 1, April 2009:** *Evaluate the factors that have contributed to not having an RN on duty on each unit on all shifts. Address these factors in order to assure that an RN is on every unit, on every shift, at all times.* **Findings:** Although when compared with the last DOJ review improvement was noted, based on data provided for August 1 – 16, 2009 SEH still does not have an RN on duty on each unit/shift.

			Specifically, there was one shift on the civil side, and 117 shifts on the forensic side that had no RN or partial RN coverage (0.5). This level of RN staffing reportedly includes overtime hours worked, although the proportion that was overtime was not specified. There were 25 shifts of RN unscheduled leave during this time period (22 on Civil and 3 on Forensic), reflecting that unscheduled absences do not account for the lack of RN coverage. Although the SEH DOJ Compliance Office Report (September 1, 2009) indicated that effective August 15, RNs would be re redeployed to ensure RN "coverage" on each shift/ward, there were occasions on both August 15 and 16 when this was not the case. In light of the total number of RN positions filled, it is unlikely that redeployment alone will ensure the required coverage. It is more likely that there are insufficient RN positions. The factors that have contributed to not having an RN on duty for each unit/shift are in the process of being evaluated. This is reasonable progress in light of the short tenure of the current CNE. **Recommendation 2, April 2009:** *Determine the targeted NCHPPD standards for each unit.* **Findings:** The Nursing Department's *Plan for the Provision of Care,* reflects that a campus wide average of 6.0 Nursing Care Hours Per Patient Day (NCHPPD) has been established as the standard. *The Department of Nursing, SEH, Resource – Staffing Assessment and Action Plan* indicates that the standard is 6.5 NCHPPD. Targeted NCHPPD standards for each unit are under

			development. The *NCHPPD Report* (August 1 – 16, 2009) displays by unit/by shift staffing standards in terms of "on duty" staff for NM, RN, LPN, PNA/FPT. Variance is reported in relationship to these numbers. The relationship between the targeted "on duty" staffing numbers and the actual targeted NCHPPD is not clear. It was reported that the Nursing Managers (NM) for each unit have responsibility to determine the NCHPPD targets for their units. While it is essential that NMs have input, the size of the hospital and the fact that staffing has been centralized suggests that a centralized approach to establishing units' targeted NCHPPD would be more appropriate. **Recommendation 3, April 2009:** *Report the actual NCHPPD delivered on a monthly basis by unit. Include in this report the number of shifts, by unit, that did not have at least one RN on duty.* **Findings:** The CNE has developed a template for a staffing report that will enable him to monitor the NCHPPD delivered on each unit on a monthly basis. The report does not include the number of shifts, by unit, that did not have at least one RN on duty. Although these shifts can be counted, the failure to have at least one RN on duty for all units/shifts is so serious as to warrant a daily count. In addition, when there has been a unit/shift without an RN, the reasons need to be analyzed and immediate action taken to ensure there are no further shifts without RN coverage. Data provided during the survey revealed that SEH did not provide their targeted NCHPPD (5 provided; 6 - 6.5 target). On the Civil side, an average of 5.8 NCHPPD was provided; on the

			Forensic side an average of 4.4 NCHPPD was provided. Although a by-shift analysis was not conducted, a review of the evening staffing patterns revealed that SEH needs to closely monitor, and possibly adjust, the numbers and mix of nursing staff on duty. Evening shift is an unstructured time during which nursing staff provide most, if not all, services. There must be sufficient nursing staff to engage, observe, and monitor patients during these hours, as well as a sufficient proportion of RNs to directly provide as well as supervise these services. **Recommendation 4, April 2009:** Evaluate and adjust as necessary the mix of nursing personnel (RNs, LPNs, PTs) considering the patient requirements for nursing care/services, including requirements associated with enhanced treatment, rehabilitative, and enhancement activities. Assure that the requirements associated with increased medical co-morbidities are considered when determining the required number of RNs. **Findings:** This evaluation is underway. The CNE has established a target average of 30% RNs on duty. The relationship between the "on duty" target, and the proportion of *positions* that are RN positions is not clear. However, the staffing numbers suggest that there are insufficient RN positions to meet the current targeted mix. Furthermore, the current targeted mix is not sufficient for all units. The CNE indicated, and I concur, that the patient population on some units requires an RN mix above 30%. He has not yet determined the number of RN positions required to deploy a higher mix on the units that require a higher overall number and proportion of RNs. (In Report 2, I discussed staffing mix,

			including the fact that the typical RN mix ranges from 30% - 50% depending on patient care needs). Not only does SEH not meet the 30% RN target, but the current RN mix is well below acceptable levels. From August 1 – 16, the Civil side RN mix ranged from 14-16%. On the Forensic side, the RN mix ranged from 15 – 25%. (It is important to note that the percent of RNs on forensic units is artificially inflated because the total numbers of nursing staff on duty were lower than other units). **Recommendation 5, April 2009:** Revise a SEH Plan for Nursing Services that at a minimum: articulates the NCHPPD with rationale; establishes the mix of nursing personnel; describes scheduling models/policies; provides a guiding decision framework for alternatives when additional staffing is required. **Findings:** The CNE has developed several related documents to address this: *Plan for the Provision of Care, Nursing Department; The Department of Nursing, SEH, Resource – Staffing Assessment and Action Plan;* and an initial *Flexible Staffing Plan.* Taken together, the documents generally address this requirement. Unit *Plans for the Provision of Care* are reportedly in the process of being developed. Integration, refinements, and consistency among the documents are the next and final steps. **Recommendation 6, April 2009:** If there are currently insufficient numbers of nursing positions to meet the targeted NCHPPD, develop an interim plan to assure the best use of resources, while long term planning is underway to secure the required positions.

			Findings: The CNE is in the process of determining if there are a sufficient number of existing nursing positions to meet the targeted NCHPPD and skill mix. Plans to consider supplemental staffing services have not been finalized. Discussions with the CNE revealed that he is considering relevant factors as he makes decisions about this option. In the meantime, he has reportedly changed unit/shift staffing assignments in order to assure the best use of existing resources. **Other findings:** The CNE has only been in the position for three months. He is to be commended for the multiple actions he has taken in this short period of time to develop a foundation for the efficient and effective use of nursing resources. He has conducted a needs assessment that has included a review of the nursing leadership structure, staffing plans, competencies, and overtime utilization. Based on his concern about the impact of not having an on-site nursing supervisor on evenings, nights and weekends, an acting Assistant Director of Nursing (ADON) was deployed to the evening shift pending establishing and recruiting into positions that will provide 24/7 hospital wide coverage by a senior on-site RN. This is an excellent plan that should contribute to achieving the reform that SEH seeks to accomplish. The CNE should be commended for initiating this action. There are currently four NM vacancies, resulting in some NMs covering two units. Furthermore, at the time of the review, and as a result of a recent upgrade, current NMs were reported to be re-applying for these positions. Stabilizing the NM positions is essential to assure the unit level coaching and supervision

			required to consistently align practice with policy/procedures. NM position responsibilities were reportedly adjusted to afford them more unit based time e.g. committee work was curtailed. However, it appears that NMs may be conducting baseline training that could be done by nurse educators and other staff development resources within the hospital. For example, NMs have reportedly been trained to provide IRP training and Seclusion and Restraint training for their direct reports. Based on reports, it does not appear that this has appreciably increased the number of trained nursing staff. Assuming baseline training responsibility also detracts from the NMs' ability to supervise care and provide incidental training/teaching/ coaching for the staff on the units. In light of the findings from chart reviews and unit observations, there is a compelling need for unit-based teaching/ coaching. If NMs are not freed to accomplish this essential supervisory function, another plan needs to be developed to assure attention to this area. A Nursing Staffing Office has been established to support the effective and efficient deployment of resources. Scheduling has been centralized, a Nursing Information System has been developed to track assignments, staff re-deployment has reportedly occurred to even out resources, position control monitoring processes are being developed, and an individual has been appointed to oversee the Nursing Staffing Offices. The ADON will provide clinical oversight to this area. These actions appear to have supported the accelerated progress that was observed in terms of foundations for determining staffing requirements, analyzing staffing trends, and taking action to resolve staffing deficiencies.

			It was reported that six RN vacancies have been posted, advertised, and interviews scheduled. This number represents a substantial reduction in RN vacancies when compared with earlier reports. However, it is unlikely to be a sufficient number to achieve the required RN mix. During unit observations, most units had only one RN. This person was required to perform charge nurse duties, administer medications, perform functions that require an RN, e.g. patient assessments, treatments, interface with physicians, conduct groups, and attend IRPs. Some of these functions occurred at the same time, making it impossible to complete all requirements. Furthermore, one RN cannot perform all of these functions and provide essential oversight/supervision of unlicensed nursing care providers. SEH needs to examine the potential links between the current RN mix and patient outcomes. Reports that were provided reflected that only four nursing staff were hired during the spring. However, there was no additional information that would support a complete evaluation of nursing vacancy rates, hiring patterns, or turnover. These data are necessary in order to comprehensively evaluate staffing trends and identify potential leverage points for effective actions. Data were also not provided for the total number of 1:1s, and the outcome of the study that was reportedly undertaken to evaluate the influence of off-unit accompaniments on nursing staffing levels (see previous report). Both of these factors influence staffing and should be reviewed on a regular basis. While it was previously reported that Ward Clerks had been hired, there was no evidence of unit based ward clerks during unit tours or in documents reviewed.

			The Nursing Education Department has been reorganized and the mission of the department clarified. The nurse educators have established a "skills lab" that is currently under-utilized. It is critical that nursing training be prioritized, that barriers to nursing staff attending training are identified and resolved, and that the nurse educators be more fully utilized. Lastly, the CNE was appointed as acting on May 15 and was permanently appointed on June 15, 2009. However, at the time of this review visit, he continued in his former role as Performance Improvement Director, albeit now in an "acting" capacity. Likewise, the day ADON, who is also responsible for RMB, was appointed in an acting capacity around May 15, and was subsequently permanently appointed. SEH also continues in her former role as Risk Management Director, now in an "acting" capacity. Given the absence of/turnover in CNE positions, the nursing department must have consistent, full-time leadership if it is to effectively move forward at a consistently accelerated pace. **Compliance:** Partial. **Current recommendations:** 1. *Immediately ensure at least one RN on duty on all units/shifts.* 2. *Determine the number and mix of staff that are needed on duty each day to meet the established standards for NCHPPD and RN mix. Use these numbers as the baseline to express the variance by role classification.* 3. *Continue to use the worked hours and census as the baseline for calculating the actual NCHPPD delivered.*

			4. Evaluate whether or not there are sufficient positions to implement the target NCHPPD and RN mix. Develop a short and long term plan to resolve variances. *5. Evaluate the degree to which the 30% RN target will ensure sufficient numbers of RNs on all units to supervise nursing care/services provided by LPNs and Psych Techs, as well as meet the patient requirements for RN direct care/service (including assessing patients, developing IRP interventions, implementing interventions, and evaluating the effectiveness of nursing interventions). The targeted RN mix should take into account the increased medical co-morbidities among patients receiving mental health services, as well as requirements associated with enhanced treatment and rehabilitative activities.* *6. Refine and assure integration among the staffing documents, distinguish current from desired staffing capability as necessary, and develop a systematic plan to resolve variances.* *7. Evaluate staffing on a monthly basis to include: average NCHPPD provided by unit, and specified variance; average on-duty RN mix by unit, and specified variance; the number, type, and percent of nursing position vacancies; turnover; overtime use; unscheduled leave use; 1:1 observations. Consider displaying these figures on one or two reports in order to support analysis and identify how these factors influence one another.* 8. Evaluate the findings from the study that examined off unit accompaniment (previously reported to have been undertaken). Determine the relevance of the findings for nursing staffing plans. *9. Relieve the CNE and ADON of PI/RM duties.* *10. Reconsider the decision to use NMs for baseline training; consider using the Nursing Education Department and/or*

			other staff development resources in the hospital; if the NMs are used, assure a structure for on the unit supervision/coaching.

	IX. Documentation		
MES		By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate assessments of the individual's progress relating to treatment plans and treatment goals.	**Summary of Progress:** Please refer to Sections V, VI, VII, VIII and X for findings and judgments regarding SEH's documentation practices in each discipline and how those practices align with the requirements of the Settlement Agreement.

