REPORT 8

St. Elizabeths Hospital

October 31 – November 2, 2011

VII. Discharge Planning and Community Integration			
MLS		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The hospital has continued to make progress reducing its inpatient census. Since October 2010, the census has decreased from 308 to 268 in July 2011 to 290 in September 2011. The census has consistently been under 300 since December 2010. 2. There has been a recent spike in admissions for the period July-October, 2011: a result of significant increases in both forensic and civil admissions for the period. Civil admissions doubled for the period June through September; forensic admissions slightly less for the same period. This increase has resulted in an overall upward census creep from 268 in July to 290 in September 2011. With a capacity of 292, there is pressure on clinical staff, including social work, to discharge individuals. Given the length of time for this review, this consultant was not able to further determine if there were any trends to this spike. 3. The Social Work ("SW") Department continues to be strengthened. All vacancies have been filled. 4. Social Work modified its instructions and processes on how to complete the Social Work Initial Assessment and Assessment Update forms and its internal audit forms (April 2011). With a few exceptions, there continues to be progress. 5. Discharge planning and community integration continues to be strengthened. SW has improved their TLC group curricula. 6. The "Community Integration Meetings," where personnel from DMH, SEH and Community agencies review "discharge ready individuals" with regard to roles, responsibility, and communication, continues to be refined. 7. SW has identified specific areas in need of improvement by social workers and are providing specific coaching and monitoring.

MLS	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Current Findings:** 1. All social work vacancies have been filled. They are key to discharge planning and community integration. 2. SW modified its audit tools that address discharge planning. These audits identify three areas of improvements. (See VII.A.3 for further discussion.) 3. Based upon this consultant's reviews and observations, discharge planning focused primarily on placement. 4. Collaboration with CSAs and DMH continues to improve. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the current strategies and audits in the CAP.
MLS	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Current Findings:** 1. The IRP includes a section that documents the identification of an individual's strengths, preferences, and personal goals. 2. The audit tools for the social work initial assessment and social work assessment update were modified in April 2011. 3. The three IRP meetings (JJ, EM, and JJ) and a majority of records reviewed included the consumer's preferences and personal goals. 4. The SW Audit Progress Findings indicate a mean of 77 with regard to discussion of individual's goals and feelings. This consultant found that this subject was well-documented in the clinical records and at the IRPs. 5. SW Update Assessment Audit documents a mean of 52 with regard to documentation of a discharge plan review. 6. Continued improvement should result in substantial compliance at the next review.

			Compliance: Partial **Current Recommendations:** 1. See VII.A
MLS	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Current Findings:** 1. The hospital and DMH continue to improve their processes for identifying barriers to discharge including revisions to the Community Integration Meeting, fully staffing its social worker department and implementing specific strategies and training around discharge planning. 2. An internal process for identifying and reviewing the clinical histories of individuals with multiple hospitalizations or readmissions within 30 days has been instituted. 3. The SW Update Assessment Audit results note three areas in need of improvement: documentation of discharge plan review (52); and discharge plan (83); and identification of discharge criteria (number?) (86). 4. Based upon this consultant's observations and reviews, there are several administrative processes between DMH and SEH that could be improved upon to facilitate discharge. (JJ, TC). 5. Continued improvement should result in substantial compliance at the next visit. **Compliance:** Partial **Current Recommendations:** 1. The hospital should continue providing opportunities for the hospital and community to collaborate. 2. The hospital and DMH should identify and resolve specific administrative/paperwork barriers to discharge. 3. SEH Corrective Action Plan, Action Steps should be implemented and monitored.

MLS	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Current Findings:** 1. SW has fully revised and implemented its TLC curricula focusing on skills necessary for community living. 2. SEH has developed specific strategies and groups for individuals considered "resistive" or ambivalent. SEH continues to refine the array of transitional and community groups within its transitional TLC. 3. Hospital data and this expert's attendance at 3 IRP meetings indicate a positive trend in inviting the community and/or family in the treatment team process. The CSA was present; all IRPs attended. 4. Continued improvement should result in substantial compliance at the next review. **Compliance:** Partial **Current Recommendations:** 1. Continue to implement and monitor the SEH Corrective Action Plan.
MLS	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Current Findings:** 1. As observed by this expert; the social worker's role in the IRP has been strengthened with regard to discharge planning. 2. SEH monitoring reports document improved attendance and participation by social work staff in the IRP process. With full SW staffing, this area should continue to improve. 3. Communication with CSAs and families, as demonstrated by invitation to IRPs, has improved. It should be noted that invitation does not guarantee participation. According to the hospital's own data (Social Work Initial Assessment and Update Assessment Audit), and based upon this consultant's observations and record reviews, areas for improvement include: the development by SW of

			interventions that are clinical and specific; documentation of a discharge plan and discharge plan review. 4. SW supervisory staff have identified specific strategies for coach/monitor social work staff to increase competence in these identified areas. 5. There continues to be improvement in developing measureable interventions. **Compliance:** Partial **Current Recommendations:** 1. Continue to implement and monitor the Corrective Action Plan. 2. Focus social work staff and individual social work supervision meetings on developing specific clinical SW interventions.
MLS	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Current Findings and Recommendations:** 1. See VII.C 2. Maintaining progress should result in substantial compliance at the next visit. **Compliance:** Partial
MLS	VII.D	By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	**Current Findings:** 1. SEH had reduced its census significantly through July, 2011. However, during this last visit, there has been an increase in both civil and forensic admissions, and a one month spike (July) of 30-day readmissions. These factors have contributed to an increase in overall census from 268 in July to 290 in September. 2. The continued revisions to the transitional TLC curricula are positive, including the addition of community groups, cognitive/skill building groups, and the revision of the SW curricula. 3. SEH has targeted specific interventions for consumers identified as "resistive" or ambivalent regarding discharge. This focus was

			evident during this tour at all levels - IRP meetings, record reviews, administrative meetings and attendance at TLC session. There is a revised discharge monitoring tool. The audit indicates significant improvement in the evidence of transition assistance (from 74% to 96%). 4. There was a significant spike in 30-day readmissions in July. 5. SEH has implemented a process to review 30-day readmissions. 6. Maintaining progress as identified in the discharge monitoring audit report and stabilizing the recent spike in admissions should result in substantial compliance at the next review. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the Corrective Action Plan. 2. Continue to monitor and take affirmative steps to analyze the admission and readmission rates by legal category.
MLS	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Current Findings:** 1. SEH has developed an acceptable process for providing a copy of the discharge plan of care to consumer and internal audit process. 2. There has been improvement in identifying specific resources post-hospitalization. Continued improvement should result in substantial compliance at the next review. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the Corrective Action Plan. 2. Target the areas of identification of substance abuse service and outpatient appointments in discharge planning trainings and individual SW coaching.

D. Nursing and Unit-Based Services			
LDL		SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	**Summary:** 1. During this abbreviated tour, a new provision (D.1) and provisions that had not previously reached substantial compliance were reviewed. 2. The findings of this report are presented in the context of a limited sample. 3. In light of the recent resignation of the CNE, SEH is to be commended for engaging a nursing services leader with extensive clinical and administrative experience as well as demonstrated ability to successfully lead change within SEH. 4. SEH does not have an adequate number of funded positions to ensure the required number of Registered Nurses. Registered Nurses are needed to provide direct services to individuals and to supervise the nursing care provided by non-licensed nursing care providers and Licensed Practical Nurses. This long-standing finding has a negative influence on several important outcome indicators and must be addressed in order to meet the requirements of this agreement. 5. During the review period, SEH did not meet requirements for RN skill mix and did not meet requirements for Nursing Care Hours Per Patient Day (NCHPPD). 6. Unit observations and record reviews revealed some positive findings in terms of engagement with individuals in care and adequate documentation in the records. However, progress is variable and much work remains to ensure that nursing assessments and interventions consistently meet requirements. 7. SEH has implemented several initiatives designed to improve services when individuals experience a change in physical status, e.g. new documentation tools, new

			structures for code blue drills, etc. Nursing progress in this area is variable. **Methodology:** Interviewed: 1. Theresia Atanga RN 2. Elizabeth Kotey RN 3. Keli Small RN 4. Daphne Jackson RN, NM 5. Nwasu Nneka RN (Agency RN) 6. Olawatoyin Ottun RN 7. Anthony Okah RN 8. Florence Nwonye RN 9. Theresa Atanga RN 10. Debra Thomas RN, NM 11. Juanita Peters RA 12. Elayne Tu Yi Ling RN, NM 13. Josephine Ugochukwy RN, NM 14. Derrall Graves RA, Escort 15. Rodney McKinley RA, Escort 16. Stacey Jackson, RA 17. Ogu Ethelbert LPN 18. Christine Brown Acosta RN 19. Dr. Bernard Arons, Director of Medical Affairs 20. Martha Pontes RN, Assistant Chief Nurse Executive 21. Michael Hartley RN, Chief Nurse Executive 22. Clotilde Vidoni-Clark RN, Acting Chief Nurse Executive Reviewed: 1. SEH Compliance Report 8. 2. SEH documents and reports prepared in advance of visit, including those referenced in the progress report. 3. SEH and Nursing Reports, Policies, Procedures, and Forms,

			relevant to the provisions in Section VIII.D and Section X and provided in advance of, as well as during, the visit. 4. SEH August 2011 PRISM report. 5. Monthly Nursing Care Hours and Skill Mix Summary reports March, 2011 – August, 2011 . 6. Staffing Analysis for DOJ (10-31-11); SEH Nursing Staffing Requirements (listing position status and plan to reach 6.0 NCHPPD/50% RN mix) . 7. Daily 1-1 and 2-1 Specials (graph and periodic mean/medians, 3/27 – 10/9/11). 8. Various on-unit documents, e.g., nursing assignment sheets; schedules for unit based groups/activities; emergency cart checklists. 9. Meeting minutes for the Violence Reduction Initiative. 10. Two Action Plans Based on Needs Assessments developed by QEC nurses. 11. Description of 1F Star Club. 12. SEH Policy: Levels of Special Observation; 102-11; September 30, 2011. 13. SEH Nursing Procedure: Levels of Observation; NPM 2-4; revised 10-14-2011. 14. Records of the following 11 individuals in care: DM; HJ; JC; JL; TR; EM; RJ; YL; JN; DM; DN. <u>Observed</u>: 1. Various nursing functions on units: 1B, 1C, 1D, 1E, 1F, 1G, 2D, 2C. 2. Intensive TLC. 3. IRP for JC, 1E.
	VIII.D.1	The Hospital will develop and implement clinical audits and oversight to ensure changes in physical status are identified and treated.	**Findings:** SEH reported that it re-organized the structure for unit medical coverage and implemented various initiatives designed to address

