REPORT 6

St. Elizabeths Hospital

November 1-5, 2010

	V: Integrated Treatment Planning		
MES and RB		By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.	**Summary of Status/Progress:** 1. Observations of IRP conferences demonstrated that the facility has made further progress in the process of the conferences. 2. SEH has developed a new IRP Manual and IRP training modules that meet requirements of the Agreement and provide adequate guidance in the process and content of integrated recovery planning. The new Manual has yet to be implemented. 3. In August and September 2010, the facility has provided adequate training to its IRP teams consistent with the new training modules and IRP Manual. 4. SEH has modified the IRP Observation monitoring tool, implemented the new Clinical Chart Auditing tool and modified the Psychiatric Update Auditing tool. The revised and new tools are well-aligned with requirements of the Agreement. 5. SEH has made further progress in the process of self-assessment data, including gathering and presentation of data (IRP Observation, Clinical Chart Audit, Comprehensive Psychiatric Assessment, Psychiatric Update and Inter-Unit Transfer Assessments) during this review period. The self-assessment was comprehensive, candid and included adequate comparative data and review of trends and patterns. 6. SEH has made further progress in the development and implementation of cognitive remediation groups based on the individuals' level of cognitive functioning. 7. SEH has made progress in the development and implementation of groups that substance use education based on the individuals' stage of change and their cognitive functioning. 8. The SEH Corrective Action Plan of October 7, 2010 contained adequate steps to assist the facility in achieving compliance with the requirements in this section. 9. Core treatment team members, with the exception of social workers, are routinely present for IRP conferences.

			10. The timing and follow-through on Forensic Review Board submissions continues to meet criteria for substantial compliance, and FRB submissions are noted for improved content. 11. The revised Therapeutic Progress Note (TPN) shows promise for meeting all relevant aspects of the Agreement, but an independent review found that TPNs could frequently not be found in the medical record.
			Methodology: <u>Interviewed</u>: 1. Anthony Kahaly, Risk Manager 2. Bernard Arons, MD, Medical Director 3. Danilo O. Garcia, MD, General Medical Officer 4. Edger Potter, MD, Supervisor of General Medical Officers 5. Hwa Woo, MD, General Medical Officer 6. Josephine Reyes, MD, General Medical Officer 7. Richard Smith, MD, General Medical Officer 8. Tyler Jones, MD, Director, Psychiatric Services <u>Reviewed</u>: 1. The charts of the following 59 individuals by Dr. El-Sabaawi (AB, AJ, AJS, AM, AP, AS, AW, AWB, BA, BE, BGW, BJ, CD, CD-2, CG, CH, CLT, CU, CW, DB, DB-2, DL, DLA, DT, ED, EI, EM, EW, FS, GAH, GD, HAS, HJ, HML, JA, JAN, JB, JC, LD, MA, MB, MH, MJ, ML, MMB, PC, RAH, RJ, RLS, RM, SDG, SJ, SK, SS, TB, TJ, TL, TT and YS 2. **T**he charts of the following 21 individuals by Dr. Boggio: AB, AS, CA, CP, DH, DJ, GB, HA-S, HM, IB, JF, JH, LH, LM, MB, PN, RG, RM, RN, TL and WJ 3. Saint Elizabeths Hospital (SEH) Compliance (self assessment) Report, October 7, 2010 4. SEH Corrective Action Plan, October 7, 2010

			5. SEH Policy #602.2-04, Integrated Recovery Planning (IRP) for Inpatient Services; revised September 13, 2010 6. SEH revised template for the IRP, version 8, effective September 27, 2010 and version 9, effective October 18, 2010 7. IRP Light Bulb Instructions, effective date: "approximately September 2010" 8. SEH IRP Manual, October 2010 9. SEH Policy (draft), High Risk Indicators, Review and Tracking, September 10, 2010 10. SEH IRP Operational Instructions, revised March 15, 2010 11. SEH IRP Training Module I: Foci, Objectives and Interventions, Updated September 29, 2010 12. SEH IRP Module II: Engagement; Updated September 29, 2010 13. SEH IRP Training Module III: Case Formulation; Updated September 29, 2010 14. SEH IRP Training Module IV: Discharge Planning, Updated September 29, 2010 15. Couching Hours to IRP Teams July 1 to August 31, 2010 16. SEH IRP Observation Monitoring Tool and Instructions, revised June 21, 2010 17. SEH IRP Observation Monitoring Summary Data, March to August 2010 18. SEH Clinical Chart Audit Form and Instructions, August 15, 2010 19. SEH Clinical Chart Audit Operational Instructions effective October 1, 2010 20. SEH Clinical Chart Audit Summary Data, July and August 2010 21. Comprehensive Initial Psychiatric Assessment Audit Form, March 11, 2010 22. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions May 1, 2010 23. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions September 1, 2010 24. Comprehensive Initial Psychiatric Assessment Summary Data