	X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications		
LDL		By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	**Summary of Progress:** 1. The SEH Restraint and Seclusion for Behavioral Reasons policy was revised to give comprehensive direction for terminating an episode of use. The corresponding Nursing procedure was also revised as was the procedure for protective measures. 2. SEH is to be commended for restraint and seclusion use that is well below the national average in both the percent of patients secluded or restrained, as well as in the total hours.
LDL			**Methodology:** <u>Interviewed</u>: 1. Brenda Lateef, RN, Nurse Educator 2. Paul Perrin, RN 3. Mark Bean, RN NM RMB 3 4. Robert Johnson, RN NM JHP 6 5. Mildred Kromah, RN 6. Allan Johnson, FPT 7. Adoracion Punio, RN 8. Deana Alice Oswosu, LPN 9. Kwason Newton, LPN 10. Olivia Hamilton, RN 11. Grace Agbaw, RN 12. Dr. Zaidi, Psychiatrist 13. Christianah Fayomi, RN 14. Ozaree Lee, PPN 15. Felix Alozie, PPN 16. Enyioma Anyatonwu, RN 17. Gloria Alford, PT 18. Regina Ogsuegbu, RN 19. Gwendolyn Chappelle, LPN

			20. Althea Wright, RN 21. Beatric Fomundian, RN 22. Ann Marshall, PNA 23. Amma Pokuaab, RN 24. Gladys Nabafu, RN 25. Cheryl Moore, PNA 26. Denise Young, PNA 27. Philo Amaechi, RN 28. Josephine Ogochukwu, RN NM, JHP 9 29. Carol Hogan, RN 30. Faye Stewart, Dining Room Supervisor (Dietary Staff) 31. Laverne Plater, RN, Nurse Educator 32. Malcolm Cook, RN, Infection Control Coordinator 33. Mamerta Benzon, RN, NM RMB 1 34. Reba Brothers, RN, NM RMB 6 35. Rosylin Yesudian, RN 36. Shirley Quarles, RN, Director of Nursing Education and Research 37. Yi-Ling Tu, RN, NM RMB 2 38. Michael Hartley, CNE **Reviewed**: 1. Medical records of the following 44 individuals: AF, AH, AK, AP, AS, AW-B, CB-1, CB-2, CB, CJ, CM, DA, DJ, EC, FH, GE, GR, JP, JS, JW, KH, LE, LR, LS, MA, MO, MT, NJ, PM, RD, RG-1, RG-2, RH-1, RH-2, RJ, RW-1, RW-2, SA, SF, SR-1, SR-2, SS, TC and YS 2. SEH DOJ Compliance Office Report, September 1, 2009 3. SEH PRISM Report, August 2009 4. SEH Restraint/Seclusion Review Tool, 9/14/09 5. SEH Operational Instructions, Restraint/Seclusion Review Tool, revised 9/1/2009 6. SEH IRP Chart Review and Process Observation Results,

			February through July, 2009 7. Comprehensive Initial Nursing Assessment; SEH Form 300.01.09; revised 5/12/09 8. Comprehensive Initial Nursing Assessment Operational Instructions (not dated) 9. Initial Interdisciplinary Recovery Plan; SEH Form 350.01.09; revised 5/7/09 10. Operational Instructions for Initial Interdisciplinary Recovery Plan, and the Interdisciplinary Recovery Plan; not dated 11. SEH Nursing Assessment Audit Questions. not dated 12. SEH Policy: Restraint and Seclusion for Behavioral Reasons, 101.1-04; revised August 11, 2009 13. SEH, Nursing Reference Manual: Restraint and Seclusion, no number; revised 5/2009; signed 8/25/09 14. SEH Seclusion and Restraint Audit Results, June, 2009 15. SEH, Nursing Reference Manual: Protective , PSS 400.7; revised 8/2009 16. SEH Policy: Medication Variance Reporting, 202-05; revised August 13, 2009 17. SEH Policy: Medication Ordering and Administration, 206-09; revised July 13, 2009 18. SEH Policy: Involuntary Medication Administration, 201-05; revised August 11, 2009 19. Medication Monitoring and Chart Review Results, February, 2009; March – July, 2009 20. Pharmacy and Therapeutics Committee Minutes, February 11, 2009 - July 8, 2009 21. Pharmacy and Medication Monthly Report, June 16, 2009 and July 7, 2009 22. SEH Nursing Reference Manual: Using eMAR for Medication Administration; no number; revised August, 2009 23. SEH Policy: Involuntary Medication Administration, 201-05;

			revised August 11, 2009 24. Advanced Instructions/Personal Comfort Planning (Form 302.01.08; revised February 11, 2009) 25. Levels of Observation Flow Sheet (no number or revision date on the form that is an attachment to the policy) 26. Doctor's Order for Restraint and Seclusion (Form 402.508.08; revised February 13, 2009) 27. List of Patients given PRN/STAT Medications between 3/1/2009 and 8/26/2009 28. List of Patients give 5 or more PRN/STAT Medications between 7/1/2009 and 7/31/2009 29. Department of Nursing, SEH, Resource – Staffing Assessment and Action Plan 30. Training curriculum for *Restraint and Seclusion for Behavioral Reasons (August 27, 2009)* 31. List of vacant nursing positions (not dated) 32. SEH Nursing Department NCHPPD August 1 – 16, 2009 (report) 33. "Feedback Loop for those who fail Training", not dated, not signed. 34. Nursing Staff Education (as of 9/15/2009), (summary report of percent of staff trained in seven topics) 35. SEH, Clinical Record, Nursing Update, Form 300.02.09; 6/30/09 36. SEH, Nursing Assessment Update Operational Instructions, not dated 37. Nursing Update Audit Tool, revised 6/30/09 38. "Instructions" accompanying Nursing Update Audit Tool, revised 6/30/09; (may be draft) 39. Nursing Assessment Update Audit Results, 8/24/09 40. SEH, Nursing Reference Manual, Nursing Competency Structure, new issuance; signed 8/24/09 41. SEH, Plan for Provision of Care, Nursing Department, Draft

			42. SEH, Nursing Reference Manual, Change of Shift Report, no number, revised 8/2009 43. SEH, Nursing Reference Manual, Nursing Intake and Output Procedure, no number, revised 8/2009 44. 24 Hour Intake and Output Form, no number, not dated 45. SEH, Nursing Reference Manual: Insulin Administration, no number; revised 8/2009 46. SEH, Nursing Reference Manual: Physical Observation, no number revised 8/2009 47. SEH, Draft Policy: Medical Response, Emergent/Urgent/Non Urgent 48. SEH, Hand Off Communication Guidelines, 207-09, new issuance, effective August 13, 2009 49. Medical Director memo: *Clarification of Use of Terms "STAT" and "PRN" at Saint Elizabeth's Hospital*, July 22, 2009 <u>Observed</u>: 1. IRP Conference: CD JHP 6; MM JHP 1 2. Meal Observations: RMB 4, 7 (Dining Room) 3. Change of shift report: RMB 2, 3, 8 4. Med pass: RMB 3, 5, 6, 7, 8
	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	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur.

		prohibited.	**Recommendation 1, April 2009:** *Using the nursing p/p template, develop the nursing p/p for seclusion, restraint, and involuntary medication.* **Findings:** The use of prone restraints, prone containment, and or prone transportation is prohibited in the SEH Restraint and Seclusion for Behavioral Reasons policy (101.1-04; revised August 11, 2009). The Nursing Restraint and Seclusion Policy (R/S nursing policy), (SEH, Nursing Reference Manual, no number; revised 5/2009; signed 8/25/09) states that patient's (sic) can only be restrained in the supine position. There was no evidence of prone restraint use in the records reviewed. **Recommendation 2, April 2009:** *See VIII.D.1 regarding training and competencies.* **Findings:** See VIII.D.1. **Recommendation 3, April 2009:** *Provide training to all nursing personnel on the new policy.* **Findings:** The training curriculum was updated in June, 2009 and all Nurse Managers participated in a train-the-trainer session on the topic. Training began in mid July. It was reported that the expectation was that all training would be completed by September 15. However, the Nursing Staff Education report reflected that only 31.8% of nursing staff has received Restraint and Seclusion training. **Recommendation 4, April 2009:**

			Implement the nursing p/p. **Findings:** There was evidence in the records that the policies and procedures had been implemented. **Recommendation 5, April 2009:** Continue monitoring. Involve clinical staff in analyzing findings, determining actions, and evaluating the effectiveness of actions taken. **Findings:** The inclusion of restraint and seclusion data in the PRISM reports is a step toward clinical staff involvement in the review of findings. However, it is not clear how their input will be systematically gathered, provided to the PIC, considered, and acted upon. The PIC is reportedly planning a meeting with clinical leadership. **Other findings:** SEH policy for Restraint and Seclusion for Behavioral Reasons (101.1-04) was revised on August 11, 2009. There are areas of concern related to the concept of drugs used as restraint. There are also areas of concern regarding alignment within and among policies, as well as between policies and forms. Lastly, technical assistance might be useful so that the remaining policy refinements can be accomplished quickly. Some of these refinements, especially for nursing policies/procedures, require establishing/refining sections within the policies so that they are appropriately identified and sequenced. Sections need to contain all content relevant to that section, including required steps in a process along with clearly articulated responsibility for

			different parts or levels of the process. The SEH definition for "Drugs Used as Restraint" is reported to be the definition required by District of Columbia law. The definition in the CMS regulations (effective January 2007) is the generally accepted definition that hospitals across the country use. When a hospital is responsible to follow more than one definition, the most restrictive aspects of the applicable definitions need to be followed to assure compliance with both. As it relates to determining if the use of a drug meets the definition of restraint, both the ***purpose*** of the prescribed medication, as well as the medication ***type and dosage,*** are key factors. The CMS definition specifies that a drug or medication is a restraint "…when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." Review of SEH's policies (Restraint and Seclusion for Behavioral Reasons and Involuntary Medication Administration) found vague and/or conflicting statements both within and between policies. There is no clear and consistent prohibition of the use of drugs to restrict a patient's movement during an emergency or control a patient's behavior when the drug (in type and dosage) is not part of a treatment of the patient's condition. The following are examples: On page 3, the SEH Restraint and Seclusion for Behavioral Reasons policy (SEH R/S policy) states: "…the use of drugs as a restraint is not authorized by this policy." On page 4, it states: "in those cases in which drugs are used as a restraint, refer to SEH Policy 201-05, Involuntary Medication Administration to

			determine whether procedures under that policy are required". This implies that the Involuntary Medication Administration policy addresses requirements for using drugs as restraint. However, in the SEH Involuntary Medication Administration policy, the definition of drug(s) used as a restraint ends with: "Note: The use of drugs as a restraint is not authorized by this policy." In fact, the reader is referred back to the SEH R/S policy (which does not authorize use) for a "detailed discussion of drugs used as restraint" (pg3). At the same time, the Involuntary Medication policy also includes a section on drugs used as a restraint. In this section there is a statement about who can order a drug used as a restraint, the circumstances under which this may be ordered, and again states that the practice is not authorized under this policy (pg 10). Notably, behavior "control" is again referenced in this policy in the definition of emergency medication. There is additional confusion and contradictory information in the Nursing R/S policy. This policy includes definitions of *voluntary emergency medication* and *involuntary emergency medication* that are not aligned with the hospital policy and that include content that meets the definition of a drug used as a restraint. This consultant has addressed the issue of drugs used as restraint in prior reports. Using drugs as restraint poses significant potential risk to patients. The conflicting information in SEH policies relative to this topic must be resolved. There are other internal inconsistencies in the SEH R/S policy e.g. "the only authorized mechanical restraints are four or five point…"(page 3) and "the only authorized mechanical restraints are four-point" (page 4). Finally, "**advanced instructions**" are

			defined as a "…component of an "***advanced directive"…***involving "…informed choice to accept or forego …services and supports." This latter aspect of the definition of advanced instructions is not operationalized in SEH's Advance Instructions/Personal Comfort Planning form(number 302.01.08, revised 2-11-09). Typically, the term advanced directive has legal implications. If the advanced directive legislation that is applicable to SEH allows/covers advanced instructions, it might be useful to augment the instructions on page 6 of the policy that address forms and reference a policy about advanced directives. Distinguishing advanced directive forms from advanced instruction forms would limit potential for confusion. The Nursing R/S policy definitions need to be aligned with the hospital policy and comport with regulatory body standards. The following illustrates some of the misalignments. The definition for "physical hold" says this is "…also referred to as therapeutic hold." This statement is inconsistent with standards and has potential to cause confusion. A physical restraint is just that, not a therapeutic hold. The definition of seclusion includes content that is inconsistent with the revised CMS standards. Additional examples of misalignments include: the nursing policy uses the term/describes "early interventions," while the hospital policy does not use this term but rather differentiates "low" and "moderate level" interventions; the nursing policy does not reference using the Advance Instruction/Personal Comfort Planning, while the hospital policy indicates that this is an important component of least restrictive alternatives that must be considered. Lastly, the nursing policy references "treatment plan" however, the hospital uses the term Individual Recovery Plan. Consistent language is critically important to guide implementation in a way that will assure

			reform. Not only are the policies misaligned, but the associated forms are not aligned with the policies. One example involves the *Levels of Observation Flow Sheet.* This flow sheet references "Release/trial out…" although there is no policy provision for "trial out." Exhibit 6 in the SEH R/S policy has a *Levels of Observation Flow Sheet* that includes "chemical restraint." The form is different from the one that is attached to the nursing policy. Since neither are numbered or dated, it is not clear which is the current authorized form. Both the SEH R/S policy and the Nursing R/S policy must fully comport with relevant standards and must align with one another. Once aligned, all forms used in association with R/S need to be re-reviewed to assure that they align with policies and that they support staff to complete the required documentation. Without this, staff cannot be expected to consistently understand, and do, what is expected of them. SEH reports that their audit revealed that staff utilized low or moderate level interventions in 75% of the occasions when restraint or seclusion was used. I reviewed the records of four patients who had been restrained or secluded. In only one of the four records, were low or moderate level interventions described (AP). However, when reviewing records that described agitation/aggression, as well as those of patients who used STAT medications, there was evidence of low or moderate level interventions that were apparently effective in preventing the use of restraint/seclusion. SEH reports concern that the use of the "quiet room" may, in fact, be de-facto seclusion use. I observed a patient resting in

			an open door room that is also used for seclusion. During this observation, the conversation between the patient and the physician validated that the patient was aware that he could voluntarily leave the room, however he chose to remain. In light of the SEH concern, it might be useful to address the "quiet room" concept in policy, and use that opportunity to also clarify the meaning of "time out." It might be helpful to think about the space available to use for voluntary quiet time, in the current environment as well as when the new hospital opens. **Compliance:** Partial. **Current recommendations:** 1. *Train all nursing staff. Consider returning baseline training responsibility to the Nursing Education Department, and resolve barriers to unit staff attendance at required training.* 2. *Methodically review all policies addressing restraint/seclusion as well as associated content in policies that address emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards.* 3. *Ensure consistency between and among policies associated with item 2 (above).* 4. *Ensure that the content on all forms is consistent with policies and supports staff to complete required documentation.* 5. *Consider technical assistance for policy refinements so that they can proceed quickly.* 6. Revise audit tools as required by the above actions. Continue monitoring. Involve clinical staff in analyzing findings, determining actions, and evaluating the effectiveness of