			this provision. Medical staff initiatives were not reviewed during this visit. While some nursing initiatives were reviewed, most were implemented on October 1 and there were few examples of successful implementation. Nursing implemented forms for documenting the following: nursing assessment of physical status change; seizures; transfer of individuals to and from outside facilities for medical treatment, and varied checklists to be used by quality nurse educators (QECs) for real time monitoring. A review of the records of individuals who were transferred revealed much variability. General Medical Officers' reports to the Director of Medical Affairs confirm variability in the quality of RN assessment and communication of relevant, complete, and accurate information when an individual's physical status changes. Content of the documentation on some forms reflects that real-time coaching is not occurring, and that there is not a clear understanding of what information is to be documented on each part of the form. Furthermore, there is considerable duplication of documentation. For example, an RN must complete the Change in Physical Status form, a narrative progress note, and sometimes a transfer form, all of which require at least some of the same information. This duplication needs to be addressed because it results in fragmented, incomplete, and/or conflicting information. The purpose of the forms needs to be re-reviewed, the forms themselves re-reviewed, instructions re-reviewed, and staff need re-training to ensure implementation occurs as designed. Code blue drills are conducted regularly. Although the committee minutes relative to findings from drills were vague, a review of the Medical Emergency Response Evaluation Audit Tools revealed that many improvement opportunities were identified. Committee

			minutes need to more accurately reflect data from these evaluations and the status of actions taken to resolve identified issues. As in the past review, there were examples of some excellent assessments completed by both new and long term SEH RNs. These assessments included applicable history, auscultation and palpation as required, vital sign assessments, physician notifications, times of transfer and return. **Compliance: Partial** **Recommendations:** 1. Quickly evaluate and resolve issues associated with implementation of nursing forms designed to strengthen documentation of assessments and interventions when individuals' physical status changes. 2. Establish mechanism to monitor implementation, aggregate findings, report and resolve emerging issues. 3. Ensure that committee minutes accurately reflect findings from Code Blue drills and the status of actions taken to resolve identified issues.
LDL	VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individuals' symptoms, actively participate in the treatment team process and provide feedback on individuals' responses, or lack thereof, to medication and behavioral interventions;	**Findings:** Based on IRP Observation Monitoring, SEH reported that RNs were present at 94% of the IRP meetings that were audited. At the IRP that was observed, an RN and other nursing staff were present and made some relevant contributions. Both SEH audit findings and results from on site chart reviews show considerable variability in nursing admission assessments as well as other nursing documentation. There are some improvements, but many aspects of documentation are not consistently present.

			SEH no longer has a dedicated RN to do the Comprehensive Initial Nursing Assessment (CINA) and it is not clear what, if any, training has been accomplished to support all RNs to effectively complete a CINA. The long planned separation of the CINA into two parts has still not been accomplished. Notably, documentation of specific and individualized nursing interventions on the CINA remains woefully inadequate at 56%. Interventions are still generic, are not prioritized, do not adequately address the individuals' priority needs, and are not incorporated into the Initial Individual Recovery Plan (IIRP). Despite three previous SEH progress reports indicating that AVATAR adjustments would be made to accomplish this, RNs still cannot enter nursing interventions directly into the IIRP. This issue must be resolved. Although there are some areas of improvement, SEH audits of Nursing Updates and progress notes reveal that the necessary review, evaluation, and critical thinking are not occurring. There are unacceptably low findings related to: risk assessment tool ratings (83%); noting cognitive/neuro symptoms (67%) summarizing vital signs and weight (72%); summarizing pertinent lab changes (56%); and identifying issues not currently covered in focus areas that have potential to become issues (78%). While some of the variability may be attributed to changes in the audit process, it is more likely that the variability reflects the overall status of change efforts within the nursing department that are impacted by the inadequacy of the RN staffing levels (see D.11 for further discussion). SEH is to be commended for providing considerable support for Nurse Manager skill development. This is vital in order to change the nursing practice culture on the units. Materials used for the training and competency determination are excellent. However, at this time, and on most units, there remains little evidence that

			the practice culture has changed. Unit assignment sheets are not completed in a manner that supports management of the unit work flow and fail to specify assignments/accountability for each staff member. In one instance, a staff member assigned to perform 15 minute checks did not check one individual at the required time interval because she was also helping in the eating area at the same time. Because of insufficient nursing staffing numbers and skill mix (see D.11), there is considerable temporary movement of staff among units on a daily basis. This is required to attempt to cover serious baseline staffing deficiencies, as well as provide coverage for unscheduled absences or 1:1 observations. The result is that nursing staff who work on a unit may not be familiar with specific unit operations. They also do not know the individuals or their treatment plans, contributing to variable levels of engagement with individuals. On some units, individuals were sleeping during the day in common areas or were sitting silently while staff clustered together in the nursing station area. Individual rooms reflected that staff did not assist individuals to keep their living space in a manner consistent with community living expectations. Groups listed on unit schedules did not occur, or occupied only 4 of 14 patients on the unit. In contrast, beginning improvements were noted on other units. For example, on one unit an RN appropriately adjusted the timing and content of a group offering to accommodate requests by the individuals. On another unit, staff were observed conducting an excellent "wrap up" group, one of several initiatives that they believe have resulted in decreased violence. The direction and outcomes of the EARN program (Engage, Assess, Reality Orientation, Needs Met) remain unclear at this time. No EARN boards were completed, though there is

			reportedly extensive documentation on some type of flow sheet. Based on unit discussions, there continue to be opportunities to better align EARN processes with those associated with a recovery oriented environment. For example, as EARN operates, specific staff do not make contact with specific individuals in care. Rather, all the staff "try" to be sure that someone checks in with the individual every 30 minutes to ask if the person needs anything. This is the antithesis of a recovery oriented environment. In light of numerous changes within nursing, this is a good time to re-evaluate EARN. It has not proven to be effective and, as a parallel process to basic nursing care, it has created additional documentation requirements. Directing energy toward the basics of what it means to work with a specific group of assigned individuals is likely to yield better outcomes. SEH reported that Nurse Managers (NM) and Clinical Administrators met with the Acting Director of Clinical Operations and the ADON during September to develop strategies to ensure that IRPs include nursing interventions, and that updates are integrated into the IRP. Outcomes are not clear at this time. **Other findings:** SEH reported that they are working with an outside consultant to restructure the Nurse Manager meetings to ensure that required senior nursing functions are effectively performed and adequately documented, i.e., review and analyze audit findings, identify trends and drill down as needed, formulate actions to resolve identified problems, and evaluate the effectiveness of those actions. **Compliance:** Partial

			Current recommendations: 1. Resolve barriers that prevent RNs from entering relevant nursing interventions into the IIRP. Train the designated RNs to prioritize and individualize interventions. 2. Expedite implementation of new policies and forms, including assignment sheets. Monitor implementation and make operational adjustments as indicated. 3. Re-evaluate the utility of EARN. If it is retained, align EARN with recovery principles and integrate activities with established basic nursing functions, e.g., consistent assignment to work with specific individuals, integration with and implementation of IRP, integration with routine documentation requirements. 4. Develop a structure and process for nursing management to analyze findings from relevant reviews, document actions to address findings, and evaluate the effectiveness of those actions. 5. NMs should provide leadership for changing nursing practice culture, and report on strategies and progress in NM meetings. Consider real time coaching for NMs in conducting nursing unit meetings. 6. Resolve outstanding CINA issues including but not limited to: separate the current assessment into two parts; ensure that screens and assessments are differentiated as required; refine suicide screen or assessment; simplify and prioritize nursing assessment domains. 7. See VIII.D.11
LDL	VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse,	**Findings:** See D.1. The SEH progress report did not address specific audit findings

		temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	for this provision. The hospital did report significant efforts to address AVATAR issues and they are to be commended for numerous initiatives in this area. **Other findings:** None **Compliance:** Partial **Current recommendations:** Implement audit tools in order to identify improvements necessary to meet the requirements of this provision.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Findings:** Although there were limited medication administration observations, in those that were observed, significant improvements were noted. These included: utilizing two methods of identifying individuals; following expected hand-hygiene; and conducting checks to ensure that the right medication was being administered at the right dose and at the right time. For the most part, staff were knowledgeable about the actions and side effects of medications. Administration of insulin met all requirements. Based on observations made during this visit, the attention that SEH has put on medication administration has resulted in positive outcomes and should support achieving substantial compliance during the next visit. **Other findings:** None **Compliance:** Partial