			March to August, 2010; 25. Psychiatric Update Audit Form July 29, 2010 26. Psychiatric Update Audit Form September 1, 2010 27. Psychiatric Update Audit Operational Instructions, not dated 28. Psychiatric Update Audit Summary Data; March to August 2010 29. Inter-Unit Transfer Audit Summary Data; March to August 2010 30. SEH Cognitive groups Capacity comparison 31. SEH document regarding modifications in the cognitive remediation programs during this review period 32. SEH TLC Group Catalogue 33. SEH Cognitive Group and Medication Group Capacity Data 34. SEH Risk Indicators March 16 to September 3, 2010 35. SEH lesson plans for the following cognitive remediation groups: Sensory Enhancement/ Re-motivation/Reminiscence, "Paper and Pencil" Cognitive Skill Building and Online Cognitive Rehabilitation Program 36. SEH Transfer for medical Evaluation form, September 201 37. IRP Training Curriculum 38. IRP Training Audit <u>Observed</u>: 1. Team meeting at unit 1C for IRP review of AO 2. Team meeting at unit 1D for IRP review of SM 3. Team meeting at unit 1D for IRP review of SS 4. Team meeting at unit 1D for IRP review of VS 5. Team meeting at unit 1E for IRP review of CB 6. Team meeting at unit 1E for IRP review of OA 7. Team meeting at unit 1E for IRP review of TS 8. Team meeting at unit 1F for IRP review of PC 9. Team meeting at unit 1G for IRP review of TW 10. Team meeting at unit 2A for IRP review of WM 11. Team meeting at unit 2B for IRP review of BW 12. Team meeting at unit 2B for IRP review of BWF

			13. Team meeting at Annex B for IRP review of ED <u>Toured</u>: 1. Transitional Mall 2. Intensive Mall 3. Units 1A, 1B and 1E

	A. Interdisciplinary Teams		
		By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	Please see sub-cells for findings and compliance.
MES	V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Findings:** Same as in V.A.2 to V.A.5, V.B, V.C, V.D and V.E. **Other findings:** During this review period, SEH made further progress towards compliance with this requirement. This expert consultant found evidence of further improvements in the process of Integrated Recovery Planning (IRP) as outlined in this section. The facility has yet to make further progress in ensuring effective participation by the individuals in the IRP conferences and improving the content of the IRPs including proper linkages between the assessments, case formulations, foci, objectives and interventions (see V.A.2 to V.A.5 and V.B, V.C, V.D and V.E.) This is necessary to achieve substantial compliance with this requirement. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Same as in V.A.2 to V.A.5. 2. Same as in V.B, V.C, V.D and V.E. 3. Implement SEH Corrective Action Plan (CAP) of October 7, 2010 relative to Section V.A.

RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Findings:** All IRP teams are led either by the treating psychiatrist or by a licensed clinical psychologist. **Other findings:** **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Findings:** The IRP training program has been substantially revised and utilizes an appropriate curriculum. The IRP manual provides better guidance for clinical staff in how to complete the IRP. Observed teams demonstrated that the team leader had a good grasp of the individual in care's treatment and discharge issues and worked with other team members in a collaborative manner. **Other findings:** **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;	**Findings:** Community members were present for all observed IRP conferences. In two of the three observed conferences, family members had been invited to participate but were unable to do so. In the third conference, family participation would have