			actions taken. 7. *Clarify and monitor use of the "quiet room" considering policy guidance for this concept as well as the concept of "time out." Explore alternative space(s) for these approaches.* 8. In the SEH R/S policy, consider moving sensory-based interventions from the examples of "moderate level of intervention" to the examples in "low level of intervention." Early use of these interventions tends to enhance their effectiveness.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur. **Recommendation, April 2009:** *See VIII.D.1 and X.A.1.* **Findings:** The training curriculum for *Restraint and Seclusion for Behavioral Reasons* (August 27, 2009) has been substantially revised and includes excellent content to address this requirement. For example, specific sections address prevention, provide excellent examples of each of the two levels of intervention, the "Advanced Instruction/Personal Comfort Planning" form is well integrated, and the "tip sheets" provide excellent "real life" information for staff. Including scenarios in the training is an excellent approach to building skills and supporting learners' to apply new knowledge. **Other findings:** Exhibit 2 of the SEH R/S policy contains an excellent description of required competencies that align with those included in the revised CMS regulations. Training curriculum and

			documentation of staff competencies must include the described components. **Compliance:** Partial. **Current recommendations:** 1. *See VIII.D.1. and X.A.1.* 2. *Align training curriculum and documentation of staff competencies with Exhibit 2 of the SEH R/S policy.*
LDL	X.A.3	the use of side rails on beds, including a plan:	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, April 2009:** *Using the nursing p/p template, revise the nursing policy that addresses side rails and medical protective devices so that it is aligned with the hospital policy and the terminology is consistent. Assure that assessment factors that influence, and risks associated with, full versus partial side rails are detailed. Clarify accountability for, and intervals of, checking the safety of the equipment.* **Findings:** The Nursing Department Protective Measures policy (PSS 400.7, revised 8/2009) is an excellent start to providing the guidance and specificity required e.g. the identification of vulnerabilities and the description of "entrapment zones" is excellent. However, in parts it is not sufficiently specific to SEH (e.g. references multidisciplinary team; does not reference IRP; accountability for inspection/equipment safety is not specified; the section on "bed rail use as restraint" does not address the

			matter), it is redundant (e.g. General Information F), and mixes definitions of restraints versus protective measures. There is little to no direction for nursing documentation of side rail use. Alignment with the hospital policy cannot be determined because the hospital policy was not provided. **Recommendation 2, April 2009:** Eliminate any remaining side rails with winged/tapered ends. **Findings:** SEH reported that seven side rails in JHP need to be replaced. Because of the age of the beds in use, SEH is in the process of determining the appropriate replacement. **Other findings:** SEH reports that four individuals in RMB use some form of side rails each night and seven individuals in JHP use them intermittently. During the previous review it was reported that five patients used side rails, three of them intermittently. Depending on the degree to which the two reports can be compared, this may reflect an increase. However, it appears that there is no systematic review of side rail use. It is not included in the PRISM report. The document that accompanies the nursing policy, titled *Bed Rails Audit,* is not actually an audit tool, but rather reflects a review of side rail use for an individual patient. This review is more appropriately documented in the IRP, consistent with IRP requirements, as well as in physician and nurse progress notes. Record reviews revealed that although there is an MD order for side-rails, use is not referenced in the IRP as required.

			A form has been developed entitled *Nursing Risk Assessment Tool for the Use of Bedrails* (no number or date; Appendix 1 of nursing policy). While there are some excellent assessment parameters, the integration with the physician, interdisciplinary team, and IRP is not referenced and is essential. **Compliance:** Partial. **Current recommendations:** 1. *Assure that relevant safeguards are in place for the patients who still use side rails with tapered ends.* 2. *Integrate side rail use into the PRISM report.* 3. *Revise the nursing policy to address the type of issues in the examples (identified above), to clarify accountability, as well as to align with other SEH policies and relevant external standards.* 4. Resolve barriers to integrating side rail use into the IRP. 5. Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken.
LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Current findings on previous recommendation:** See X.A.3 and X.A.3.b. **Recommendation, April 2009:** Monitor for compliance. **Findings:** SEH reports substantial compliance in this area, however no monitoring data were reported.

			Other findings: The action steps listed in the SEH DOJ Compliance Office Report (September 1, 2009), address only the design/defects in side rails. There is no plan identified to ascertain the degree to which the use of side rails as restraints is systematically and gradually minimized. **Compliance:** Partial. **Current recommendation:** *See X.A.3.*
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation, April 2009:** Monitor to assure compliance. **Findings:** See X.A.3. **Other findings:** The hospital policy reportedly includes a requirement that the use of side rails must be addressed in the individual's IRP. Chart reviews revealed that the IRPs do not consistently and directly address the use of side rails or strategies to reduce reliance on them. Although a physician order specified the purpose and number of side rails to be used, nursing documentation did not consistently reflect the implementation. Directives in the Nursing Department Protective Measures policy

			relative to the use of side rails are not aligned with IRP requirements e.g. the nursing policy states that RNs must assess patients using bedrails every 6 months. **Compliance:** Partial. **Current recommendation:** *See X.3.A.*
LDL	X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	Please see sub-cells for findings and compliance.
LDL	X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, staff interviews and unit observations, I concur. **Recommendation 1, April 2009:** *Implement all new forms and processes as planned.* **Findings:** See X.A.1. and X.A.2. **Recommendation 2, April 2009:** *Continue IRP training and monitoring.* **Findings:** The pilot results of the SEH Clinical Chart Audit (August 2009) reported that in 100% of the cases IRP objectives and interventions were modified "as needed" following restraint or

			seclusion use. The audit also found that the clinical formulation was updated to address risk (92%) and foci were updated to reflect risk (96%). With the exception of assignments to mall groups, this was not evident in my review of the records (AP, AF, AS, LR). **Other findings:** SEH reported that a restraint and seclusion audit for the period of February to June, 2009, revealed that staff used the comfort plan in 27% of the episodes and used low or moderate level interventions in 75% of the episodes. This generally corresponds to the findings from my own chart review. There was evidence in the records that Advanced Instructions/Personal Comfort Plans were more consistently present and updated in patient records. This provides a valuable tool for individualized support and management for patients experiencing a crisis. There was some evidence in the records that these plans were implemented by nursing. There was also evidence that nursing staff implemented and/or considered less restrictive interventions. A significant barrier to consistent implementation of the comfort plan may be associated with the fact that none of the IRPs that were reviewed integrated the comfort plan. They also did not address interventions to prevent or manage a behavioral emergency, even when there was evidence that a patient experienced repeated behavioral emergencies. Unit observations revealed varying degrees of nursing staff engagement when patients exhibited potentially aggressive behavior e.g. targeted yelling at others, and/or aggressive or threatening physical postures. Although staff observed from a distance, little to no verbal intervention or direct physical presence was provided. Nursing documentation reflected a similar helpless approach to

			patients who exhibit aggressive behavior, with rote interventions such as "re-directed." The language used to describe patient behavior on these occasions reflects a continued lack of understanding of the etiology of such behavior. This is not surprising given the fact that training in mental health diagnoses has not been completed and that the treatment team provides little to no direction or assistance. The SEH IRP Chart Review and Process Observation Results, (February through July, 2009) revealed considerable variability in the RN presentation of assessments in the IRP (23 – 90%). The inadequate number of RNs, and their subsequent inability to prepare for and participate in IRP in a meaningful way, may also be a contributor to the lack of the treatment team attention to developing interventions for challenging behaviors. Staff injury data provide valuable perspectives relative to early interventions as well as restraint/seclusion use. Therefore, I requested and reviewed only the staff injuries that occurred in the process of providing patient care. Data, as well as summary reports for each injury, were provided for the 3/1/09-8/31/09 time frame. Staff injuries accounted for nearly one-fourth of all physical injury incidents. Over half of these involved "physical assaults". A review of the individual reports revealed that many were considered to be "unprovoked" or without early cues, despite evidence that there were antecedent behaviors. In addition, a number of injuries occurred following staff "direction." Both of these observations indicate that many nursing staff still do not understand the meaning of behavior and they need assistance with interventions. Further, the observations are consistent with documentation in the patient records, my own direct

			observations, and staff interviews. The lag in nursing training, the low number of RNs, and the absence of on the unit supervision/coaching/teaching hamper progress in these areas. The staff injury data are not included in the PRISM reports. It is not clear if/where/how the data are reviewed and used to improve the treatment environment. The information contained in these reports is vital to contribute to an understanding of what is needed to establish an environment where both patients and staff are safe. **Compliance:** Partial. **Current recommendations:** 1. *Include data on staff injuries in the PRISM reports. Monitor staff injuries, identify trends, take actions to resolve trends, and evaluate the effectiveness of actions taken.* 2. *Implement a system to concurrently review interventions used to prevent and/or manage behavioral emergencies when patients repeatedly experience those emergencies.* 3. *See VIII.D.11 Regarding RN staffing levels and use of NMs.* 4. *See VIII.D.1. Prioritize training on mental health diagnoses.* 5. *Resolve barriers to the development of meaningful and applicable IRPs.*
LDL	X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, and unit observations, I concur. **Recommendation 1, April 2009:** Develop instructions to accompany the seclusion and restraint

			audit. Measure inter-rater reliability on a monthly basis. **Findings:** SEH reported that instructions were developed and both the tool and instructions were refined several times over the review period. The audit results for the period of February, through June, 2009 showed that there were no instances in which staff used restraint/seclusion for convenience or as punishment. SEH found that in 8% of the episodes there was evidence that restraint/seclusion was used as an alternative to active treatment. SEH reported that treatment options have been improved and that there are now four TLCs serving 210 individuals. Individuals not served on a TLC have access to unit-based activities. Inter-rater reliability was not reported. **Recommendation 2, April 2009:** *Reconfigure RMB 3.* **Findings:** SEH reported that the decision was made to reconfigure RMB 3 from a behavior management unit to a "continuing care unit for persons who are not progressing as expected and need more in-depth assessment and interventions." Although the unit description, and perhaps the treatment approach, has changed, the patient population still includes an appreciable number of individuals with some of the most challenging behavior. In addition, it appears that RMB 6 may have been/continue to be impacted by the reconfiguration of RMB 3. The mix of patients on both units bears monitoring. **Other findings:**

			In June, both a Clinical Administrator and new Nurse Manager were hired for the RMB 3 unit. Unit observations and discussions with them and other staff revealed that they have brought additional structure, a sense of calm, and much needed clinical expertise to the unit. The RMB 3 Unit Schedule reflects an array of group offerings/activities and some RMB 3 patients attend the treatment mall for full or partial days. RMB 3 is piloting "EARNS," a nursing approach that was designed by the CNE in order to enhance staff engagement with patients. One unique aspect of this program involves strategies that affirm the staff as well as the patients. It is likely that this influences the considerable enthusiasm that staff had for the program. Staff described the positive effects of EARNS, indicating they were in the process of "fine tuning" the program. During several different unit observations, most of the nursing staff were observed to be engaged with patients. Unit based schedules were provided/reviewed for RMB 1, 2, 3, 4, and 6. From Monday – Friday, daytime hours, all units had an array of offerings. RMB 4 and 6 should be commended for the number of evening and weekend groups that are conducted by nursing staff. Other units should expand their evening and weekend offerings similarly. **Compliance:** Partial. **Current recommendations:** 1. *Continue implementation of the EARNS approach and accelerate the plan to extend the model to other units.* 2. *Finalize the S/R audit and refine instructions as needed.* 3. *Resolve inter-rater reliability issues and measure inter-rater*

			reliability on a monthly basis. 4. *Monitor the RMB 3 and RMB 6 patient mix and program development/mall integration.* 5. Expand evening and weekend programming.
LDL	X.B.3	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** SEH reports substantial compliance. Based on document review, record review, staff interviews and unit observations, I find partial compliance. **Recommendation, April 2009:** Monitor for compliance. **Findings:** SEH prohibits the use of restraint/seclusion as part of a behavioral intervention, and reported that there are no plans that include these measures. However, there are no questions on the restraint/seclusion audit that address this issue. It is not clear how SEH is monitoring to assure continued compliance. **Other findings:** No IRPs reflected the use of restraint/seclusion as a part of behavioral interventions. **Compliance:** Partial. **Current recommendation:** *Develop a mechanism to monitor for compliance.*
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** SEH reports partial compliance in this area. Based on document and record review, I concur.