			Current recommendations: Continue to monitor medication administration.
LDL	VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors;	**Findings:** SEH has successfully focused efforts on decreasing the rate of missed documentation for routinely scheduled medications. Monthly reports show reductions in rates of missing documentation from a high of 1.22% in May to 0.57% in August. In addition, SEH is monitoring missing documentation at both the unit and practitioner-specific levels, noting that 48% of the nurses had no missing documentation in August. The success of this effort suggests that SEH will be able to take other effective actions to address findings in VIII.D.4. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	VIII.D.8	Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;	**Findings:** See VIII.D.2, D.3, D.4, and D.9 There is considerable duplication in nursing documentation, e.g., RN and RA write general narrative notes for the same time periods within a shift; information must be documented in both forms and narrative note. The quality of the documentation is variable. There were some excellent notes that thoroughly described an individual's physical or behavioral status and the effectiveness of interventions. However, notes are rarely linked to IRP objectives and the words used to describe the behavior of

			individuals in care are frequently judgmental and reflect highly personalized reactions. Change of shift reports included relevant information about behavioral and physical status, including attendance and participation in TLCs. Additional improvement opportunities include specifying implications for nursing interventions on the oncoming shift. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Develop clearer expectations for RA documentation with a close eye on minimizing potential for duplication of/conflict with the RN note content. 2. See D.2.
	VIII.D.9	Ensure that each individual's treatment plan identifies:	Please see sub-cells for findings and compliance.
LDL	VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Findings:** See VIII.D.2, and VIII.D.3 SEH reported that Nurse Managers (NM) and Clinical Administrators met with the Acting Director of Clinical Operations and the ADON during September to develop strategies to ensure that IRPs include nursing interventions, and that updates are integrated into the IRP. The hospital also reported that monitoring this provision will resume in September 2011. When it does, care needs to be taken to ensure that issues

			identified in the last report relative to scoring instructions are addressed. **Other findings:** The intensive TLC provides a small dining area for individuals who are on special diets or are at risk for choking or seizures. This area is monitored at all times by an RN. During the visit, the RN monitoring this area identified the individuals at risk for choking, was knowledgeable about the specific reasons for the individuals' risks, described the different circumstances that pose choking risk, and described appropriate interventions. In an eating area on 1B, several staff were observed to be with individuals at risk for choking. **Compliance:** Partial **Current recommendations:** 1. Explore and resolve factors that contribute to an absence of nursing interventions in the IRPs, especially interventions to address violence and physical health status. 2. Monitor policy implementation, identify trends, take action to address trends, and monitor effectiveness of actions taken.
LDL	VIII.D. 9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Findings:** See VIII.D.2, 3, 4, and 9.a. **Other findings:** None **Compliance:** Partial **Current recommendations:**

			1.See VIII.D.2, 3, 4, and 9.a 2. Align audit scoring instructions to ensure monitoring of interventions that nursing staff will implement.
LDL	VIII.D. 9.c	the frequency by which staff need to monitor such symptoms.	**Findings:** See VIII.D.2, 3, 4, and 9.a. **Other findings:** None **Compliance:** Partial **Current recommendations:** See VIII.D.2, 3, 4, and 9.a.
LDL	VIII.D. 11	Ensure sufficient nursing staff to provide nursing care and services.	**Findings:** The SEH nursing staffing plan requires 6.0 NCHPPD and a 50% RN skill mix. Although there has been some improvement in the overall numbers of RNs, SEH continues to fall seriously short of staffing requirements. Moreover, SEH continues to fail to have a sufficient number of funded positions to meet these requirements in upcoming reviews. (**Note**: The Staffing requirements are expressed in two different ways: Nursing Care Hours Per Patient Day (NCHPPD) and Registered Nurse (RN) Skill Mix. NCHPPD is a single number that takes into account the unit census and the ***minimum total numbers of nursing staff*** who must be on duty in a 24 hour period to meet individuals' requirements for nursing care. The RN Skill Mix is the ***minimum percentage of all nursing staff FTEs who must be RNs.*** The appropriate skill mix is necessary to provide direct services that require an RN's knowledge and skill, as well as to supervise the care provided by non-licensed nursing care providers and Licensed Practical Nurses. The SEH staffing

			plan requires 6.0 NCHPPD and a 50% RN skill mix. The latter number takes into account the need for significant culture change in the SEH nursing practice culture in order to meet the requirements of this agreement.) A revised SEH Master Staffing Plan (7-11-2011) was provided that reflects staffing numbers under different census scenarios. This may reflect technology requirements associated with formulas for reports rather than a decision to change to a census-driven staffing model. The nature of clients served and services provided is such that a census driven model would not be appropriate for SEH. From March 2011 through August 2011, SEH failed to provide the required baseline of 6.0 NCHPPD. SEH provided an average of 4.3 NCHPPD and required the addition of overtime and agency staff to bring the average to 5.3 NCHPPD. During this same reporting period, SEH failed to provide the required RN skill mix. The average RN Skill Mix was 33%* during the reporting period. (*This number is artificially inflated due to calculation methodology). A review of the number of recently hired RNs reveals that SEH is making slow improvement. However, the pace is too slow to provide the necessary foundation for meeting the requirements of this agreement within the timeframes specified. Furthermore, slow incremental improvement may make it more difficult to change the nursing practice culture. Thus, the failure to establish and fund all the RN positions necessary to meet the requirements of this agreement, coupled with the apparent failure to take into account market factors that influence RN recruitment, puts SEH in a very challenging situation. A much more aggressive recruitment plan with accelerated timeframes is needed.

			Because of the abbreviated nature of this visit and challenges with report production, actual work schedules were not reviewed. However, other reports reflect that SEH continues to supplement heavily with overtime and agency staff to cover basic staffing requirements as well as the rising level of 1:1s. For example, a median of 15 1:1s per day was reported for the 10-9-11 pay period requiring 45 staff members per day just to do 1:1. This practice is very costly. Furthermore, emerging research links overtime use with increased potential for medical error that jeopardizes patient health and safety. The use of agency staff can also be problematic. For example, an agency RN who was interviewed during the tour had an extremely limited command of spoken English and did not have sufficient understanding of nursing actions in a recovery-oriented environment. Previously reported outcome indicators reflecting the inadequacy of the current RN Skill Mix persist. Medication variations are woefully under reported, violence and incidents continue, and documentation in the records reveals variable quality of nursing care. See D.1 and D.2 for additional detail. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Establish and fund positions to achieve a 50% RN skill mix and deliver 6.0 NCHPPD. 2. Immediately hire additional RNs. 3. `Monitor the total NCHPPD to ensure that the addition of

			required numbers of RNs brings the NCHPPD up to the minimum required level (6.0).

	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.	**Methodology:** Interviewed: See VIII.D Reviewed: See VIII.D Observed: See VIII.D. **Summary of Progress:** 1. During this abbreviated tour, only provisions that had not previously reached substantial compliance were reviewed. 2. The findings of this report are presented in the context of a limited sample. 3. SEH seclusion and restraint use remains below national benchmarks. 4. SEH has achieved Substantial Compliance in X.B.2 and X.C.7
	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 staffand a clear definition of each, and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Findings:** Previously reviewed SEH policies addressing requirements for seclusion and restraint use have adequately described the range of restrictive alternatives available to staff and were therefore not re-reviewed. There has been a decline in the timeliness and use of comfort plans (plans that reflect the individual's triggers, crisis symptoms, and preferred strategies for calming). See

			X.B.1. SEH reported that there were no instances of prone restraint use. **Other findings:** None. **Compliance:** Partial **Current recommendations:** See X.B.1.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Findings:** SEH has adopted a training program called *Safety Care* to replace the previous program designed to equip staff to prevent and manage behavioral crises. Trainers were identified and trained in August, and clinical staff training began in September. The hospital has developed a reasonable training plan that prioritizes staff whose training in the previously utilized model has expired. SEH expects all staff to be trained in *Safety Care* by Spring 2012. The content of the new program should assist SEH staff to effectively minimize circumstances that give rise to behavioral emergencies and to, as much as possible, resolve those emergencies without restraint or seclusion.. During orientation, SEH requires that all <u>new</u> employees receive training in seclusion and restraint as well as a model (currently *Safety Care*) for preventing and managing behavioral emergencies. Training databases revealed that this is occurring. SEH requires the same two trainings for existing employees at designated intervals. Based on the data provided, it appears that the number of employees who have received the required

			seclusion and restraint training has fallen since the last tour. Reportedly this might be related to the transition to the new *Safety Care* program. The issue is expected to resolve soon since seclusion and restraint content is incorporated into *Safety Care*. Collaborative Problem Solving training continues on all three shifts. The content of this training should further support staff efforts to minimize the circumstances that give rise to behavioral emergencies. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Closely monitor outcomes of behavioral emergencies while merging two models for crisis intervention. 2. Implement *Safety Care* training plan. 3. On an annual basis, require staff to attend *Safety Care* update training and demonstrate relevant competencies.
LDL	X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	Please see sub-cells for findings and compliance.
LDL	X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Findings:** SEH continues to report that restraint and seclusion use is well below the national public rates in the percent of individuals restrained or secluded and in the hours of use. SEH also reported that the requirements of this specific provision were

			met in 100% of the records reviewed. A key strategy for implementing less restrictive measures at SEH involves the use of a "comfort plan" that documents the individual's triggers, symptoms of potential crisis, and preferred less restrictive measures. However, there were few comfort plans in the records that were reviewed, they were not updated consistent with policy requirements, and there was little to no evidence that the contents were used to prevent and/or manage behavioral emergencies, e.g., the comfort plan for an individual who was secluded in July 2011 was a year old. The decision by SEH not to include the contents of the comfort plan in the IRP is confusing at best because: 1) the IRP provides the foundation and direction for all interventions; 2) the comfort plan is the mechanism SEH has selected to implement the evidence-based practice of involving individuals in care to determine how to best prevent behavioral emergencies; and 3) the findings of SEH's own study revealed that comfort plans were used in less than one-third of the situations involving individuals who were repeatedly violent. During the last visit, there was emerging evidence that the value of the plan, and the need for regular updates, was not taken seriously. During this visit, there was evidence that the number, quality, and timeliness of comfort plans has declined. Although the use of seclusion and restraint remains low, violence remains a serious issue requiring clinical attention. Well-developed and implemented comfort plans play a critical role in addressing violence. A second serious issue relates to the use of metal handcuffs, attached to a leather belt, on individuals in care who are in Class A status and must move from Admissions to a unit and/or to and from the unit(s) and appointments in the medical suite. Within an hour or two, I observed three instances in which individuals were