			been inappropriate considering the clinical issues presented by the individual in care. The hospital's own data indicated that family members had only been invited to two-thirds or less of the scheduled IRP conferences and that community members had been invited to less than 60% of scheduled conferences. The hospital has instituted a change in practice to make the team social worker responsible both for initiating these invitations and documenting their outcomes. **Compliance:** Partial **Current recommendations:** Continue with identified corrective action plan.
RB	V.A.2.c	require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;	**Findings:** All core team members with the exception of social workers attended 90% or more of scheduled IRP conferences. The team social worker only attended 65% of these conferences. The hospital has identified vacancies in the Social Work Department as the primary reason for this attendance rate, and believes that a reduction in the number of vacancies to one will significantly improve the attendance rate of the team social worker. Social work supervisors also discussed plans to provide coverage when necessary. **Compliance:** Partial **Current recommendations:** 1. Continue with current corrective action plan. 2. Analyze social worker attendance rate monthly and develop additional corrective action plans as necessary if

			data continues to show an unacceptable level of social worker attendance at scheduled IRP conferences.
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Findings:** Both the hospital's data and direct observation of IRP conferences evidenced that treatment teams are functioning in an interdisciplinary fashion. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
MES	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Findings:** SEH has implemented an adequate system to ensure psychiatric input into the development and review of behavioral interventions. The system requires that the initial behavioral interventions are developed by the IDT psychologist based on the recommendation of the IDT, including the psychiatrist. The IDT reviews the effectiveness of the initial interventions and makes recommendations to continue and modify these interventions, as needed. If the IDT determines that the initial interventions are not effective, a referral is made to the PBS team leader for development of a more formal behavioral guideline or plan. If a guideline or a plan is developed, the PBS team leader meets with the treatment team to review the guideline/plan and the IDT psychiatrist signs it prior to implementation. With this structure, SEH reported using a relatively higher volume of initial interventions than guidelines or plans due to the efficacy of the interventions in most cases. In addition to this system, the facility's Psychiatric Update template provides prompts to assess specific behavioral and/or

			psychodynamic issues that may affect the individual's lack of progress. This information can facilitate the integration of psychiatric and behavioral modalities. SEH presented self-assessment data based on the Psychiatric Update (Reassessment) tool (March to August 2010). The average sample was 9% of the reassessments (target sample was two updates per unit psychiatrist). The mean compliance rate was 97% for the indicator that assessed if the Psychiatric Update contained an appropriate plan that included integration of behavioral and psychiatric interventions. **Other findings:** Chart reviews by this expert consultant found general evidence that the psychiatrists have reviewed and signed the behavioral plans/guidelines prior to their implementation. Completion of the prompt to assess specific behavioral and/or psychodynamic issues that may affect the individual's lack of progress was generally inconsistent. Review of the Psychiatric Updates (see VI.A.7) also found that the content of information regarding clinical developments during the interval was generally generic and inadequate. An adequate review of clinical developments during the interval is necessary to ensure the actual integration of behavioral and psychiatric modalities in practice. In a personal interview with this expert consultant, the facility's Director of Psychiatric Services presented an adequate plan to improve documentation in this area. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Continue to provide a summary of the aggregated monitoring

			data regarding the integration of psychiatric and behavioral modalities. The data should include the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). 3. Ensure that documentation in the psychiatric updates regarding significant developments during the previous interval reflects integration of behavioral and psychiatric modalities, as clinically appropriate.
RB	V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur.	**Findings:** The scheduling of IRP conferences continues to be done by the clinical administrators on each unit. **Compliance:** Substantial **Current recommendations:** Maintain current level of practice.
RB	V.A.3	provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;	**Findings:** The hospital has instituted a new training program that has an appropriate criteria and has developed an IRP manual that provides better guidance to clinicians in how best to complete IRPs. This has been provided to over 90% of the core clinical staff. Additionally, a training module in engagement has been provided to over 90% of the core clinical staff. In both cases, results indicated that 100% of those attending the training had been deemed competent by a post test measure.

			Compliance: Substantial **Current recommendations:** 1. Continue work with new consultant regarding treatment planning. 2. Provide re-training where necessary based on audits of written IRPs.
RB	V.A.4	consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	**Findings:** Social worker attendance at IRPs has only averaged 65%, but all other clinical disciplines have been in attendance at over 90% of audited IRP conferences. **Compliance:** Partial **Current recommendations:** See V.A.2.c
RB	V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Findings:** The hospital's data indicated that in August 2010, compliance with this provision of the Agreement was at only 79%, although at other times compliance has been higher. An independent review of a random sample of medical records found that 90% of comprehensive (7 day) IRPs were completed according to policy, 90% of 14-day IRPs were completed on time, and 80% of 30- and 60-day IRPs were completed on time. **Compliance:** Partial

			Current recommendations: 1. Continue auditing as per the instructions in Cell V.B.9. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Utilize plan presented in hospital's compliance report to ensure that managers have access to this data in a timely manner and can follow up appropriately with those teams having trouble achieving compliance.