			Recommendation 1, April 2009: Implement the new doctor's order form with additional options for individualized release criteria. **Findings:** The new doctor's order form was implemented. **Recommendation 2, April 2009:** Review and revise the nursing p/p for Physician Order Transcription to assure that the order that contains release criteria is transcribed exactly as written to the *Levels of Observation Flow Sheet* form. **Findings:** The nursing policy for Physician Order Transcription policy was not provided, although there is indication that this topic is integrated into some of the policies/procedures associated with each type of physician order e.g. medications. Although the SEH report indicates that the matter is addressed in the nursing policy for R/S, it is not sufficiently specified in that policy. Further, unless there is no longer a nursing Physician Order Transcription policy, steps to transcribe a physician's order for restraint/seclusion also needs to be in the policy that describes steps to take when transcribing all types of physician orders. **Other findings:** SEH reported that in 75% of the episodes, restraint or seclusion was terminated as soon as the individual was no longer an imminent danger. The audit also revealed that in 27% of the episodes there was documentation to reflect assessment for readiness for release every 15 minutes, and in 25% of the episodes there was documentation that the patient was informed

			of release criteria every 30 minutes. The findings from my record reviews were generally aligned. In the records reviewed, the *Levels of Observation Flow Sheet* did not contain any release criteria or contained release criteria that did not match the physician's order. However, physician orders also did not consistently specify release criteria. There was evidence that the prompt on the form that calls for documentation of "target symptoms" was sometimes confused with behavioral release criteria. (See X.C. 3. below). The concept of "gradual release" is discussed in the revised Restraint and Seclusion for Behavior Reasons curriculum. It is also referenced in the examples of behavior release criteria that were reportedly provided to staff (see X.C.3). This concept is not addressed in the SEH or Nursing Department's R/S policies. **Compliance:** Partial. **Current recommendations:** 1. *Remove "target symptoms" from the Doctor's Order Form.* 2. *Clarify the term "gradual release;" assure that the clarification is aligned with relevant regulations/standards and included in policies.* 3. *See X.C.3.*
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.
LDL	X.C.1	the specific behaviors requiring the procedure;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record

			review, I concur. **Recommendation 1, April 2009:** *Implement the new order form.* **Findings:** The new order form contains prompts to document the specific behaviors requiring restraint/seclusion. SEH reported that in 82% of the episodes, the specific behaviors were documented in the order. **Recommendation 2, April 2009:** Continue monitoring. **Findings:** See above. **Compliance:** Partial. **Current recommendations:** See X.B.4. and X.C.3.
LDL	X.C.2	the maximum duration of the order;	**Current findings on previous recommendation:** SEH reported partial compliance. Based on document and record review, I concur. **Recommendation, April 2009:** Monitor for compliance. **Findings:** The "Doctor's Order…" form contains a prompt to record the maximum duration of the order and it was present in the records

			reviewed. SEH reported that the R/S audit does not track this information so no data were provided. **Other findings:** Record review revealed that the maximum duration of the physician order was present. **Compliance:** Partial. **Current recommendations:** 1. Include this criterion in the R/S audit. 2. Monitor this requirement, analyze trends, act to resolve identified trends, and evaluate effectiveness of actions taken.
LDL	X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	**Current findings on previous recommendation:** See X.B.4 SEH reported partial compliance. Based on document and record review, I concur. **Recommendation, April 2009:** Revise the behavioral release criteria in the *Doctor's Order for Restraint and Seclusion* form (see above discussion [in previous report]). **Findings:** These were revised. SEH reported that in 50% of the audited episodes, there were individualized criteria for release. **Other findings:** Although the SEH policy describes release criteria, the low finding is likely to be influenced by the fact that physician orders did not consistently contain behavioral release criteria.

			Furthermore, there was evidence that the area of the form that calls for documentation of "target symptoms" caused confusion. For example, release criteria were left blank, and "target symptoms" were entered as follows: "mood and psychosis" (LR). Not only does the phrase "target symptoms" have potential to be confused with release criteria, but it also conveys that restraint or seclusion are used to *target* symptoms, and therefore are considered to be treatment interventions. This is not the case. Most of the examples of release criteria that were reportedly distributed to assist staff to write behavioral release criteria were not behaviorally written. In addition, a number were "compliance" oriented, rather than related to the emergent behavior that required restraint or seclusion. The examples also reference "progressive removal of restraints" and this is not addressed in the hospital policy. If SEH determines that clinicians need additional support/examples to write behavioral release criteria, consideration might be given to involving the Psychology Department for assistance in providing examples of behaviorally written release criteria. **Compliance:** Partial. **Current recommendations:** 1. *Consider involving the Psychology Department for assistance in writing behavioral release criteria.* 2. *Remove "target symptoms" from the Doctor's Order form.*
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Current findings on previous recommendation:** SEH reported partial compliance. Based on document and record review, I concur.

			Recommendation, April 2009: Continue monitoring for sustained compliance. **Findings:** SEH reported that in 50% of the episodes the individual's treating physician was promptly consulted. However, they also note that the audit tool does not accurately capture occasions when the ordering physician and the treating physician are one in the same. They note that this will be revised. **Other findings:** In all of the records reviewed, the physician was contacted as required by SEH policy. Although there are no definitions to distinguish these, the SEH policy currently authorizes the attending *or* treating physician to provide the order to restrain/seclude. **Compliance:** Partial. **Current recommendation:** Clarify policy expectations relative to who orders seclusion/restraint, and if "order" and "consult" are one in the same, and align audit accordingly.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, April 2009:** *See X.A.1.* **Findings:**

			See X.A.1. **Recommendation 2, April 2009:** Revise the *Levels of Observation Flow Sheet* form to make explicit the requirement to notify the patient of release criteria every 30 minutes. **Findings:** SEH reports that the audit revealed that in 25% of the episodes there was evidence that the patient was notified of the behavioral criteria for release every 30 minutes. The *Levels of Observation Flow Sheet* form was not revised as recommended in April 2009. More importantly, it also appears that SEH has not implemented an alternative strategy to assure the required documentation. SEH reports that the 15 minute "assessment for readiness for release" (code L on the form) is the point when staff are expected to inform the individual of the release criteria. However, there is no code for staff to document this. Only the assessment is coded, not the discussion of release criteria. It is not clear why the form has not been changed to support staff to actually document that they have informed the patient. **Other findings:** There is confusion in the SEH policies that impacts staff ability to meet this requirement. The SEH R/S policy says that every 15 minutes the RN must assess for release readiness and inform the patient of release criteria. However, it also says that the RN informs the patient of release criteria every 30minutes (p.10). The Nursing Department policy indicates that this is done every 30 minutes (pg. 5), however this is not included in the section of the policy that discusses assessment and interventions

			during seclusion or restraint. The codes on the *Levels of Observation Flow Sheet* are extremely confusing. For example, there is a code for assessment of readiness for release, but no code for staff to document a discussion of release criteria. The only other code related to release is in the area of 30 minute checks. However, this code also does not address discussion of release criteria; it is code that only addresses the patient meeting the criteria. Discussion of criteria (staff intervention) and meeting criteria (patient behavior) may not occur at the same time. Furthermore, although the RN is required by policy to assess more frequently than once an hour, the only code to reflect RN assessment appears in the hourly check section. Lastly, the codes for patient behavior do not provide any options to document behavior that might begin to reflect release readiness such as relaxed body posture, interacting with staff, resting quietly. Only problems/negative behaviors are listed. The codes for staff interventions do not reflect the range of interventions required by patients in restraint/seclusion e.g. encouragement, support, reassurance, implementation of IRP interventions. The combination of policies that are not clear and well organized, forms that don't align with the policies and support staff to meet requirements, and perceptions that staff simply don't do what they are "supposed" to do, creates a culture that may not provide the best support continued improvements. **Compliance:** Partial. **Current recommendations:** *1. See X.A.1.*

			2. *Revise the Levels of Observation Flow Sheet form to support staff to document requirements and to align with the SEH goal of providing a recovery-oriented, trauma-informed treatment setting.*
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Current findings on previous recommendation:** SEH reports continued noncompliance. Based on document and record review, I concur. **Recommendation, April 2009:** Explore and resolve barriers to compliance. **Findings:** SEH reports that there was documented evidence of treatment team debriefing within 24 hours in 17% of the episodes, and the episode was addressed at the next IRP meeting in 9% of the episodes. SEH reports that a number of steps to improve compliance have been taken. However, the steps involve prompts and tips that seemingly do not occur proximate to the time the debriefing must take place. Furthermore, it is not clear if these steps were determined by/endorsed by clinicians and took into account their identified barriers and ideas about what would support success. **Other findings:** In the records reviewed, there was no evidence of debriefing and no evidence that the IRP addressed the episode, etiology of behavior, or provided direction for future preventative interventions. The Advanced Instructions/Personal Comfort Planning form was not consistently updated, although there was one present in the record. **Compliance:**

			Noncompliance. **Current recommendation:** *Explore and resolve barriers to compliance.*
LDL	X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation, April 2009:** Explore and resolve barriers to documenting the assessment. **Findings:** Physician assessment was sometimes present in the records reviewed. A physician's order was consistently present. **Other findings:** SEH reported that there were no occurrences when a patient was restrained or secluded without a doctor's order. They further reported that in 70% of the episodes, there was a face-to-face assessment within one hour of the episode. My record reviews revealed similar findings. **Compliance:** Partial. **Current recommendations:** 1. *Explore and resolve barriers to documenting the assessment. Consider asking physicians if it would be helpful to include an assessment component on one of the existing forms.* 2. Continue monitoring.
LDL	X.C.8	ensure that any individual placed in seclusion or	**Current findings on previous recommendation:**

		restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	SEH reports partial compliance. Based on document review, I concur. **Recommendation, April 2009:** See VIII.D.1. **Findings:** See VIII.D.1. **Other findings:** Although the training curriculum was substantially revised and now states what the staff member is expected to achieve as a result of training, the actual competency results were not provided. **Compliance:** Partial. **Current recommendation:** *See VIII.D.1.*
LDL	X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, unit observations, and staff interviews, I concur. **Recommendation 1, April 2009:** *Develop instructions to accompany the seclusion and restraint audit. Measure inter-rater reliability on a monthly basis*. **Findings:** See X.B.2. **Recommendation 2, April 2009:**

			Display data using run charts (see above discussion) where appropriate. **Findings:** In light of the low use of restraint/seclusion, SEH has determined that the use of run charts is not appropriate. I concur. **Recommendation 3, April 2009:** *Involve clinical staff in analysis, identification of trends, formulating actions, and evaluating the effectiveness of actions taken. All of this should be clearly documented and tracked.* **Findings:** SEH notes that the PIC is planning to conduct a meeting with the clinical leadership group in September to review the data. **Other findings:** Based on strategies used to reconcile data, SEH reports that they believe that the reported number of seclusion and restraint incidents is accurate, although they have some concern that the use of the "quiet room" may, at times, represent de-facto use of seclusion. SEH is continuing to develop a method to track the use of emergency involuntary psychotropic medication. Currently, STAT medication orders are used to identify the type of medication, and method of administration. This is being used as a proxy measure for emergency involuntary psychotropic medications. It is not clear what is done with this screening. Although this is a reasonable temporary approach, the barriers to tracking this requirement, and auditing adherence to policy,

			need to be resolved so that measurement can begin. **Compliance:** Partial. **Current recommendations:** 1. *Resolve barriers to tracking emergency involuntary medication.* 2. Develop an audit tool to monitor adherence to policy, analyze findings, act to resolve trends, evaluate the effectiveness of actions.
LDL	X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on documentation and record review, I concur. **Recommendation 1, April 2009:** Explore and resolve barriers to compliance. **Findings:** There is no evidence in the SEH report to indicate that treatment teams have been asked what would support their ability to meet this requirement. **Recommendation 2, April 2009:** Establish levels of assistance that teams can access when faced with a patient whose behaviors are challenging and frequently require seclusion or restraint use. **Findings:** Other than Medical Director review, there is no structured approach to enable teams to access peer or outside consultative assistance.

			Recommendation 3, April 2009: Conduct clinical case reviews on patients who have been high users of seclusion or restraint. **Findings:** SEH reports implementation of comfort plans as an action step for this recommendation. Comfort plans do not take the place of case reviews nor do they constitute assistance for treatment teams. **Other findings:** The SEH report indicates that the hospital policy requires that IRPs be reviewed only when the patient meets established triggers e.g. three or more times in a four week period. The audit tool does not specifically review this requirement. Rather, the questions are aligned with the hospital policy (pg 14) that specifies thresholds and time. Although SEH reports that the incidents of seclusion or restraint must be discussed at the IRP, and reflected in both the psychiatric and clinical formulation updates, this does not meet the specific requirement that the IRP be specifically reviewed and modified within the context of the use of emergency measures. It is not clear if the treatment teams do not conduct the review because they don't remember, or because they really don't know how to address repeated and challenging behaviors. If it is the latter, access to peer or outside consultation, might be helpful to them. Consultants from outside the treatment team can bring valuable perspectives and offer evidence- based or promising practices that could be incorporated into the IRP.

			Compliance: Partial. **Current recommendation:** *Determine and resolve barriers to timely and relevant IRPs.*
	X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	Please see sub-cells for findings and compliance.
LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation 1, April 2009:** *Review and evaluate the differences between PRN/STAT reports and audits.* **Findings:** In response to this recommendation, the Medical Director issued a memo clarifying the difference between use of PRN and STAT medications. A second action step involved Medical Director review of identified patients who were "frequent users" of PRN or STAT medications. **Recommendation 2, April 2009:** *Determine a method to establish a database that will allow monitoring of emergency involuntary psychotropic medication administration.* **Findings:**

			SEH reports that they are assessing Avatar's capability to track emergency involuntary psychotropic medication administration. **Recommendation 3, April 2009:** Involve the P&T Committee in reviewing findings. **Findings:** Volume counts are reported in the *Medication Monitoring and Chart Review Results (2-26-09)* and the *Pharmacy and Medication Monthly Reports (6-16-09 and 7-7-09).* There is no analysis documented in the P&T Committee minutes. **Other findings:** SEH provided a *List of Patients who received PRN/Stat Medications between 3-1-2009 and 8-26-2009.* A cursory review of this 251 page list revealed a mix of medications e.g. MOM, and psychotropics. The same was true of the *List of Patients given 5 or more PRN/STAT Medications between 7/1/2009 and 7/31/2009.* A review of that list reflected that in all instances PRN medications were only prescribed for non-psychiatric reasons. "STAT/other" medications were a mix of oral and injectable psychotropic medications. Although the behaviors/purpose was not consistently reflected, some orders stated "emergency" while others stated "now". However, it was difficult to ascertain if these different terms represented a differentiation of patient behavior or the practitioner's order writing style. The Involuntary Medication Administration policy is comprehensive, organized, and sequenced in an understandable manner. There was evidence in the records that this policy was being appropriately implemented.