			handcuffed. Escorts later indicated that handcuff use is hospital policy. The Assistant CNE who supervises escorts confirmed that this is a routine practice and that the practice had been directed "from above" based on the individuals' Class A legal status. The discussion and practice reflects a lack of understanding of regulations associated with restraint use and exceptions involving the use of "public safety" measures associated with individuals who have specific status associated with the judicial system. However, the hospital restraint policy actually specifically prohibits handcuffs or metal mechanical restraints in the building. Upon further discussion, SEH staff revealed that individuals also remain in metal handcuffs during medical or dental procedures in the clinic due to their legal status and potential risk. This reviewer had a productive meeting with two RA escorts and the Acting CNE. Strategies were identified to reduce risk of harm or unauthorized egress from the hospital without using metal handcuffs. The Acting CNE indicated that she would provide leadership for dialogue in various forums to address identified issues, including the fact that restraint use in the hospital must comport with all restraint policy requirements. She also indicated that she would immediately direct that individuals in Class A status be accompanied from Admissions to units wearing clothing rather than hospital gowns and without handcuffs. **Other findings:** SEH reported that the modified RA role is still under development. As SEH strengthens the nursing professional practice environment, care must be taken to reinforce the RN role, especially the role of the Charge RN. Other "lead" roles that are developed should be directed to the individuals in care first, and then to other staff in the form of orienting, mentoring,

			and coaching other RA staff as assigned. **Compliance:** Partial **Current recommendations:** 1. Determine why there has been a decrease in completing and using Comfort Plans. Based on findings, develop a method to ensure that the plans are utilized in the same way as the IRPs, e.g., direct individualized interventions. 2. If RA role modifications are made, ensure role clarity and that services are focused on individuals in care. 3. Monitor to ensure that individuals in Class A status are accompanied from Admissions to units without metal handcuffs and in street clothes rather than hospital gowns. 4. Determine and implement strategies to promote safety and security without the use of metal handcuffs when individuals in Class A status visit the medical/dental clinics.
LDL	X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Findings:** SEH reported that 100% of the episodes of restraint/seclusion met this requirement. SEH plans to audit the number of treatment hours scheduled and attended when reviewing seclusion and restraint use. **Other findings:** None **Compliance:** Substantial **Current recommendations:**

			Maintain compliance
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Findings:** SEH reports that this requirement was met in 57% of the records that were reviewed, representing a decrease over the previous reporting period which was 88%. **Other findings:** None **Compliance:** Partial **Current recommendations:** Continue monitoring to evaluate the degree to which the current improvement plan is effective.
LDL	X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Findings:** SEH reports that audit findings revealed that 93% of the records reviewed met this requirement. This is an increase over the last visit (86%). **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.8	ensure that any individual placed in seclusion or	**Findings:**

		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 that 57% of the records revealed that this requirement was met. This low finding is probably influenced by issues associated with the transition period between the new *Safety Care* training program and previous training modules. See X.A.2 **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.2
LDL	X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Findings:** SEH reported that it has implemented a high risk individuals tracking system that is simplified. See Section XI. **Other findings:** Various tracking logs provide detailed information about specific incidents with a heavy emphasis on follow up with specific staff. In most instances, the recommendations that appear on these logs involve sanctions for identified staff members or direction to a department head. On the face of it, the recommendations seem reasonable. However, the fact that some of the recommended actions are already taking place, e.g., competency-based training in specified topics, suggests that further analysis is needed. Looking more broadly at event patterns and at clinically relevant variables would support a more thorough analysis to inform necessary system and process changes.

			It appears that a huge volume of data emerges from very complex and detailed systems. Not all data sets contain clinically relevant variables, especially those that may be associated with violence as well as seclusion or restraint use. In addition, analysis of the data is at times limited and fragmented. This situation may well distract from and obscure the ability of hospital leadership, and especially clinical leadership, to identify root causes of emerging issues across the hospital. It may be time for SEH to evaluate the utility of the massive amount of data being collected, with an especially critical eye on whether or not the data inform or distract from necessary clinical improvements. The level of data analysis must also be reconsidered. It is especially important that data derived of very small samples with associated variables of questionable utility not be pushed out to unit staff with the vague expectation that they use it for improvement. For example, violence data involving a very small "n" is not actionable because variables such as day of the week are not meaningful when only one or two individuals are involved. A well-worn phrase seems currently applicable: it is critical to distinguish "signal" from "noise". Sending "noise" to staff can be very frustrating for them, partially because sending data communicates that staff have some responsibility to use it. **Compliance:** Partial **Current recommendations:** 1. See X.A.1 and X.B.1 2. Review and evaluate the utility of existing data sets. Determine if different data sets and/or summaries for trend analysis are needed. Determine what is "signal" and what is "noise".
	X.F	By 12 months from the Effective Date hereof,	Please see sub-cells for findings and compliance.

		SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	
LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Findings:** Previously reviewed policies regarding Emergency Involuntary Psychotropic Medication (EIPM) use met requirements and were not re-reviewed. SEH reported difficulties with the database established to evaluate EIPM use. Therefore, despite the fact that SEH reported high levels of compliance with this provision, during discussions with the Director of Medical Affairs, it was agreed that insufficient data currently exist to adequately evaluate progress on this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. Monitor the use of EIPM. 2. Develop a simple mechanism to evaluate IRP changes following tiered levels of review.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Findings:** See X.F.1 **Other findings:** None **Compliance:** Partial

			Current recommendations: See X.F.1
LDL	X.F.3	the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.	**Findings:** See X.F.1 **Other findings:** See X.E **Compliance:** Partial **Current recommendations:** See X.F.1 and X.E.
LDL	X.G	By 12 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Findings:** See X.A.2. **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.2.

Section 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:** As was the case in the May 2011 review, all individuals in care are housed in the new hospital—a building constructed with particular attention to the safety of the individuals in care and staff. Seclusion rooms directly visible from the nurses station, comfort rooms on each unit, access for individuals to several common areas on each unit, the use of video cameras, enclosed courtyards with furniture bolted to the floor, wardrobes with sliding doors rather than hinged doors, and bathrooms where privacy curtains hang from ceiling tracks, eliminating stall uprights are some of the features of the hospital that contribute to the safety and quality of the environment. Several incidents reviewed revealed environmental issues related to upkeep and unit equipment that placed individuals at risk of harm. • Specifically, the investigation of neglect of TB found that he was able to leave the hospital grounds on 8/29/11 because the patio fence had been pulled away from the pole, creating an opening that allowed TB to climb up and over the fence. Once over the fence, he took the unlocked chains off the gates and ran into the construction area, squeezed under a fence in the construction area, ran through the cemetery and escaped. The opening in the patio fence had been identified five weeks earlier and a Facilities Operations Specialist had been instructed to contact a contractor immediately and get the fence repaired. He did not follow these instructions. The gates were unlocked because a Security Officer, at the request of the construction company, gave instructions to leave the gates unlocked and to "dummy lock" them. He did this without notification to or authorization from his supervisors. Further, the Perimeter Intrusion Detection System did not work; it was most likely disarmed by a weed trimmer. • The investigation into the death of PS (5/10/11) found that rounds were not done the evening of his death using a flashlight

			to observe individuals because there were no flashlights on House IB. By the time PS was found unresponsive by unit staff and EMS and the police had responded, they (EMS and police) stated that PS had been dead for three or more hours. My unit tours found that each had working flashlights. • The investigation of the allegation of abuse of DT (7/15/11) found that DT, in violation of hospital policy, was placed in handcuffs, leg irons and a transportation belt after he was physically aggressive toward staff as he attempted to retaliate against a peer who had assaulted him earlier. During the investigation, a Safety Officer who responded stated that he heard several staff call for leather restraints, but no one appeared to be able to locate them. Several other staff in the course of the investigation confirmed that there were either no leather restraints on the unit or staff could not locate them and that is why Safety brought the metal restraints and they were placed on DT. The investigation concluded that the application of restraints without a physician's order and the use of metal restraints constituted abuse. The Assistant Nurse Administrator surveyed units following this incident to ensure that each had a set of leather restraints. She reported the positive finding that in each unit the leather restraints were kept in a file cabinet drawer behind the nurses station. This consistent placement would allow all staff to access restraints on any unit if needed. My follow-up found the same positive finding on three of the four units visited 1F, 1D, and 1G. On 1E the restraints were in a bin in the supply room. • It was found during the investigation of the death of DJ (4/19/11) that tags identifying the individual and type of diet were placed on meal trays with only moisture to adhere them to the tray. The circulating air in the tray warmers fluttered the tags and could possibly blow a tag off a tray. There was no determination that this problem contributed to the death of

DJ, as his meal tray was not available for inspection following his death. It was, nonetheless, recognized as an issue that had the potential for harmful consequences and which required remedial action by Dietary Services. The Recommendations Database indicates implementation on October 28 of a process for labeling and distributing meal trays that addresses the risks identified.

- The listings of incidents for the time period, May4-June 2 and for the period, August 3-September 1 documented the hospital's attention to contraband incidents—some of which represented a risk of harm to individuals in care as shown below.

Incident date	Individual	Contraband found
5/25	BM	Cash
5/5	CT	Lighter, Razor, Matches
5/25	RH	Cigarette butts
5/5	WD	Razor, Lighter, Matches
5/11	WD	Smoke, nothing found
5/24	WD	Cigarettes, Matches
8/5	CT	Cigarette
8/31	CT	Lighter
8/11	JV	Cigarettes, Matches
8/9	BH	Cigarettes, Matches
8/9	MB	Big Rock, pillow cases w/ batteries
8/9	MB	Hypodermic Needle

On a very basic level, an essential element in providing a safe and humane environment is the prompt and effective response to individuals who have been injured. A review of ten incidents occurring in August that resulted in injuries to individuals yielded positive findings: In each incident, the vital signs of the injured individual were checked and a

			physician was summoned and he/she assessed and treated the individual or sent the individual out for treatment as indicated. This sample of 10 individuals included 4 who were the victims of peer assaults, 2 who engaged in self-injurious behavior, 2 who were injured in a fight with a peer, 1 who fell and 1 who had an unexplained injury. During the tour of House 1D, we were shown a suite of two rooms at the far end of a hallway identified by staff as the Security Suite. It consisted of two stripped down sleeping and toilet/shower areas (metal bunks and toilets). Glass doors permit staff to see all activity in the rooms. It was explained that both rooms were in use the previous night—one by an individual who was admitted the night before and placed there because the only standard bedroom available had a broken window—leaving this area as the only option on 1D. Staff asserted that the area is not locked when in use and the individuals using the rooms have access to the unit. Staff also said individuals in these rooms are kept in line-of-sight supervision. Another staff member clarified that a physician's order is required if an individual is placed there for clinical reasons and the individual must be kept in line of sight, but these protections do not apply if individuals use these rooms because of overcrowding. The staff assignment sheet for the night the rooms were occupied did not identify a staff member responsible for line of sight observation of the individuals. However, an individual who used one of the rooms said a staff member sat outside the door during the night. SEH Executive Director confirmed this is the only area of its kind in the hospital and is rarely used. Hospital policy clearly states the responsibility of all staff members to report allegations of abuse and neglect, and further that staff who fail to report are subject to disciplinary action, which could include termination. Reporting responsibilities are covered during orientation training and in annual Abuse/Neglect/Exploitation training. The A/N/E training records of 13 sampled staff members found that 10 had

completed annual training in the last year as reported by HR department and shown below.

Staff ID	Date of A/N/E training	Date of Hire
TA	4/29/2011	5/12/2008
PA	3/22/2010	3/19/2007
AP	3/23/2011	4/15/1988
OA	3/23/2011	5/9/2007
GM	5/3/2011	5/9/1995
SR	3/23/2011	6/9/2008
MA	3/26/2010	7/6/2005
SM	3/28/2011	3/2/1992
CM	3/15/2011	1/22/2007
JM	3/15/2011	7/6/1993
TF	3/19/2010	10/1/2007
EZ	5/2/2011	12/19/1990
GP	3/4/2011	10/1/1987

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

Please see Section XIII.B2 for a summary of progress related directly to protecting individuals from harm.

<table>
<tr><td></td><td colspan="3">XII. Incident Management</td></tr>
<tr><td>BJC</td><td></td><td>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.</td><td>Summary of Progress:
Two SEH policies, 302.4-09 and 302.1-03 govern incident management from definitions and reporting responsibilities through the investigation by the Risk Manager. The Unusual Incident Investigation policy (302.4-09) addresses the process for removing a staff member alleged to have abused or neglected an individual in care stating that such employee shall be immediately removed from individual in care areas, assigned to other duties pending the outcome of the investigation, or placed on administrative leave. An exception is permitted when, upon written request of the employee's supervisor, an Executive Staff member in consultation with the Risk Manager concludes the employee does not need to be reassigned from clinical duties or placed on administrative leave and "he or she shall ensure that the employee does not have contact with the putative victim." In short, in all abuse/neglect incidents, the policy requires that at a minimum the named staff member be removed from the alleged victim. The Risk Manager and PID Director agreed to consider revising the policy to unambiguously state this expectation. This issue is raised not merely to indicate that the policy needs to be simplified and clarified, but because in the investigations reviewed, practice did not comply with the policy. Specifically, in 5 of 9 sampled investigations of alleged abuse or neglect (cited below) where staff member perpetrators were identified, the investigation reports stated the staff members were not removed from the alleged victim.

<table>
<tr><td>Incident type</td><td>Incident Date</td></tr>
<tr><td>Abuse allegation –individual given placebo injection</td><td>June 7,2011</td></tr>
<tr><td>Abuse allegation-staff allegedly pulled individual into</td><td>July 21, 2011</td></tr>
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a room by her arms		
Abuse allegation- staff used metal restraints on an individual during a behavioral episode	July 15, 2011	
Abuse allegation—choke hold allegedly used during a prone containment	June 2, 2011	
Abuse allegation—individual alleged he was pushed and consequently injured	Incident date not determined	

In addition to policies setting standards for the management of incidents, PID and the Risk Manager specifically have implemented procedures essential to a robust incident management system. These include, but are not limited to, procedures for identifying under-reporting or failure to report, maintenance of an incident database, a review and approval process for investigation reports and maintenance of a database for tracking recommendations resulting from incident review. Specifically, to address the possibility of under-reporting, the Risk Manager each day reviews the nursing report to identify any events that would constitute an incident but which were not reported as such. If he finds such an event, he requires that an incident report be completed. Incident reports are entered into a database that enables tracking and trending by such variables as persons involved, incident type, date, time, location, level of injury, a rating of the severity of the incident. The SEH Risk Manager and the Incident Review Specialist investigate major unusual incidents. The investigations include face-to-face interviews with the parties involved, a review of the incident history of the alleged perpetrators and victims, a listing of documents reviewed, and a

			determination at the close of the investigation of whether the allegation is substantiated or not substantiated. All of this work is clearly and comprehensively documented in the investigation report. The report may conclude with recommendations for addressing issues uncovered by the investigation. All investigation reports are reviewed by at least one PID staff member. Those completed by the Incident Review Specialist are reviewed and approved by the Risk Manager and the PID Director, who reviews and approves all investigation reports. Recommendations made in investigation reports are entered into a database and are reviewed and revised, rejected or approved by the Executive Team and implementation status is tracked.
BJC			**Methodology:** <u>Interviewed</u>: S. Bergmann, Director, Performance Improvement Department A. Kahaly, Risk Manager and Supervising Investigator B. Arons, MD, Medical Director <u>Reviewed</u>: 1. Policy 302.1-03: Unusual Incident Reporting and Documentation 2. Policy 302.2-04: Sentinel Event/Root Cause Analysis Policy(revised 9/20/11) 3. Level of Observation Nursing Procedure (revised 10/14/11) 4. Policy 102-11: Levels of Special Observation (revised 9/30/11) 5. Policy 302.4-09: Unusual Incident Investigation (revised 4/4/11) 6. Policy 302.5-10: High Risk Indicator Tracking and Review

			(revised 9/30/11) 7. 12 investigation reports 8. A/N/E annual training dates for selected staff members 9. Aggregate incident data from PRISM 10. Recommendations database 11. Risk Management Investigations Log 12. IRPs of five high risk individuals for evidence of Medical Director's review: JW, HJ, CL, RG, CD 13. IRPs of ten individuals on High Risk lists: CT, HJ, RG, DJ, CL, CD, TA, DN, FS, JW 14. Risk Indicator Report
BJC	XII.A	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Findings:** There has been no change in the policy or procedure governing incident management. Policy 302.1-03: Unusual Incident Reporting and Documentation, revised April 5, 2011, requires all staff to be responsible for understanding the policy and respond to incidents in the manner prescribed by the policy. The policy defines the two types of incidents: Unusual Incidents (UI) and Major Unusual Incidents (MUI), requires training on the policy at orientation and annually, and includes provisions that protect persons who report an allegation of A/N/E in good faith from retaliation. Investigations are to be completed in 45 days unless the Office of Accountability is notified that an extension is required. The Risk Management Investigation Log (3/1-8/31/11) records the opening and closing dates of the completed investigations and the number of days from incident discovery to completion of the investigation report. The latter provides clear evidence that the Risk Manager is self monitoring compliance with the 45 day timeframe.

The investigation reports for 11of the 12 investigations reviewed yielded the following results related to meeting timeliness expectations:

Incident Type Allegation of:	Incident Date	PID	Date Closed
Sex Assault	4/21/11	4/22/11	6/10/11
Neglect/death	5/10/11	5/10/11	8/16/11
Abuse	6/7/11	6/7/11	7/8/11
Physical Abuse	7/21/11	7/22/11	9/15/11
Physical Abuse	7/15/11	7/18/11	9/19/11
Sexual Abuse	2/11-3/3/11	6/2/11	7/12/11
Physical Abuse	6/2/11	6/2/11	7/29/11
Neglect	5/6/11	5/6/11	6/20/11
Physical Abuse	unknown	6/17/11	8/1/11
Neglect—unauthorized leave	8/29/11	8/29/11	10/5/11
Neglect	6/7/11	6/8/11	8/1/11

The need for the autopsy findings delayed the completion of the investigation of neglect related to the death of PS. Of the remaining 10 investigations reviewed, five met the 45 day

			timeframe set in policy. The report of the death of DJ (4/19/11), completed by the Office of Accountability is not included in this table. **Compliance:** Substantial **Current recommendations:** 1. Continue current processes for incident management, investigation report development and approval and efforts to complete investigations within the policy timeframe. 2. Continue monitoring of outcomes of these efforts.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Findings:** All of the investigation reports reviewed identified the type of allegation, and the synopsis of the incident matched the incident type. Though not specifically stated, the language used to define A/N/E in the Unusual Incident Reporting and Documentation policy implies that the alleged perpetrator is someone other than another individual in care. In response to a direct question to check the accuracy of this interpretation, the Risk Manager affirmed that all abuse and neglect incidents must name as the alleged perpetrator someone other than another individual in care. A review of 10 sampled investigations of alleged abuse/neglect found that nine correctly identified the alleged perpetrator as a staff member on the face sheet. In the investigation report of alleged neglect of CD who, while on 1:1 observation was able to swallow several objects, the question: Was the alleged perpetrator a staff member? was mistakenly answered in the negative. Although the time and circumstances of the SIB and therefore the specific staff member responsible for the observation of CD when the swallowing occurred could not be identified

			(several staff had been assigned 1:1 observation duty), the neglectful person who allowed the SIB to occur had to have been a staff member. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.A.2	immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Findings:** The hospital uses a standard form for the reporting of incidents across all settings. The Unusual Incident Reporting and Documentation policy clearly states the responsibilities of staff members involved in the identification, reporting and investigation of incidents and the timeframes within which the required actions are to be completed. Additionally, the Risk Manager checks the nursing report daily to identify any situations that would constitute an incident and ensures a report is completed. No instances of failure to report were evident in the investigations reviewed. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures	**Findings:** All of the investigation reports reviewed reflected the consistent application of standard investigative procedures. Persons interviewed are identified, their interviews summarized and the date and location of the interviews provided, a listing of documents reviewed was provided and determinations were

		shall:	made using the preponderance of the evidence standard. **Compliance:** Substantial **Current recommendations:** Continue current practice.
BJC	XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations.	**Findings:** See the cell below for a description of the Recommendations Database. Recommendations from investigations are among those tracked as are recommendations from studies and from committees. The table in the cell below tracks the implementation status of several recommendations from incident investigations as recorded in the Recommendations Database. In the investigation reports reviewed several staff members were found to have engaged in misconduct and were counseled or otherwise disciplined: • The investigation of the substantiated allegation of physical abuse of BP found that the named staff member used more force than was necessary to escort BP into the Therapeutic Learning Center. The named staff member was verbally counseled. • The actions or inaction by a named staff member were found not to have caused or contributed to the death of PS. However, the named staff member was found to have been neglectful when she did not check on PS after she administered medication to him and when she did not ensure that security checks were completed as appropriate. This staff member retired prior to discipline.