			Compliance: Partial. **Current recommendations:** 1. *Develop reports that monitor the use of emergency involuntary psychotropic medication administration.* 2. *Develop an audit tool to monitor adherence to policy requirements.* 3. Determine which position/body will review and analyze findings, take actions to address trends, evaluate the effectiveness of actions taken, and document the process.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, I concur. **Recommendation, April 2009:** See X.F.1. **Findings:** The Medication Ordering and Administration and the Involuntary Medication Administration policies require that the physician assess the individual within one hour of the administration of emergency involuntary psychotropic medication. SEH reports no data and no audit tool has been developed to address this requirement. However, when medication was administered on an emergency basis and the patient was also restrained or secluded, the chart audit reflected that within one hour the physician assessed the patient in 70% of the episodes. **Other findings:** Chart reviews revealed that physician assessment occurred within an hour, although it was sometimes documented by

			nursing. **Compliance:** Partial. **Current recommendation:** *1. 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.	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, I find noncompliance. **Recommendation, April 2009:** See X.F.1. **Findings:** See X.F.1. and X.E. **Other findings:** In the ten charts reviewed, only one had an IRP update (CB). That update designated a nursing "point person," but gave no direction regarding what the point person should do. **Compliance:** Noncompliance. **Current recommendations:** *1. See X.F.1. and X.E.* *2. Determine and resolve barriers to timely and relevant IRPs.*
LDL	X.G	By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document and record review, staff interviews, and unit observations, I concur.

		assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Recommendation, April 2009:** See VIII.D.1 and X.C.8. **Findings:** See VIII.D.1 and X.C.8 **Other findings:** See VIII.D.1 and X.C.8. **Compliance:** Partial. **Current recommendations:** See VIII.D.1 and X.C.8.

	XI. Protection from Harm		
BJC		By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.	**Summary of Progress:** 1. The hospital is preparing to move into a new facility in the spring. The long-awaited move will enhance the environment and, in a hope shared by many, positively affect the behavior of individuals and staff alike, making the hospital more humane and safe. 2. Hospital policy and staff training clearly present the responsibility of staff to report suspected abuse, neglect and exploitation. Both further identify the range of consequences for failure to follow this policy. 3. The Risk Manager, who presently investigates the vast majority A/N/E incidents (sometimes with the assistance of the Safety Officer), is equipped by training, talent, and temperament for this work. All investigations are reviewed by the Director of the Performance Improvement Department. 4. The adoption of a face sheet and the documentation of the date and time of investigation interviews have sharpened the investigation reports. 5. The hospital's review of the criminal history and abuse registry check of all employees comports with the requirements of the District of Columbia. 6. In none of the investigations reviewed did the staff fail to provide for the physical needs of an individual who was hurt. In many of the investigations of allegations of A/N/E, the removal of the staff member until the conclusion of the investigation was documented. Similarly, in allegations of sexual assault, the victim and perpetrator were separated.

	XII. Incident Management		
BJC		By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	**Summary of Progress:** 1. The Performance Improvement Department has implemented a Serious Event Review Committee (SERC) which conducts a multi-axial review of serious incidents and forwards recommendations to prevent similar occurrences to the Executive Director. If accepted by the Executive Director and the Executive Committee, should he choose to bring them to the committee, implementation of the recommendations is monitored by the Performance Improvement Committee. The complete process has been applied to one incident (July sexual assault) through to the monitoring of the implementation of recommendations. Several other incidents have been reviewed by the SERC and recommendations made. Each of the five SERCs reviewed was completed in a timely manner-- within two weeks of the incident. 2. The hospital recently hired an employee to work in QA to assist the Risk Manager in the investigation of incidents. Both the PID Director and the Risk Manager have accepted nursing leadership positions and are presently dividing their time between the two jobs. The hospital is recruiting to fill their items. 3. The hospital has developed a document, Description of Monitoring System, describing the function of various oversight committees. This clarifies expectations and should reduce redundancy. 4. PRISM report (Performance Related Information for Staff and Managers) provides historical aggregate on a variety of issues, including incidents, the results of internal audits of the use of restraint and seclusion, discharges and IRPs. The hospital has begun providing unit-specific data to the units. 5. This review period has seen an improvement in accuracy of

			UI reports 6. The requirement to apply the preponderance of the evidence standard in making determinations at the conclusion of investigations is written into the revised incident investigation policy.
BJC			**Methodology:** <u>Interviewed</u>: 1. Michael Hartley, Director of Performance Improvement Department and Nurse Executive 2. Martha Ponte, Risk Manager and Assistant Director of Nursing 3. Christine Arena, Quality Assurance Coordinator 4. Anthony Kahaly, Director, Office of Consumer Affairs 5. James Gallo, Director of HR at SEH 6. Paula Little, Employee/Labor Relations 7. Sheletta Snyder, Director of Training & Professional Development 8. Jana Taylor, Director, Policy and Procedures <u>Reviewed</u>: 1. 15 incident investigations 2. 21 Unusual Incident reports 3. Policy 302.1-03: Unusual Incident Reporting and Documentation (revised 7/21/09). 4. Policy 312-07: Quality Assessment Performance Improvement (revised 8/11/09). 5. Policy 301-01: Reporting Suspected Patient Abuse, Neglect and Exploitation 6. Policy 302.4-09: Unusual Incident Investigation (effective 8/13/09) 7. July Unusual Incident Report

			8. Aggregate incident data 9. Training records related to A/N/E for 18 staff members 10. Risk Management and Safety Committee minutes 11. Clinical records of 10 individuals related to incident follow-up. 12. Five Serious Event Review Committee Summary Reports
BJC		By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Make the changes cited above to policies 301-01 and 302.1-03. **Findings:** Policy 301-01: Reporting Suspected Patient Abuse, Neglect and Exploitation was revised in July 2009. Further revisions are necessary including the removal of incompatible definitions of sexual assault which in one definition is perpetrated by staff and in the second is perpetrated by another individual. When this was pointed out to the Policy and Procedures Director, she began to make the correction. Additional work on the policy is needed to remove the reference in the definition of Unprofessional Relationship to "sexual activity/intimacy by an employee or contract worker with a patient." Such actions constitute sexual abuse as defined earlier in the policy and should be recognized and dealt with as such. **Recommendation 2, April 2009:** Ensure consistency between relevant policies and PID procedures. **Findings:** This was not an issue during this review, as some policies have been revised.

			Compliance: Partial. **Current recommendations:** 1. Revise policy 301-01 to remove the incompatible definitions of sexual assault. 2. Amend the definition of Unprofessional Relationship to ensure it is not so broad as to include activity that would constitute sexual abuse.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Continue monitoring each use of restraint and seclusion and take measures to ensure that each is recorded on an UI reporting form. **Findings:** The hospital acknowledged that its own audits have found that not all restraint and seclusion events are reported on an UI reporting form, as required by policy. **Recommendation 2, April 2009:** Determine and correct the cause of the discrepancy in the R&S data between the Trend Analysis and the Risk Management Incident tracking form. **Findings:** The hospital did not determine the reason for the discrepancy, but instituted audits and feedback to units to improve consistent reporting.

			Recommendation 3, April 2009: Review and make corrections to UI reports. **Findings:** Problems in the proper identification of the type of incident were evident in several of the investigation reports reviewed. For example, the 4/29/09 in which SA alleged she was the victim of sexual assault by another individual in care was erroneously identified as an allegation of sexual abuse. Similarly, the 3/16/09 allegation of sexual assault upon KA by another individual in care was identified as an allegation of sexual abuse. **Recommendation 4, April 2009:** Correct errors in the incident database. **Findings:** This is an ongoing priority of the PID. See also the finding below. **Recommendation 5, April 2009:** Provide training or take any other measures the hospital believes will improve the accuracy of the UI reports. **Findings:** *Recognizing and Reporting Suspected Patient Abuse* training is provided in orientation and annual training. This training module includes illustrations of how to complete a UI reporting form. Review of 21 Unusual Incident Reports found no errors in 17. Errors in the remaining four are described in XII.E.1.b. **Compliance:** Partial.

			Current recommendations: 1. Continue current practice of reviewing UI reports for accuracy. 2. Make the necessary revisions in policy recommended in XII.A and emphasize in training the difference between sexual abuse and sexual assault.
BJC	XII.A.2	immediate reporting by staff to supervisory personnel and 'he's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Develop written guidelines on disciplinary actions for failure to report allegations of staff misconduct in the manner prescribed in policy.* **Findings:** The HR leadership at the hospital report that any of several categories in the Table of Penalties (Exhibit 2 attached to Policy 301-01) could be applied for failure to report allegations of staff abuse. No category specifically addresses failure to report. The penalties range from reprimand to removal. Further, the HR leadership reported that HR has never been asked to bring disciplinary action for failure to report. **Recommendation 2, April 2009:** Ensure that the portion of the UIR reserved for the Risk Manager is completed. **Findings:** This was not an issue during this review. **Other findings:** Policy 301-01 clearly states that the consequence for failure to report suspected A/N/E shall be grounds for corrective or

			adverse action up to and including dismissal. None of the investigations reviewed involved a failure to report an allegation of A/N/E. **Compliance:** Partial—based on lack of specific relevant information. **Current recommendation:** Ensure that the failure to report as prescribed in hospital policy is identified in investigation reports and appropriate action ensues.
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;	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Document decisions and rationales for removing and returning staff members who allegedly engaged in misconduct while the investigation is in process*. **Findings:** Policy 301-01 states that upon receiving notice that an allegation of abuse, neglect or exploitation has been made against an employee, the "supervisor shall immediately remove the employee from any patient care areas or assign them to other duties pending the outcome of an investigation…." **Other findings:** In the 3/16 and 4/29 allegations of sexual assault (cited in XII.A.1), the individual named as the aggressor was moved to another unit away from the victim and placed on 1:1 supervision. Findings related to removing staff members named in A/N/E allegations show variable compliance with the hospital policy.

			• In three investigations reviewed, the investigation report specifically states that the named staff person was removed from contact with any individuals in care or from contact with the alleged victim: 4/27/09 incident involving FH, 4/17/09 incident involving CT and the 6/19/09 incident involving EI and FH. • In contrast, the named staff member in the 6/3/09 allegation of neglect was not removed. • In the investigation of the incident involving MK (3/6/09) the named staff member was not removed from MK until 3/17/09 and removed from contact with all individuals on 3/24/09. **Compliance:** Partial. **Current recommendation:** Implement the policy provision related to removing staff when named in an A/N/E allegation even-handedly or amend the policy to permit specified exceptions.
BJC	XII.A.4	adequate training for all staff on recognizing and reporting incidents;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice. **Findings:** The Training Director reported that all staff received A/N/E training beginning in February 09. The hospital has set the expectation that staff will receive annual training in Consumer Rights and A/N/E. In the future, annual refresher training will be conducted separately from orientation training. This will

			encourage a more fruitful discussion of actual examples taken from Unusual Incident Reports. Review of the training records for 18 staff members found that no A/N training record was available for three—one of whom was a contractor. The remaining 15 staff members were trained in February and March 09. **Compliance:** Substantial. **Current recommendation:** Implement current plan to enrich annual A/N/E training for experienced staff members.
BJC	XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents sheSEH and District officials;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Write specific guidelines for disciplining staff members who fail to report allegations of staff misconduct as required in policy. **Findings:** See the findings in XII.A.2. **Other findings:** Nearly all staff have been trained in the recognition and reporting of A/N/E (hospital wide training occurred in February and March 09), and hospital policy clearly states the obligation of staff to report incidents and the possible consequences for failure to report. **Compliance:** Substantial.

			Current recommendation: Continue current practice.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice. **Findings:** All units reviewed had the name and telephone number of the Risk Manager posted in a common area. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, April 2009:** Clarify policy 302.1-03 to direct that in "all cases involving potential criminal action," Security shall notify MPD. **Findings:** The July revision of the *Unusual Incident Reporting and Documentation* policy clarifies the responsibility to ensure that all cases involving potential criminal action are reported to MPD. The hospital reports that training on the revised policy was provided to security staff. **Other findings:**

			In none of the investigations reviewed was this policy violated. In several investigations reviewed (allegations of sexual assault), the police were called and they interviewed the parties involved. **Compliance:** Substantial—based on limited information. **Current recommendation:** 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 acts by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Include the right of staff members and individuals in care to be free of retaliation for reporting A/N/E and how to report threats or retaliatory actions in all training provided on the subject.* **Findings:** The July 09 revision to the A/N/E Reporting policy explicitly states that any employee or patient who reports suspected A/N/E shall be free of retaliatory action by SEH, DMH, or the Government of the District of Columbia. **Recommendation 2, April 2009:** Address in investigations the reason for delays in reporting, as the delay may be related to fear of retaliation. **Findings:** In all of the relevant investigations reviewed, the investigator documented a rationale provided by the individual in care for a delay in reporting an allegation of A/N/E.