			• The investigation of the use of metal restraints on DT in violation of hospital policy resulted in the suspension of one of the staff members involved. • Progressive discipline was provided to the physician named in the abuse allegation wherein DJ was administered an IM placebo. The physician resigned. **Compliance:** Substantial **Current recommendations:** 1. Continue tracking recommendations for programmatic and staff-specific corrective actions.
BJC	XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Findings:** The Recommendations Database, developed by the Performance Improvement Department, has been operational since the last review. A summary of the data is provided to hospital leadership periodically. This document includes a short description of the issue that gave rise to the recommendation, the recommendation, the name of the party responsible for implementing or ensuring implementation of the recommendation and the current status of implementation. Current status includes the date the responsible party was advised of the recommendation, and the closure/implementation date, if the action has been completed. As shown in the table below, implementation of several recommendations was delayed by two or more months, while others showed timelier implementation. The full database also showed this variability in timely implementation. I selected a sample of nine recommendations of various types and reviewed the documentation provided to PID that

supported the status update as "completed." In each case the back-up documentation was convincing.

Recommendation Date	Resolution Date
HR to determine appropriate action for 2 staff involved in conflict that affected their work performance Recommended: 3/4/11 Responsible party notified: 6/1/11	Both staff counseled; one temporarily assigned to another unit. Now working in the same unit constructively. Completion date: 10/16/11
Revise R/S policy to require that Seclusion Rooms be locked at all times when not in use and that they may not be used as quiet rooms or time-out rooms. Recommended: 5/20/11 and 5/27/11	Policy 101.1-04 was revised effective 6/6/11 and includes both of the provisions recommended.
Revise Emergency Response Policy or nursing procedure to require that individuals in care needing to be sent to ERs be constantly observed until EMS arrives. Recommended: 4/29/11	Recommendation was rejected by the Executive on 6/15/11.
Several recommendations made on 9/2/11 addressed repositioning the view of video surveillance cameras: institute continuous slow pan of nursing station camera to	Each recommendation was either implemented as recommended or an alternative arrangement was made which met the objective of the

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<table>
<tr><td>capture each house's dayroom and hallways; shift camera in entrance hallways to better capture the front of the nurses station; institute 360 degree slow pan of the patio camera to capture patio, patio doors and fence/gate.</td><td>recommendation
Completion date: 10/24/11</td></tr>
<tr><td>HR/Nursing Leadership to determine whether to implement action related to the substantiated physical abuse allegation of CD.
Recommended: 5/27/11</td><td>Named staff member was provided counseling and provided training in R/S for Behavioral Reasons
Completion date: 10/16/11</td></tr>
<tr><td>Individuals should hold community meetings on each unit to set expectation of non-violence and agreed upon commitments to non-violence.
Recommended: 8/19/11.</td><td>On each of the units toured, I questioned staff about when community meetings were held on their unit. Each responded supplying the day and time.
Completion date: 10/20/11</td></tr>
</table>

Compliance:
Substantial

Current recommendations:
Continue current practice in maintaining the database and take appropriate actions when implementation appears to have stalled.
</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E</td>
<td>By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and</td>
<td>Findings:
The monthly report tracks and trends incidents over a 12 month</td>
</tr>
</table>

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<tr>
<td></td>
<td></td>
<td>trending of incidents and results of actions taken. Such a system shall:</td>
<td>period by type, time of occurrence, location, unique individuals, severity, and cause (for physical injury incidents).
The August Unusual Incident report (most recent one available) cites the total by month of each of the 28 types of incidents for the period September 2010 through August 2011. The yearly total was 2570. The sample data below includes a
<table>
<tr><th></th><th>12 mo total</th><th>% total incidents</th><th>12mo mean</th><th>August total</th></tr>
<tr><td>Aggressive behavior</td><td>194</td><td>8.2%</td><td>18</td><td>42</td></tr>
<tr><td>Physical assault</td><td>522</td><td>20.3%</td><td>44</td><td>60</td></tr>
<tr><td>Contraband</td><td>140</td><td>5.4%</td><td>12</td><td>15</td></tr>
<tr><td>Falls</td><td>248</td><td>9.6%</td><td>21</td><td>24</td></tr>
<tr><td>Physical injury</td><td>373</td><td>14.5%</td><td>31</td><td>37</td></tr>
<tr><td>Psychiatric emergency</td><td>278</td><td>10.8%</td><td>23</td><td>24</td></tr>
<tr><td>Property destruction</td><td>30</td><td>1.3%</td><td>3</td><td>10</td></tr>
<tr><td>A/N/E</td><td>80</td><td>3.1%</td><td>7</td><td>7</td></tr>
</table>
comparison between the August tally and the 12 month mean for selected incident types and reveals substantial increases in August above the mean for aggressive behavior and physical assaults. August figures exceeded the mean for 12 of the 28 (43%) incident types.

Five incident types account for 10% or more of the annual total: physical assault (20.3%), medical emergency (12.9%), medical refusal (16.5%), physical injury (14.5%) and psychiatric emergency (10.8%).

This report included a Summary of Key Findings which include the following:</td>
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</table>

			• Units 1E, 1D, and 1B were the houses with the greatest number of major unusual incidents. • Half of all unusual incidents took place during the day shift. Peak times were between 7-8AM and 8 PM. • Over the 12 month period, on average 15 individuals were involved in 4 or more unusual incidents each month. December '10 with a total of 9 was the lowest and the highest month was February '11 with a total of 21. The August total was 19. • The rate of unusual incidents per 1000 patient days is calculated for each month. The highest rate occurred in August 2011 (27.6). **Compliance:** Substantial **Current recommendations:** Continue current practice of collecting, displaying and promulgating incident data. Develop incident reduction initiatives based on particular findings and identify them as having their origin in the review of incident data.
BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Findings:** The High-Risk Indicator Tracking and Review policy (revised September 30, 2011) identifies three levels of intervention to address an individual's risk factors. The first level is review by the IRP team of any individual involved in an incident or placed on the high risk lists for the first time or when a trigger event has occurred. (Trigger event is an incident that poses a significant danger or is likely to result, or has resulted in, serious consequences to the health and safety of staff, individuals in care, or visitors). The second level review is completed and documented by the Director of Psychiatric

			Services/designee of any individual who meets a high risk threshold (multiple episodes of R/S, 3 or more unusual incidents in a 30-day period and 3 or more episodes of emergency involuntary medication administrations in a 24-hour period.) The third level is review by the Clinical Consultation Team. Each review is documented in the individual's record. During a discussion about sections of the policy that require revision, the PID Director agreed to ensure these would be corrected. Further, she reported that the hospital had determined, independent of the discussion, that some of the timeframes for removal of an individual from a high risk list would be amended. The issues identified and shared with the PID Director include: • The policy states that when it is determined that the IRP psychiatrist has not written the required note, the Director of Psychiatric Services will follow up with this psychiatrist to "verify the psychiatrist's documentation of a review of trigger events within 24 hours." Since the absence of the note initiated the notification to the Dir. of Psychiatric Services, the only way he/she could verify the presence of the note within 24 hours of the trigger event is to have the psychiatrist write a back-dated note. Since this was not the intent of the policy, the unfortunate phrasing will be corrected. • The listing of categories of behavioral high risks includes under "Inappropriate Sexual Behaviors" confirmed sexual assaults. The policy needs to make a distinction between inappropriate sexual behavior and sexual assaults—given the seriousness and possibly criminal nature of sexual assaults. • The criteria for the high risk behaviors of suicide and falls do not include a recent history of suicide attempts

			or falls, but rather rely exclusively on the results of suicide risk assessments and falls risk assessments. The PID Director explained that in practice a recent history of these behaviors would place someone on the high risk list. The policy will be amended to conform to actual practice. **Compliance:** Substantial **Current recommendations:** Revise the High-Risk Indicator Tracking and Review policy as planned by the hospital and to also address the issues raised above.
BJC	XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Findings:** On a monthly basis the hospital prepares a Risk Indicator report that identifies individuals who were involved in 3 or more major incidents within the past 30 days. The comparison of the earliest list (May 4-June 2, 2011) with the most recent list (August 3-September 1, 2011) provides a view of the effectiveness of the risk management system, albeit a limited and early one. The findings that the list has grown longer recently and that some of the same individuals appear on both lists are ones one would hope not to see. • There are twice as many individuals on the August list as are on the May list: The May list has 11 names and the August list, 22. • Three individuals on the May list appear again on the August list. • On the May list, 4 individuals were involved in more than 3 major incidents in the past 30 days (range is 4-

8 incidents), In contrast, 17 individuals on the August list were involved in more than 3 incidents in the past 30 days (range is 4-13 incidents).

The same substantial increase in August is evident in the lists of individuals involved in physical assaults in the past 30 days.

- The May listing of individuals involved in 2 or more physical assaults (as aggressor or victim) includes 8 individuals involved in 19 physical assaults, whereas the August list includes 19 individuals involved in 61 physical assaults.

The hospital developed a list of 26 individuals who had been repeat aggressors in 3 or more incidents during the period, June 1-August 31, 2011. One half of the individuals (13) were aggressors in 3-4 incidents during the three month time period. The other 13 individuals were involved in 5-20 incidents.
When compared with data from the last tour, one again finds an increase in the number of individuals engaging in this high risk behavior multiple times.

#individuals as aggressor in:	Feb 1-April 30, 2011	June 1-Aug 31, 2011
3-4 incidents	5	13
5-6 incidents	7	8
7-9 incidents	2	3
12-13 incidents	2	1

14 or more incidents	0	1
Total	16	26

Weekly assault data for the 22 week period, 12/31/10-6/2/11 shows wide variability in frequency from 5 assaults in the week May 6-12 to 19 assaults in the week of 4/22-4/28. Assaults in 9 of the 22 weeks (41%) were equal to or greater than the 22 week mean (11 assaults).

The units display the high risk lists on a wall (not accessible to individuals in care) discretely covered, so that direct support staff can easily access this reference to learn which individuals are at risk. During our tour, a staff member, when requested to direct us to the posted listing, complied and showed us the list which was tacked upside down and therefore unreadable. She removed the list, so we could look closely at it and then returned it to the wall—again upside down. This raises questions about if, and how, direct support staff is using the high risk lists. In contrast, as cited below, our review found that IRP teams are referring to the lists and addressing the high risk status of individuals.

An individual's high risk status should be cited in the Present Status section of the IRP case formulation, according to SEH policy. Review of the IRPs for 10 individuals with 30 identified behavioral and medical risks found that 22 of the 30 risks (73%) were cited in the Present Status, as shown below.

Individ-ual	Risk	IRP Date	Cited in Present Status

				CT	Violence	9/30/11	Yes	
					Fall	9/30/11	No	
				HJ	Violence	11/1/11	Yes	
					Inapp. Sexual behavior	11/1/11	Yes	
					Treatment refusal	11/1/11	Yes	
					Unauth. Leave	11/1/11	Yes	
				RG	Violence	10/19/11	Yes	
					Inapp. Sexual behavior	10/19/11	Yes	
				DJ	Violence	9/29/11	No	
					Inapp Sexual behavior	9/29/11	No	
					Self harm	9/29/11	No	
				CL	Violence	8/25/11	Yes	
					Treatment refusal	8/25/11	Yes	
				CD	Violence	9/19/11	Yes	
					Self harm	9/19/11	Yes	
					Unauth leave	9/19/11	Yes	
				TA	Violence	9/23/11	No	
					Inapp sex behavior	9/23/11	No	
					Victimization	9/23/11	No	
				DN	Violence	9/22/11	Yes	
					Fall	9/22/11	Yes	
					Seizure	9/22/11	Yes	
				FS	Inapp sex behavior	10/18/11	No	
					Treatment refusal	10/18/11	Yes	
					Fall	10/18/11	Yes	
					Choking/aspir	10/18/11	Yes	

	ation		
	Seizure	10/18/11	Yes
JW	Victimization	10/25/11	Yes
	Fall	10/25/11	Yes
	Choking/aspiration	10/25/11	Yes

SEH policy requires that the Medical Director document his review of any individual involved in 3 or more incidents in 30 days. The clinical records of five individuals who met this criterion were reviewed and each contained the required note by the Medical Director.

Individual	Date of MD's note
JW	9/21/11
HJ	9/21/11 and CCT note on 10/24
CL	8/11/11
RG	9/11/11
CD	8/18/11 and CCT note on 6/22

Compliance:
Substantial—the review of the clinical records of a sample of individuals at risk for various behaviors and/or medical conditions and of individuals involved in multiple incidents found compliance with the hospital's policies and procedures for High-Risk Indicator Tracking and Review.

Current recommendations:
1. Consider reformatting the High Risks lists to make them easier to read when posted on a wall, as is the hospital's

			expectation. Consider removing the risk factors that are not relevant for the particular unit. This will also permit the use of a larger font and larger check boxes.

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:** Reduction in incidents of aggression/violence remains a priority of the hospital leadership and is an anticipated and critical outcome from new initiatives as well as standard incident management and policy development and review processes. New initiatives include implementation of the high risk indicator clinical review process and the Recommendations Database, and the Unit Partnership Initiative that aims to forge a bond between PID and unit staff by PID's sharing of unit-specific incident data and unit staff's engaging PID in "on the ground" issues with which unit staff are dealing. SEH developed and has revised policy that establishes a risk management review process for individuals whose behaviors, primarily aggression (to self or others) and victimization or whose medical conditions place them at risk. The hospital plans to further refine this policy (e.g. change some criteria for removal of persons from high risk lists) based on findings learned from early implementation. The hospital is currently implementing all phases of the High Risk Indicator Tracking and Review policy. Additionally, the High Risk Database Monthly Tracking Log indicates that the hospital is completing its own audits of the implementation of the High Risk tracking system. The hospital consistently produces data that provides hospital leadership with information helpful in refining policies and procedures and critical in assessing outcomes. The hospital completed a report (dated 9/30/11) entitled, Analysis of Aggressive Acts and Treatment Teams' Responses, that parsed aggression data by type, location, day of the week, time of day, individuals' length of stay and diagnoses. It also included close examination of factors related to the individuals most frequently engaged in aggressive acts.

			At this time, some evidence indicates that a greater number of individuals are engaging in more frequent incidents of aggression. During the period February 1-April 30, 16 individuals were aggressors in 3 or more incidents as compared with recent figures for the period June 1-August 31 when 26 individuals were aggressors in 3 or more incidents. Similarly, in the period May 4-June 2, 4 individuals were involved in 4 or more incidents (all types) in 30 days, but this number climbed to 17 individuals in the period August 3-September 1. A study of hospital food was in the planning stages at the time of the last tour; the hospital has completed this study. The Executive Summary of the Six Sigma project: Improving Consumers' Satisfaction with the Hospital Food identifies three themes linked to consumers' dissatisfaction: portion size (too small), insufficient variety in the menu, inability of consumers to choose their meals. To encourage trust that the survey process would result in changes, the hospital implemented three "quick fixes": a condiment tray from which consumers can choose which condiments to put on their food, posting menus in each House, offering juice and cereal choices for breakfast. As of September 2011, the core team conducting the study has identified seven additional action steps to be implemented to more fully address the needs expressed by consumers. A report entitled Performance Improvement Projects for the period March-August 2011 listed 12 completed or ongoing projects and four future projects. Many of the projects listed are described more fully in sections of this report. They include: • Amending the High Risk Indicator Policy and tracking and auditing of its operations • Developing a database to support High Risk Indicator Tracking • Updating the Unusual Incident Database to facilitate pulling aggression incident data by unit • Analysis of unusual incidents by type and time

			• Conducting monthly audits of IRP conferences, inter-unit transfers, R/S and discharges • Maintaining the Recommendations Database • Developing and implementing the Unit Partnership Initiative • Completing the study of food service and delivery • PID analysis of the variance between the length of time from admission to the hospital and the commencement of treatment at the TLC • In depth analysis of 13 individuals who had the highest frequency of assaultive behavior for the period 10/1/10-5/31/11. Performance Improvement Committee minutes also note that encouraging the development of community meetings has been a successful aggression-reduction tool in other hospitals. SEH adopted this practice. Minutes also state that the RFP for nonviolent crisis intervention curriculum is out for bid.
BJC			**Methodology:** <u>Interviewed</u>: 1. S. Bergmann, Director, Performance Improvement 2. K. Apraku-gyua, Quality Improvement Supervisor <u>Reviewed</u>: 1. High Risk Lists for September 2011-aggregate data by unit 2. Current High Risk Lists identifying individuals 3. Analysis of Aggressive Acts and Treatment Team's Responses (PID report dated 9/30/2011) 4. Aggression data for the period June 2011-September 2011. 5. Recommendations database 6. High Risk Database Monthly Tracking log (September 28, 2011) 7. Six Sigma project: Improving Consumers' Satisfaction with the

<table>
<tr><td></td><td></td><td></td><td>Hospital Food Executive Summary
8. PowerPoint presentation on violence
9. Performance Improvement Projects document (March-August 2011)
10. Special Study entitled Analysis of Aggressive Acts and Treatment Teams' Responses (September 30, 2011)
11. Selected minutes of the Performance Improvement Committee</td></tr>
<tr><td>BJC</td><td>XIII.B</td><td>Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:</td><td>Findings:

The PID Special Study entitled Analysis of Aggressive Acts and Treatment Teams' Responses (September 30, 2011) tracks and trends acts of aggression at SEH for the period October 2010-May 2011. In response to my request, the PID Director made data available for some aggression variables through September 2011. The monthly average number of physical assaults for the period Jan-May (47.4) and June-Sept (48.5) are comparable. Historical data provided by the hospital in a PowerPoint presentation indicates that 64 assaults per month were recorded in the period June 1-December 1, 2010. Thus, the number of assaults has diminished since 2010, but has remained stable in 2011.

Physical assaults in 2011
<table><tr><td>Jan</td><td>Feb</td><td>March</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sept</td></tr><tr><td>44</td><td>63</td><td>50</td><td>47</td><td>33</td><td>49</td><td>34</td><td>60</td><td>51</td></tr></table>
Total patient related aggression incidents (property destruction, SIB, physical and sexual assault, non-physical contact aggressive behavior)
<table><tr><td>Jan</td><td>Feb</td><td>March</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sept</td></tr><tr><td>68</td><td>84</td><td>58</td><td>58</td><td>54</td><td>73</td><td>55</td><td>106</td><td>89</td></tr></table>
Relating aggression data to census for the period June -Sept 2011, the hospital found that rates per 1000 patient days ranged from 6.9 in July to 12.6 in August.</td></tr>
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			The study identified several key findings: • A disproportionate number of individuals with a high number of aggressive acts have an Axis 11 diagnosis. • Non-compliance with treatment was a factor in less than 5% of the individuals engaging in aggressive acts. • Almost half (49%) of the aggressive acts were peer-to-peer only, while 42% were individual-to-staff only. • 13 individuals engaged in 8 or more aggressive acts during the period October '10-May'11. More than half of these individuals had a history of childhood trauma. • Individuals with lengths of stay of more than 30 days but less than one year account for about a quarter of the population but comprise slightly more than half of those with high frequency of aggressive acts. Please see the Summary of Progress for a description of the hospital's Performance Improvement Projects, many of which are aimed at reducing aggression/violence. **Compliance:** Partial –The hospital has implemented all processes associated with its High Risk tracking system and has compiled and analyzed data on aggression, but the anticipated and critical outcome from these efforts, reduction in aggression/violence, is not yet in evidence. **Current recommendations:** 1. Continue to comprehensively study factors that impact the safety of individuals in care in an effort to identify root causes. Track outcomes of corrective measures implemented.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Findings:** As noted above, SEH examined closely the aggressive incidents by individuals involved in the greatest number of acts of aggression.