			Compliance: Substantial--based on limited information. **Current recommendation:** Continue current practice.
BJC	XII.B	By 24 months from the Effective Date thereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Current findings on previous recommendation2:** **Recommendation 1, April 2009:** *Include the use of the preponderance of the evidence standard in the policies and procedures being written for the Performance Improvement Department.* **Findings:** The *Unusual Incident Investigation* policy (302.4-09) effective 8/13/09 states "the preponderance of the evidence standard shall be used to evaluate all investigations conducted by Risk Management pursuant to this policy." **Recommendation 2, April 2009:** *Reference the standard in making determinations (substantiated or not substantiated).* **Findings:** The investigations reviewed did not reference the preponderance standard in making determinations. **Other findings:** As referenced in other portions of she report, SEH has developed and continues to revise policies and procedures to support the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Additionally, the hospital has recently hired a staff

			member to assist the Risk Manager in completing investigations. **Compliance:** Partial—in view of the need to make further revisions in the relevant policies. **Current recommendation:** Make the recommended revisions in the incident reporting policy.
BJC	XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Adopt a standard face sheet for A/N/E investigations that states the type of incident, date of the incident, date received in Risk Management, synopsis of the allegation, names of the alleged victim, named staff member and witnesses, and the determination.* **Findings:** This recommendation has been implemented, at least in part. The investigations reviewed would be improved with the discrete listing of the persons interviewed and the documents reviewed. **Recommendation 2, April 2009:** *Follow standard investigation procedures, including the dating of all interviews and a summary of the contents. Do not accept only written statements from persons critical to an investigation unless there is no alternative.* **Findings:** In all of the investigations reviewed, interviews include the date and time conducted. See also XII.B.3 for investigations that could have been improved, some by conducting additional

			interviews. **Recommendation 3, April 2009:** Make determinations based on preponderance of the evidence. **Findings:** The revision of the policy covering the investigation of incidents specifically references the requirement to apply the preponderance of the evidence standard in making determinations. **Recommendation 4, April 2009:** Take measures to ensure that reports of incidents reach the Risk Manager in the time frames required by policy through training and feed-back to units which submitting late reports. **Findings:** Each of the investigations reviewed clearly identified the date the report was received by the Performance Improvement Dept. and the date it was assigned to the Risk Manager for investigation. **Other findings:** All of the investigations reviewed were completed by the Risk Manager and/or the Safety Officer. These two staff members are independent and impartial and through training and experience are suited for this assignment. In the investigations reviewed, retraining of staff members was commonly a recommendation when the staff member had been found to have not met programmatic requirements. **Compliance:**

			Partial. **Current recommendation:** See findings and recommendations in XII.B.3.
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;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Continue to implement current procedures wherein the Risk Manager investigates or supervises the investigation of incidents specified in the Settlement Agreement. **Findings:** The Risk Manager and/or Safety Officer (both of whom are qualified by training and experience to conduct investigations on behalf of persons in mental health settings) conducted the investigations reviewed. **Recommendation 2, April 2009:** Continue the procedure of having the PID Director review and approve <u>all</u> investigation reports. **Findings:** All investigation reports reviewed were forwarded to the PID Director or to the Chief of Staff. **Other findings:** The PID Director and Risk Manager are each serving in two capacities with the Director also serving as the Nurse Executive and the Risk Manager taking on the responsibilities of the Assistant Director of Nursing. The hospital is recruiting to fill the vacancies in PID as the leaders in the department transfer to their nursing leadership duties full time.

			Compliance: Substantial—at the present time. **Current recommendations:** Ensure that all staff members who may be required to conduct investigations in the future are suited to the task by skill and temperament.
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	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Implement plan to have all investigations reviewed and signed by the PID Director. Any investigations that do not meet practice standards should be returned for additional work.* **Findings:** Areas for improvement were identified in several of the investigations reviewed. Examples include: • In the investigation report of the allegation of abuse reportedly witnessed by a psychiatrist, the investigator did not assertively attempt to reconcile the interview statement of the psychiatrist with his description of the incident in his written statement. In the latter, he described the named staff member as using foul language, threatening to kill the individual, and brandishing a mop as though it were a baseball bat. In his interview, he did not mention the threat to kill the individual or brandishing the mop as a weapon. He characterized the named staff member as going "ballistic," but said he did not see the event that occasioned the outburst. • There is no explanation for the determination that staff

			members were not negligent in preventing the sexual assault of KA (3/16/09) by PM, although this incident allegedly occurred in the hallway. [The MPD determined this was not a sexual assault because there was no penetration.] • The investigation report of the alleged rape of AW (7/8/09) fails to document the investigator's interview of the four individuals named as perpetrators or otherwise involved. The investigator said she did speak with them but did not document this. • During the investigation of the allegation of neglect of FH (reported 6/19/09) wherein the named staff member was alleged to have been sleeping while assigned 1:1 observation of FH, the investigator did not interview any other staff or individuals present on the unit at the time. The determination of not substantiated was based on the denial by the named staff member and FH's statement that night staff take good care of him. FH is blind. • The investigation of the fire on RMB-6 on 7/28/09 identified the check sheets for 6:00 and 7:00PM as questionable. The 6:00 check shows an X for all individuals. X is not a designated legend symbol. At 7:00PM all individuals were identified as receiving medication, although they had been evacuated and then moved to another unit. The investigation did not pursue this issue. • Similarly, in the investigation of the 7/8/09 sexual assault of AW, the question of the reliability of the checks was raised, but not pursued. • Particularly in investigations when many persons are interviewed and provide written statements (such as in the 7/8/09 sexual assault), the investigator needs to identify specific findings to support the recommendations. In the sexual assault investigation, several recommendations relate to training and/or disciplinary action for staff members, but

			the specific misconduct is not clearly documented. A compilation of interview summaries is not sufficient. Each recommendation must rest on a specific finding. **Recommendation 2, April 2009:** *Implement plans to hire another investigator so that investigations are completed in a timely manner and other Risk Management monitoring can proceed.* **Findings:** The hospital has recently hired a staff member to assist the Risk Manager in conducting investigations. The hospital is also recruiting for a new Risk Manager as the staff member in that position was made the Assistant Director of Nursing at the end of May 09. **Other findings:** As previously noted, the PID Director has assumed the position of Nurse Executive while continuing to function as the PID Director. The hospital is recruiting to fill the PID Director position. **Compliance:** Partial. **Current recommendations:** 1. *Identify specific findings to support recommendations made in investigation reports.* 2. *Ensure that all parties who may have direct knowledge of an incident are questioned.*
BJC	XII.B.4	include a reliable system to identify the need for, and monitor the implementation of,	**Current findings on previous recommendation:**

appropriate corrective and preventative actions addressing problems identified as s result of investigations.

Recommendation, April 2009:
Implement the PID procedures for the Investigation and Review of Incidents as planned. Document the monitoring of implementation of the approved recommendations.

Findings:
The review of the implementation of recommendations is an area of incident management that continues to require improvement. There is no system presently operating at the hospital that consistently tracks recommendations through to implementation and assesses their efficacy. For example, the tracking log for recommendations from the review of deaths in 2008 and 2009 identifies numerous recommendations, but does not identify the party responsible for ensuring implementation and does not set a target date for reporting back to the Mortality Review Committee.

A limited review of the implementation of some recommendations made at the close of incident investigations reveals successful implementation of some, but not others as reported below. The Performance Improvement Department acknowledges that this is an area that continues to need attention.

Incident date	Recommendation	Implemented Y/N
7/28/09	Develop Charge Nurse competencies	Yes
3/16/09 4/29/09 7/8/09	Assign a "roaming monitor" at times when staff are particularly busy	No
3/16/09	Perform a formal risk assessment for physical and sexual violence for PM	Not completed until 9/09—after second incident on

		7/8/09.
3/16/09 7/8/09	Draft a document identifying specific actions to be followed when an allegation of sexual assault is filed ASAP.	No
7/8/09	Increase frequency of security checks on RMB-6 from q 60 mins.	Yes
	Implement a razor control log	Not effectively- one razor appeared to be missing, suggesting it had not been returned. Staff not aware. Upon further investigation, razor had been returned to the wrong placeholder in the secure cabinet.

While, as demonstrated above, several of the recommendations reviewed were implemented, there is no reliable system for compiling recommendations and monitoring their implementation.

Review of a limited sample of disciplinary taken in response to incidents revealed the hospital has or will be taking action.

Incident date	Finding	Action
7/8/09	Record falsification	Termination in

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<tr><td></td><td></td><td>probation</td></tr>
<tr><td>3/4/09</td><td>Excessive force</td><td>Discipline being determined</td></tr>
<tr><td>6/3/09</td><td>Confirmed neglect</td><td>Verbal counseling</td></tr>
<tr><td>4/30/09</td><td>Unauthorized seclusion</td><td>Verbal counseling and retraining</td></tr>
<tr><td>7/28/09</td><td>Misconduct</td><td>Discipline being determined</td></tr>
</table>

Compliance:
Noncompliance.

Current recommendations:
1. Promulgate the expectation that parties responsible for the implementation of recommendations from incident investigations will report on the status of implementation to PID. Designate responsibility within PID for maintaining a log/database tracking the recommendations and responses back.
2. PID should undertake an independent review of at least a sample of recommendations reported as successfully implemented.
3. Consider the advisability of using electric razors rather than disposable or straight razors. If this is not possible introduce a razor log that is initialed by the staff member keeping track of the razors.
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<td>BJC</td>
<td>XII.C</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendation 1, April 2009:
Ensure that the Sentinel Event Committee includes a senior psychiatrist when the case under review raises issues in his/her domain.</td>
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			Findings: The summary of the Serious Event Review Committee deliberations on the attempted suicide of TJ does not include a psychiatrist in attendance. **Recommendation 2, April 2009:** Implement the policies and procedures of the PID for identifying and monitoring recommendations from investigations. **Findings:** See findings in XII.B.4. The hospital has yet to develop procedures for the systematic review of the implementation of recommendations made at the conclusion of incident investigations. Recommendations made at the conclusion of Serious Event Review Committee deliberations will be tracked through to implementation, according to department policy. **Compliance:** Noncompliance. **Current recommendation:** See recommendations above.
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.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Assign a discrete number to each UIR. **Findings:** This is no longer a problem; each incident has a discrete number.

			Other findings: The hospital was able to produce a copy of all the incident reports requested. These included the names and role of the persons involved, the date and type of the incident and a narrative summary of the incident. The database has the capacity to identify incidents sorted by the names of the employees involved as well as by the names of the individuals in care. **Compliance:** Substantial. **Current recommendation:** 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:	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Implement PID policies and procedures that direct the approval, implementation and monitoring of recommendations emerging from incident investigations*. **Findings:** See findings in XII.B.4. **Other findings:** As reported in XII.E.1.a and XII.E.1.d, the hospital is reporting some incident trends in its PRISM report. Since the monitoring of the implementation of corrective measures is, in many instances, not yet fully operational, the efficacy of these measures is not yet identifiable. As an example, the PID at the hospital agreed in the September

			meeting to lead a Violence Reduction Initiative. **Compliance:** Partial. **Current recommendations:** 1. *Identify and undertake procedures for monitoring recommendations from investigations.* 2. *Evaluate the success of initiatives undertaken to address tracking and trending data.* 3. *Define the components of the Violence Reduction Initiative and plan for its implementation.*
BJC	XII.E.1	Track trends by at least the following categories:	Please see sub-cells for findings and compliance:
BJC	XII.E.1.a	type of incident;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Take measures to bring the problem of under-reporting to the attention of unit and discipline leadership. PID should undertake a review of communication and transportation logs to identify events that should have been reported on UIRs and were not. Social workers and others reviewing clinical records should be alerted to the need to identify events that should have been reported as incidents and ensure a UIR is completed. **Findings:** Underreporting has been discussed in the Risk Management and Safety Committee.

Other findings:
The hospital produces a monthly PRISM report that tracks incidents by type. Current data was being reviewed and readied for graphing at the time of our visit. Data in the form of a line graph covering the period October 08 through March 09 indicated that:

- Individual-to-individual assaults have followed a V line, starting high with nearly 40 incidents in October 08, moving progressively to a low point of slightly less than 20 in January 09 and heading upward again reaching 35 assaults in March 09.
- Physical injuries (not requiring hospitalization) reached a high point of 32 in March 09.
- Individual-to-staff assaults also rose from a January 09 low of 8 to 15 in both February and March.
- In contrast, authorized leaves have declined since December 08's 13 to 7 in March 09.

The hospital also provided assault data by 1000 patient days. This data indicated that in the period October 08-April 09, the rate ranged as follows: October 08, 13.0; January 09, 8.6; March 09, 12.7; and April 09, 12.1.

Hospital data for the period October 08-July 09 provides the number of incidents by type for each month. The ten-month totals show that assaults/altercations are clearly the most frequent type of incident:

Incident type	Ten-month total
Assault/Altercation	398
Physical Injury	211
Medical Emergency	140

			<table><tr><td>Falls</td><td>126</td></tr><tr><td>UL/Disappearance</td><td>106</td></tr><tr><td>A/N/E allegation</td><td>71</td></tr><tr><td>Restraint & Seclusion</td><td>63</td></tr><tr><td>Contraband</td><td>51</td></tr><tr><td>Fire</td><td>11</td></tr><tr><td>Crime</td><td>6</td></tr><tr><td>Suicide Attempt/Gesture</td><td>6</td></tr><tr><td>Death</td><td>5</td></tr></table> The hospital has undertaken an initiative (Unit PRISM) to share with each unit its incident data. **Compliance:** Substantial. **Current recommendation:** *Continue current plans for making incident data specific to a unit (Unit PRISM) available to units hospital-wide.*
BJC	XII.E.1.b	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** Monitor UIR forms for accuracy and provide any necessary training. Make the necessary changes in the database to improve its accuracy. **Findings:** Review of 21 Unusual Incident Reports found no errors in 17. Errors in the remaining four are described below.

Incident #	Type	Issue
2009-03-073	A/N/E	No staff member identified as alleged aggressor, although narrative indicates the identity could be easily ascertained.
2009-07-046	A/N/E	This is an allegation of individual-to-individual assault that is labeled an allegation of abuse.
2009-03-149	A/N/E	The staff member alleged to have neglected the individual is identified as "other" rather than the alleged perpetrator.
2009-03-093	A/N/E	The name of the victim in the narrative and the name of the victim identified in the UI report are not the same.

Review of the July 09 UI Report indicates that fewer omissions identifying the level of severity are occurring on UI reports. Specifically, in October 08 the severity level was not identified in 116 of the 158 reports (73%) contrasted with 2 of 98 reports (2%) in July 09.

Recommendation 2, April 2009:
Train staff completing UIRs to list individuals who saw or heard the incident on the reporting form.

Findings:
The hospital reports that training in completing UIRs includes the need to list witnesses.

Other findings:
The hospital has the capacity to produce pattern data on staff members involved in incidents, but has not yet done so.

			Compliance: Noncompliance. **Current recommendation:** *Identify in investigation reports a review of the named staff member's incident history.*
BJC	XII.E.1.c	individuals involved and witnesses identified;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Setting inclusion criteria, expand the list of repeat victims and repeat aggressors to cover all units of the hospital. Alert units/teams when an individual is added to the list.* **Findings:** This recommendation has yet to be implemented. **Recommendation 2, April 2009:** *Establish a protocol whereby the IRP team will respond by identifying interventions it has/will undertake in response to the alert.* **Findings:** The hospital reports that when an individual has been involved in three incidents in 30 days, the Medical Director and the Forensic and Civil Division Chiefs. They review the clinical record and talk to the treating psychiatrist. Feedback is supposed to occur to PID, but is not. **Recommendation 3, April 2009:** Monitor the implementation of the interventions on at least a sample basis.

			Findings: The hospital reports that the Risk Manager will be using a tracking tool (blank copy provided) to track recommendations. **Other findings:** The hospital has the capacity to produce a listing of any individual's incident history. In addition to identifying for close treatment review individuals who are repeatedly involved in incidents, a similar level of review needs to occur for individuals who are involved in particularly serious incident regardless of the frequency. **Compliance:** Partial. **Current recommendation:** *Document in investigation reports a review of the individual's incident history.*
BJC	XII.E.1.d	location of incident;	**Current findings on previous recommendation:** **Recommendation, April 2009:** *Take appropriate measures to reduce the incidents on RMB-3 and RMB-6.* **Findings:** The most recent assault data (March 09) shows RMB-6 has the highest rate of physical assaults. Ten of the approximately 50 assaults reported in March 09 occurred on that unit—far exceeding the count for the month from any other unit. Review of total incident data for October 08-July 09 indicates that RMB-3 incidents reached the high point in April 09 with 28.

			Since that time the numbers have declined: May=13, June=10, July=15. **Other findings:** In each of the months October 08-March 09, the Civil units were the scene of more physical assaults than the Forensic units, accounting for nearly 62% of all physical assault incidents. The hospital produced data on physical assault incidents for each unit for each month in the period October 08-March 09. JHP-01 has been the scene of two or fewer assault incidents each month during the six month review period—the best performing unit. Hospital data on the precise location of assault incidents for the review period indicates that 53% occur in the day room. Individuals' bedrooms and bathrooms each account for 11% of these incidents and rank second to dayrooms. **Compliance:** Substantial. **Current recommendations:** 1. Continue to produce the trending and pattern data required by the Settlement Agreement. 2. *Link specific actions undertaken to patterns identified.*
BJC	XII.E.1.e	date and time of incident;	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Implement plans to discuss the unit-specific incident data with the unit staff and leadership. Briefly document the outcomes of these discussions.*

			Findings: The hospital has implemented plans to provide specific data to units in the form of the Unit Prism report. **Recommendation 2, April 2009:** *Identify in writing the purpose and responsibilities of the Risk Management & Safety Committee meetings.* **Findings:** In the document entitled "St. Elizabeths Hospital Description of Monitoring System" describes the composition and function of the Risk Management and Safety Committee. **Other findings:** Data presented by SEH for the period October 08-March 09 indicates that there is no substantial difference in the day of the week that assaults occur. However, fewer assaults occur on Saturday and Sunday-- 10.6% for each of these days as compared with 15-16% for weekdays. Time of day of physical assault data for the six month review period presented by the hospital indicates that lunch and dinner times are the occasions for the highest percentages (31.4%) of these incidents: 11AM & 12 noon=13.8%, 4PM & 5PM=17.6%. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
BJC	XII.E.1.f	cause(s) of incident; and	**Current findings on previous recommendations:**

			Recommendation 1, April 2009: Focus the work of the Risk Management & Safety Committee by writing guidelines describing its function, composition, responsibilities, etc. **Findings:** This recommendation was implemented in the SEH document "Description of Monitoring System." **Recommendation 2, April 2009:** Identify contributing factors when investigating incidents. Bring these to the attention of the Risk Management & Safety Committee or other relevant committees when incidents are reviewed. **Findings:** The investigations reviewed identified some contributing factors. A close and comprehensive analysis using a standardized formal procedure for identification is occurring for those incidents reviewed by the SERC. **Compliance:** Partial. **Current recommendations:** 1. *Apply the SERC procedures to serious incidents as this procedure is particularly successful in identifying contributing factors and identifying corresponding recommendations.* 2. *Continue with plans to implement procedures for tracking the implementation of recommendations from the investigations on a regular basis.*

BJC	XII.E.1.g	actions taken.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Implement plans for the review, approval, and monitoring of recommendations resulting from incident investigations. Document monitoring findings. **Findings:** Some actions taken in response to incidents and incident pattern and trending data are tracked in the Risk Management and Safety Committee minutes. For example, the March 09 minutes cite the development of a "suicide awareness" initiative that includes a presentation prepared by the Risk Manager and the Safety Officer. The minutes would be more helpful if the task tracking component were more specific as to the actions to be undertaken and a time frame. **Compliance:** Partial. **Current recommendation:** Keep a tighter task tracking form for the Risk Management and Safety Committee minutes.
BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Implement plans to identify medical and behavioral high-risk indicators*. **Findings:** The Key Performance Indicators identified in SEH's PRISM report include 30 day readmission rate, elopement rate, patient

			injury rate, medication variance rate, restraint & seclusion hours rate and percentage of individuals restrained or secluded. **Recommendation 2, April 2009:** See also recommendation in XII.E.1.c. **Findings:** Presently there is no clear expectation that incidents will be reviewed and documented at each IRP review and the recovery plan adjusted accordingly. Review of the clinical records of several individuals involved in incidents revealed that in many instances the treatment review following the incident made no reference to the incident or there was no progress note documenting the incident. Examples include: • AH involved in sexual assault (7/8/09). No explicit mention of incident in IRP review. • PM was also involved in 7/8/09 sexual assault. Again, no explicit mention of incident. • JN was also involved in 7/8/09 sexual assault. The incident is referenced in the Present Status section of IRP. • DJ involved in 7/8/09 sexual assault. No mention of the specific incident. Intervention: Staff will observe patient for ingestion of foreign objects and sexually inappropriate behavior. • AF made an allegation of physical abuse (6/30/09). No mention of the allegation in progress notes. Although the hitting objects incident was mentioned in his discharge summary, the summary did not note that the incident resulted in an abuse allegation. • The IRP for AK dated 5/12/09 fails to mention the misuse of the quiet room in such a manner as to constitute seclusion without an order on 4/30/09.

			• MK's allegation of physical abuse (3/6/09) was not mentioned in the IRP review or in a progress note. • No progress note was written documenting the physician's allegation that nursing care was not being provided to RM's leg wound. • The IRP following the 4/27/09 allegation of verbal abuse made by made FH makes no mention of the allegation. No progress note was written indicating the incident had ended in an allegation of abuse. In contrast, SA was the alleged victim of a 4/29/09 sexual assault. A progress note was written about the incident as well as a psychology note. The incident was also noted in discharge summary. **Other findings:** Hospital data on assaults indicates that in March 09, 20 assault incidents resulted in injury and 30 did not result in an injury. Fewer assaults resulted in injuries in December 08, January and February 09. **Compliance:** Noncompliance. **Current recommendation:** Clearly set the expectation that incidents will be reviewed and documented each IRP meeting and the recovery plan adjusted as appropriate.
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	**Current findings on previous recommendation2:** **Recommendation 1, April 2009:** *Identify a number of behavioral and medical high-risk indicators*

		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.	*and begin to identify those individuals who meet the criteria.* **Findings:** This recommendation has yet to be fully implemented. Presently individuals who are involved in three incidents in 30 days are identified and their treatment reviewed with the treating psychiatrist. **Recommendation 2, April 2009:** Alert the IRP teams as individuals meet an indicator and request a response from the team indicating the interventions in place or planned to address the risk. **Findings:** This recommendation has yet to be fully implemented as explained in other portions of the report. **Recommendation 3, April 2009:** Identify criteria for when a review of an individual's treatment should move beyond the team to receive attention from senior clinicians. **Findings:** This recommendation has been implemented only to the extent that the treatment of individuals who are involved in three or more incidents is reviewed by a senior clinician. **Compliance:** Partial. **Current recommendations:** *1. Identify a number of behavioral and medical high-risk indicators and identify those individuals who meet the*

			criteria. 2. *Develop a progressive structure of clinical review that ensures review by an interdisciplinary team of senior clinicians for those individuals whose behavior and/or medical condition warrants it.*

	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. QA internal audits have influenced hospital performance in the functioning of IRP teams, protections surrounding the use of restraint and seclusion and in ensuring the safe transfer of individuals within the hospital and to outside hospitals. 2. The SERC review process for serious incidents is particularly successful in identifying contributing factors and formulating recommendations. When the entire process is complete, the recommendations will be monitored for effective implementation. 3. The hospital's PRISM report provides important aggregate data, often accompanied by analysis. The hospital's plan, recently implemented on a limited basis, to share with each unit, the data specific to that unit promises to yield positive outcomes, as units and teams are made aware of areas for improved performance. 4. The hospital, under the direction of PID, is embarking on a Violence Reduction initiative.
BJC			**Methodology:** <u>Interviewed</u>: 1. Yolanda Williams, PI Coordinator 2. Andre Marquez, QI Coordinator 3. Tiffany Lee, PI Coordinator 4. Christine Arena, Quality Assurance Coordinator 5. Martha Pontes, Risk Manager <u>Reviewed</u>: 1. PRISM reports 2. PID audit findings

			3. Trending and pattern data 4. SERC summary reports <u>Observed</u>: Performance Improvement Committee meeting
BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Identify additional high-risk indicators, continue tracking and trending. Develop policies around expectations for the response of IRP teams and other clinicians/disciplines to individuals who reach triggers. See cell below [in previous report]. **Findings:** The hospital has not yet identified high risk indicators beyond the use of restraint and seclusion and the three incidents in 30 days. The hospital was able at my request to produce a list of incidents sorted by victim and aggressor. This list is not produced on a regular basis and is not analyzed and shared with the units. **Compliance:** Partial. **Current recommendation:** Identify additional high risk behavioral and medical indicators and procedures for alerting teams that an individual has met one of the indicators and the expectation of a response from the team.
BJC	XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of	**Current findings on previous recommendations:**

		corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Recommendation 1, April 2009:** Implement the PID procedures as planned. **Findings:** PID has defined and described the function of the hospital's monitoring bodies. Although not yet a smooth system for the tracking monitoring data, identifying an action plan and monitoring outcomes, the system has this potential under strong leadership. **Recommendation 2, April 2009:** *Develop policies necessary for the implementation of a quality management system for addressing the treatment needs of high risk individuals*. **Findings:** These policies have yet to be developed. **Other findings:** The Quality Assurance Department is presently undertaking a number of internal audits, looking at R/S, transfer and discharge documentation and IRP process. • A tool for auditing a sample of episodes of restraint/seclusion has been through several revisions and was used for the review of 15-20 R/S episodes in the period February-May 09. These reviews identified the need for further revision in the auditing tool. The tool presently in use was finalized in July. Findings from these audits include: o Little or no documentation of treatment team debriefings, o Observation flow sheets are often incomplete or not in the record,

			o Documentation of de-escalation efforts is showing improvement. • An audit of a sample of closed records for individual discharged during the last six months has produced variable findings. Most recently in September the audited records all contained an aftercare appointment date. • An audit of a sample of individuals who have been transferred within the hospital or between hospitals has looked at the completeness of the transfer note and in the relevant cases whether an IRP has been completed within seven days. The PIC has undertaken an initiative to revise the transfer form completed by the GMO. • QA auditors are attending IRP reviews and providing immediate feedback to teams. They report a significant improvement in interdisciplinary discussion. The auditors are also reviewing clinical records to determine if discipline updates and IRPs are current. **Compliance:** Partial. **Current recommendations:** 1. *Continue current auditing and expand this activity as resources permit.* 2. *Develop policies necessary for the implementation of a quality management system for addressing the treatment needs of high risk individuals.*
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Current findings on previous recommendation:** **Recommendation, April 2009:** Implement the procedures prescribed by the PID policies and begin work on drafting policies/procedures addressing the

			treatment needs of individuals reaching high-risk indicators. **Findings:** Implementation of this recommendation is still in process. **Other findings:** The finest example of the hospital's efforts to identify a comprehensive plan aimed at preventing the recurrence of a problem is the operation of the SERC review process. **Compliance:** Partial. **Current recommendation:** Adapt the principles of the SERC review process in addressing incidents not serious enough to come to that committee's attention.
BJC	XIII.B.2	the anticipated outcome of each step; and	Previous report: *The hospital will not be able to meet this requirement of the Settlement Agreement until it has identified additional high-risk indicators, has identified individuals reaching these indicators and has policies and procedures for responding to the treatment needs of individuals who reach the indicator criteria. It will likewise be essential to implement the PID policies and procedures for approving, implementing and monitoring recommendations emerging from incident investigations.* This finding and recommendation remain accurate at this time.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	See cell above.

BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Ensure that recovery teams are aware of their responsibility to review incidents and high-risk indicators, including restraint and seclusion episodes, when they convene.* **Findings:** As noted in XII.E.2, a review of the recovery plans of 10 individuals indicates that there was no documented review of the relevant incident by the recovery teams in the vast majority of cases. **Recommendation 2, April 2009:** See also XIII.B. **Other findings:** The hospital has plans for the review of the implementation status of recommendations by PID staff members. Some internal auditing, using a standard audit tool has begun and has influenced performance. Protections related to the use of restraint and seclusion and increased dialogue among the members of IRP teams as cited as examples. **Compliance:** Partial. **Current recommendations:** 1. *Identify high risk behavioral and medical indicators and procedures for the review of the individuals who reach an indicator.* 2. *Continue to expand the internal audits performed by PID.*

BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	Previous report: *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.* The hospital is not yet able to meet the requirements of this portion of the Settlement Agreement—this statement remains accurate. The hospital has expanded the mass of data it is aggregating and is identifying patterns and trends. For example, the acknowledgement that assaults are occurring on an almost daily basis (5/12/09 Workplace Violence Reduction subcommittee minutes) The hospital needs to identify the individuals in care who are significant contributors to the trends identified and construct a hierarchical review of their treatment by senior clinicians.
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	Previous report: *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.* While this statement remains accurate, the hospital has moved toward compliance.
BJC	XIII.C.3	modifying corrective action plans, as necessary.	Previous report: *The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.* This statement remains accurate. Before the hospital can modify corrective actions based on their effectiveness, it must develop a system for the systematically logging recommendations and following them through to implementation.
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve	**Current findings on previous recommendations:**

		SEH's quality/performance goals, including identified outcomes.	**Recommendation 1, April 2009:** Identify, as planned, additional medical and behavioral indicators. **Findings:** This recommendation has not yet been implemented. **Recommendation 2, April 2009:** Adopt procedures to ensure that IRP teams address the treatment needs of individuals involved in incidents and who have reached triggers. See XIII.B. **Findings:** This recommendation has yet to be implemented. **Other findings:** The internal audits performed by PID staff (see XIII.B) are moving the hospital forward in meeting goals for reducing the use restraint and seclusion, improving recovery planning conferences, ensuring evaluations that support treatment decisions are completed in a timely manner, and facilitating the smooth and safe transfer of individuals within the hospital and to outside hospital. **Compliance:** Partial. **Current recommendation:** Expand audits to identify performance problems and provide the guidance and training necessary to effect correction.

	XIV: Environmental Conditions		
BJC		By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	**Summary of Progress:** 1. The hospital continues to develop and submit for approval an emergency evacuation plan in a timely manner. 2. The move to the new hospital is planned for spring 2010. This move will eliminate any number of the environmental problems related to the age of the buildings. 3. The hospital has revised the contraband policy and has been successful in reducing the incidents of contraband. With the elimination of cigarettes as a contraband item, the hospital has eliminated the need to notify DMH of every incident where an individual in care is found in possession of a cigarette. 4. The consumer survey, initiated in 2009, provides the hospital with a basis from which to identify issues that require further inquiry from individuals in care. This also provides the opportunity to work on issues in concert with a council of individuals.
BJC			**Methodology:** <u>Interviewed</u>: 1. Robert Winfrey, Safety and Security Supervisor 2. Several individuals and staff during the tour of the units <u>Reviewed</u>: 1. Environmental Self-Assessment Report dated 8/28/09 2. Consumer Survey and Survey Findings 3. Contraband Policy <u>Toured</u>: Six units: RMB-3, RMB-4, RMB-6, RMB-7, JHP-7, JHP-6

BJC	XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Assess the environment to determine areas where individuals are likely to have privacy and where the air vents can present a suicide hazard.* **Findings:** The hospital reports that air vents were ordered in August 09. Sixty six units will be replaced in JHP. The vendor estimates they can complete installation of the new vents on two units each day once the materials arrive. **Recommendation 2, April 2009:** *If not already done, alert all units to the hazard presented by the air vents.* **Findings:** The hospital has reported that the Director of Forensic Services was advised of the survey results of vents that need to be replaced. **Recommendation 3, April 2009:** *Identify ways to minimize the hazard presented by the vents. This might include bolting furniture to wall/floor away from vents, replacing the vents with a finer screen that still permits adequate airflow.* **Findings:** See the finding above regarding the ordering of air vent replacements. **Other findings:**

			Suicide hazards are still present in bathrooms, where typically many suicide attempts occur (nationally). **Compliance:** Partial. **Current recommendation:** Include a discussion of suicide hazards in orientation training.
BJC	XIV.B	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Provide information in the next progress report on incidents involving contraband. **Findings:** SEH data on contraband incidents reveals the number of these incidents is declining. Contraband incidents averaged five per month over the period October 08-July 09. The four month period April -July 09 has seen a lower incidence. April & May=3 incidents each month, June=2 and July=1. **Other findings:** The hospital revised the Contraband policy in July 09. This policy prohibits bringing weapons and contraband into the facility; it does not address contraband found in the possession of an individual in care. The search policy addresses the latter. The contraband policy eliminates cigarettes as a banned item, while upholding the no-smoking policy. Matches are considered contraband. Employees are prohibited from carrying contraband or weapons on their person or into their workplace. **Compliance:**

			Substantial. **Current recommendation:** 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.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Determine if there is a problem staffing the evening shift and take appropriate measures to address the issue*. **Findings:** Review of nursing staffing for the 16 day period August 1-16, 09 revealed the following: • Each of the RMB units had at least one RN on duty for each shift, except the evening shift of 8/11/09 for RMB 7. • In contrast, in JHP 12 % of the shifts in the review period did not have a RN on duty. Specific dates and shifts are provided in the table below.

No RN on duty			
JHP 1	8/16	All shifts	
JHP 1	8/4,7,8	Evening	
JHP 1	8/1,2,3	Night	
JHP 3	8/1,2,3,5,6,8	Day	
JHP 3	8/1,2,3,4,5,6,7,16	Evening	
JHP 3	8/2,3,13,16	Night	
JHP 6	8/5, 8	Day	
JHP 6	8/5	Night	
JHP 8	8/2	All shifts	
JHP 8	8/3,8	Day	
JHP 8	8/4,6,8,11	Evening	
JHP 8	8/1	Night	
JHP 12	8/2,3,16	Day	
JHP 12	8/1,2,4,6	Evening	
JHP 12	8/1,7,12	Night	

JHP Units 2, 7, 9 and 10 had at least .5 RN on each shift during the report period.

Recommendation 2, April 2009:
Take any other steps necessary to staff units commensurate with the needs of the individuals.

Findings:
See also other portions of the report dealing with staffing issues.

Other findings:
The July UI report shows variability in the incidence UL/Disappearance incidents during the period October 08-July 09. Specifically, October 08 had the highest number with 22. Five other months in the ten month period had 10 or more

			incidents. Most recently (July 09) only four incidents were reported. **Compliance:** Partial. **Current recommendation:** Determine if the shortage of RN coverage evident in the sample time period is representative of a larger problem. If yes, develop and implement a plan to address this staffing issue.
BJC	XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice. **Findings:** Elevators were operable during our visit. **Other findings:** The move to the new building may provide the opportunity to move individuals who use a wheelchair onto the first floor. **Compliance:** Substantial—based on limited information. **Current recommendation:** Continue current practice.
BJC	XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire	**Current findings on previous recommendation:** **Recommendation, April 2009:** Continue current practice.

authority.

Findings:
The Safety and Security Supervisor stated that the newly revised safety and evacuation plan was sent to Dr. Mary Campbell (DMH) on September 17 for a joint review completed by Dr. Campbell and the Fire Marshall. The approved plan will be returned to St. E's.

Other findings:
Review of the Fire Drill Scoring Sheets for 2009 for RMB revealed the following:

Date	Time	Evacuation time	Score
8/18/09	5:15 PM	2 min 50 sec	10
7/8/09	9:00 AM	3min 06 sec	9
5/28/09	5:55AM	3 min 30 sec	8
5/19/09	5:00PM	2 min 50 sec	9
4/6/09	11:35AM	3min 0 sec	9
2/19/09	5:40 PM	3 min 0 sec	9
2/5/09	6:20 AM	2 min 50 sec	9
1/8/09	9:00 AM	3 min 0 sec	10

The Scoring Sheets for JHP for 2009 revealed the following:

Date	Time	Evacuation Time	Score
8/18/09	5:35 PM	3 min 0 sec	10
6/11/09	9:00 AM	2min 50 sec	9
5/28/09	6:25 AM	3 min 0 sec	9
5/19/09	5:30 PM	3 min 0 sec	10
3/5/09	10:30 AM	3 min 0 sec	9
2/17/09	5:15 PM	2 min 45 sec	10
2/5/09	6:00 AM	2 min 50 sec	9

			Scoring: Good drill=10-12; Fair drill=7-9; Re-drill w/in 24 hours=6 or less. I cannot reconcile these fire drill dates with findings the investigations of the fires in RMB on 7/16 and 7/28. The investigation of each of the fires specifically states that the last fire drill preceding the incident occurred on April 6, 2009. The fire drill forms cited above show two fire drills in May and one in July preceding the two fire investigations. **Compliance:** Substantial—as related to the Evacuation Plan. **Current recommendation:** *Address the discrepancy between the fire drill log and the fire investigations cited above. Ensure the log is completed immediately following the drill.*
BJC	XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	**Current findings on previous recommendations:** **Recommendation 1, April 2009:** *Consider revising the protocol for the quarterly surveys from a blitz style to avoid alerting the units that the inspections are underway.* **Findings:** The hospital made some attempt to avoid alerting the units that the quarterly survey was underway. Specifically, RMB units were inspected on various days from June 30-August 4. All JHP units were inspected on August 4 or 5, however. **Recommendation 2, April 2009:** *During the hospital quarterly surveys, ask a sample of individuals*

			to show how they store their clothing and personal hygiene supplies. **Findings:** The hospital implemented this recommendation by asking a sample of 25 individuals to show how they stored their clothing and personal hygiene supplies. Of the 25 individuals, one had no storage bin for dirty clothes and one had no personal hygiene supplies. One recent admission "did not have many clothes." Everyone else had neatly folded clothes or clothes on hangers and a full set of personal hygiene items. (I was surprised to read many references to clothes hanging on hangers, as I was told that hangers were not permitted.) **Recommendation 3, April 2009:** *Address the standing water issue in the showers with expertise from the maintenance department and infection control, if necessary*. **Findings:** During the current tour, standing water was no longer a problem in the bathrooms/shower rooms observed. **Recommendation 4, April 2009:** *Adopt a weekly review of the environment by unit leadership that includes a review of personal clothing care and storage*. **Findings:** This recommendation has not been successfully implemented. **Other findings:** The hospital has addressed the problems associated with storing dirty clothes by providing individuals on some units with a plastic

			storage container with lid. Review of the 8/28/09 Environmental Self-Assessment Report indicates that all units were clean and odor free, clean clothes were properly stored and all beds had a full complement of linens (including pillows) which were visibly clean. Similarly, the self-assessment found that all walls, flooring and furnishings were in good repair and all ceiling tiles were in place. Notwithstanding, observations made during this tour suggest that further effort is needed to provide individuals with personal hygiene supplies, linens, and clothing, particularly underwear, and privacy when using the restroom, as described below: • RMB-6: Several beds without pillows; on bathroom stall without a door; one individual with no personal hygiene supplies (these were provided during our stay on the unit.) • RMB-7: Several beds without pillows; several individuals without an adequate supply of underwear or none at all (per their report and observation). Slow leak in the ceiling of the shower room. • JHP-7: Water on the floor of the shower room and wet washcloths on the floor. One individual, JR, is incontinent. Axis III diagnoses includes incontinence, but no objectives or interventions addressing this condition. • JHP-6: Strong urine odor in bathroom and one stall with no door. • RMB-3: Fluorescent ceiling lights flickering in one bedroom; incomplete supply of hygiene supplies (no toothpaste or toothbrush) for CW, NM and JH; inadequate supply of clothing for JH and no underwear (by report and observation) for MB. Underwear was supplied to JH while we were touring.

Review of a sample of findings from the consumer survey (N=212) revealed the following:

Statement	% positive response (agree/strongly agree)
Better able to deal with crisis	70%
Medications are helping	63%
Deal better with daily problems	75%
Treated with dignity/respect	54%
Staff believed I could grow and recover	73%
Felt comfortable asking about my treatment	73%
Had a choice of treatment options	50%
Doctor discussed what medication is for	59%
Felt I had enough privacy	50%
Felt safe	59%
Environment was clean and comfortable	58%

Compliance:
Partial.

Current recommendations:
1. Redirect the efforts of staff assigned responsibility for the oversight of individuals' personal needs to include duties to ensure the individual has a supply of clean clothing and a full complement of personal hygiene supplies.
2. Address such problems as refusing to launder clothing and throwing clothing in the trash as treatment issues.
3. Continue the consumer survey and consider the advisability of addressing the issues brought forward in concert with a

			council of individuals.