			Findings include: • Discipline assessments did not always capture an individual's aggressive potential before an incident occurred but almost always identified it after an aggressive act. • IRP objectives and interventions addressed the risks once they were identified, but they were not modified in over 30% of the IRPs, despite the aggression continuing. • Behavioral interventions were completed in 85% of cases and when they were not effective the individual was referred for more intensive PBS intervention. Comfort plans and items were used in less than one-third • In most of the incidents, individuals in care were given STAT medications and in all cases the effectiveness of the medication was documented. The section of the report dealing with the most frequently aggressive individuals concludes with seven recommendations related to changes in treatment expectations, communication, trauma informed care training and policy revisions. Among these recommendations are: • Consider adding an indicator regarding diagnoses review and update to the IRP observation audit tool. • Ensure auditors are using feedback forms to provide findings to treatment teams. • Nursing should work with PBS Team to identify barriers to implementing behavioral interventions. IBIs may need to be simplified in order for staff to implement them consistently. • Ensure all direct care clinical support staff are current in trauma informed care training. • PID and clinical staff should work together to update the High Risk Tracking and Review policy as needed. • The raw data should be shared with each of the 13 individual's treatment team. • Provide training opportunities for direct care staff focused on

			interventions for individuals with cognitive or MR diagnoses. **Compliance:** Substantial **Current recommendations:** Follow the recommendations cited above in the Recommendations Database.
BJC	XIII.B.2	the anticipated outcome of each step; and	**Findings:** Please see XIII.D for a description of the hospital's work in assessing the level of aggression in the hospital, identifying its sources and characteristics, and in ensuring senior clinicians review the treatment of individuals who are frequently involved in acts of aggression. **Compliance:** Substantial **Current recommendations:** Continue implementation of initiatives aimed at reducing violence and improving the quality of care provided.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	**Findings:** As discussed, the Recommendations Database includes the name of the staff member responsible for ensuring the implementation of the recommendation, the target date for implementation and the current status of implementation. See further details in the cell below. **Compliance:** Substantial **Current recommendation:** Continue current practice.

BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Findings:** As noted, the Recommendations database includes information about the current status of implementation of the each recommendation. A review of the Recommendations Database search results for the period July 1- October 31, 2011 finds a total of 27 recommendations. Nine of the 27 are identified as implemented and closed. The majority of the remainder are identified as initiated, but not yet implemented. The "initiated date" is the date the responsible staff member was notified of his/her responsibility to track the implementation of the recommendation. See also XII.C for findings about the documentation supporting implementation status. Several incidents involved individuals under 1:1 observation (death of DJ and incident involving CD swallowing objects) raised questions regarding procedures for providing enhanced observation. These incidents followed the presentation of a concern to the Performance Improvement Committee by the Risk Manager regarding the need for clearer definitions in policy of the levels of observation and staff responsibilities. A new policy was in draft form in June 2011. The finalized policy Levels of Special Observation became effective on September 30, 2011. It reduces the number of levels of observation and with the corresponding nursing procedures answers common questions about observing individuals in the bathroom or in their bedrooms. The policy defines three levels of observation (each requires a physician's order for initiation and discontinuation and orders are valid for 24 hours): observation every 15 minutes, 1:1 constant line of sight and 1:1 constant arm's length. In an emergency the policy authorizes a nurse to initiate a level of special observation and requires the timely review of the situation by a physician. The Nursing Procedures Manual was revised (10/14/11) to be consistent with the hospital policy and provides additional specific instructions. For example, staff must remain within arm's length of individuals on 1:1

			constant arm's length level of observation including during personal hygiene and bathroom activities and at night when sleeping. Individuals under this intense level of observation are those with active suicidal thoughts/behaviors, impulsive SIB, individuals in 4-point restraint and individuals who are active elopement risks who are not authorized to leave the unit. For all levels of enhanced observation, staff are to engage the individual in therapeutic interactions and activities and document his/her observations every 15 minutes on a specific form designed for this purpose. Each Performance Improvement Committee meeting addresses issues or data or recommendations related to violence/aggression. **Compliance:** Substantial **Current recommendations:** Continue current practices.
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	**Findings:** The Recommendations Database identifies the action (recommendation) to be implemented and the staff member responsible for ensuring its implementation as well as a short synopsis of the circumstance that lead to the recommendation. This might be an incident, a recommendation from a committee or a recommendation made based upon the findings of a hospital study. Recommendations are reviewed monthly by the Executive Committee and accepted, revised or rejected. PID provides each month to each of the houses incident data specific to that house. This material is not merely dropped off at the house or made available, but rather the Quality Improvement Supervisor or another PID staff member meets with staff, explains the data and engages in a conversation with the staff where he/she hopes to learn what other data would be helpful to the staff and additionally to learn

			of any issues that PID should be aware of or which PID might be able to assist in addressing. This exchange is part of the PID initiative entitled "Unit Partnership" that has been running since June. It aims to build communication between PID and the houses. Minutes are kept and supplied back to the units within 48 hours of the conversation. The PID data provided to the house is typically kept in the staff break room. Data is presented in table and graph form. For example, the July data specific to 1C shows the unit had 12 Unusual Incidents which involved 10 unique individuals. This is more precisely presented by each type of incident. A bar graph shows the time of day of the incidents on 1C and a second bar graph shows the time of day of incidents hospital wide. Using pie charts, PID shows the portion of the hospital's total number of incidents of a particular type that are attributed to 1C. As described earlier, the hospital has fully implemented some of the Violence Reduction Initiatives that were in the planning or very early implementation stages during the last visit. These include operationalizing the Clinical Behavioral Consult Team (CCT); the Unit Partnership Initiative that provides house-specific incident data to each house; a substantial review of aggression as presented in the Analysis of Aggressive Acts and Treatment Teams' Responses report; development, use and monitoring of the Recommendations Database; revision in the Levels of Observation policy, High Risk Trigger identification, review and tracking; and supporting community meetings that focus on violence reduction. The High Risk Database Monthly Tracking Log provides the results of the hospital's internal audit of the operation of the High Risk Trigger review process. Findings reported on September 28, 2011 include: • 95 individuals are on high risk lists • The IRPs of 92 of the 95 individuals address the high risk • The Medical Directors response was present in 29 of 36 relevant IRPs

			• 11 individuals met the criteria for CCT; six CCT meetings had been held and five were scheduled. **Compliance:** Substantial **Current recommendations:** Consult with house staff asking whether another format for presenting PID data might be more helpful it might be helpful to them, e.g. presentation of the house's incident history over time in graph form with a trend line, so that staff can assess their progress in reducing incidents, particularly those related to violence and injuries.
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	**Findings:** As reported earlier, the hospital's thorough collection and analyses of incident data has been sufficient to permit the identification of areas of progress (principally in the application of processes to direct review by senior clinicians to those individuals whose behaviors put them or others at risk) and areas where progress has yet to be realized--reduction in assaultive acts. **Compliance:** Substantial—as evidenced by the Analysis of Aggressive Acts and Treatment Teams' Responses report and the production and analysis of other incident and aggression data. **Current Recommendations:** Continue maintaining a focus on decreasing aggression and monitoring progress or lack thereof.
BJC	XIII.C.3	modifying corrective action plans, as necessary.	**Findings:** There is in place a reasonable process by which all recommendations made as a result of a study, analysis of data, or as a result of an incident investigation is reviewed by the Executive Staff and approved,

			modified or rejected. There is no evidence that this procedure has failed to meet its intent—review by senior staff who have an expansive view of the needs of the hospital of recommended changes in policies and procedures. **Compliance:** Substantial **Current recommendations:** 1. Continue current review process for recommendations aimed at reducing violence and improving the quality of care and the quality of life of individuals in care.
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Findings:** Please see the Summary of Progress for a description of the hospital's Performance Improvement Projects, many of which are aimed at reducing aggression/violence. The hospital has untaken extensive and meaningful efforts to assess the level of aggression in the hospital, identify its most common sources and characteristics, and to ensure that senior clinicians review the treatment of individuals who are frequently involved in acts of aggression. However, the hospital has yet to see a drop in the level of aggression as evidenced by: • No decrease in the monthly average number of physical assaults in the later months of 2011 (June-Sept.) as compared with the first five months of the year. • An increase in the number of individuals who were aggressors in 3 or more incidents in the period June 1-Aug 31 as compared to Feb.1-April 30. This increase was also evident in the period June 1-Aug. 31 as compared to Feb.1-April 30. • There was an average of 11 assaults per week during the period 12/31/10-6/2/11. The highest week saw 19 assaults. • In May 2011, 8 individuals were involved in 19 assaults. In

			August, 19 individuals were involved in 61 assaults. • The rate of unusual incidents per 1000 pt. days was highest in August 2011. August reporting figures exceeded the 12 month mean for 12 of the 28 incident types **Compliance:** Partial—Processes are in place and implemented, but outcome measures do not yet show effectiveness in reducing violence/aggression. **Current recommendations:** Continue identification and implementation of Performance Improvement Initiatives and evaluate outcome.