	B. Integrated Treatment Plans		
		By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:	
MES	V.B.1	where possible, individuals have input into their treatment plans;	**Findings:** During this review period, SEH developed and implemented a training plan for IRP development that includes four modules: Engagement; Clinical Formulations; Foci, Objectives and Interventions; and Discharge Planning. The engagement module adequately addressed this requirement. The module provides training on eliciting the individual's input in both the process and content of treatment and specific techniques for engaging the individual in IRP planning and for implementing the IRPs as intended. The facility has reorganized its IRP manual to include the current training modules. SEH reported that each IRP team in the facility has received IRP mentoring and formal competency-based training during the review period. Both outside consultants and internal mentors have participated in these activities. The internal mentors have observed at least two IRP conferences each month per unit, and provided mentoring feedback to the treatment teams in accordance with guidelines that were developed jointly by the Chief of Staff and the Performance Improvement Department. The guidelines provided areas for mentors to focus on during and after IRP observations, including engagement of the individuals. All internal mentors received formal training on the current IRP modules before

assuming their mentoring responsibilities.

The facility's data regarding provision of mentoring hours showed that in July and August 2010, the IRP teams received a combined total of 20.17 and 18.5 hours, respectively. The formal training was based on the IRP Modules provided in August and September 2010. The hours of this training are presented for each corresponding area in this report.

SEH provided data regarding the competency-based training of IRP members in the engagement module (August and September 2010). The following is a summary (two hours of training were provided to Clinical Administrators and Psychiatrists and one hour to other disciplines):

Discipline	# attendees and attendance rate	# competent (of attendees)
Clinical Administrator	12 (100%)	12 (100%)
Psychiatry	21 (95%)	21 (100%)
Psychology	12 (86%)	12 (100%)
Nurse Manager	8 (100%)	8 (100%)
Medical	1 (NA)	1 (100%)
Social Work	12 (92%)	12 (100%)
Total	66 (94%)	66 (100%)

*Of all employees required to attend

The facility used its IRP Process Observation Monitoring Audit to assess its compliance with this requirement. The tool included adequate indicators and operational instructions to address this requirement. The following is an outline of the relevant indicators, with months of monitoring, average sample size (%S) and mean compliance (%C) rates:

			• Individual attends the IRP Conference (March to June 2010, %S=7%, %C= 84); • Individual attends the IRP Conference (July to August 2010, %S=10%, %C= 95%); • Individuals have input into their treatment plans (July to August 2010, %S=10%, %C= 90%); • Individuals have input into development of objectives (March to June, %S=7%, %C=%77) and • Individuals have input into development of interventions (March to June, %S=7%, %C=%91%). **Other findings:** The expert consultants attended 11 IRP conferences to assess the IRP conference process. There was general evidence that the facility has maintained progress in the following areas: 1. Facilitation of the IRP conference by the Clinical Administrators; 2. Timeliness of the meetings; 3. Attendance and participation by core members specified in the Agreement; 4. Participation by Recovery Assistants (direct care staff) in the review; 5. Attendance by the individuals; 6. Review of disciplinary assessments; 7. Review of some risk factors; 8. Discussion of key questions to be addressed during the individual's presence; and 9. Quality of the interactions between the IRP teams and the individual. In addition, the facility has made further progress in the

			following areas: 1. Overall participation by the individual in the IRP conference; 2. Review of the diagnosis with the individual; 3. Review of the group activities to which the individual was assigned and the individual's preferences regarding these assignments (in some meetings); 4. Review of the individual's strengths, life goals and cultural preferences (in some meetings); and 5. Attendance by community case managers in the conferences and their participation (in some meetings). However, persistent process deficiencies were noted in the following areas: 1. Adequate update of the present status of the individual, including factors that contributed to hospitalization, functional status, all applicable risk factors, interventions and response, use of restrictive interventions, rating scales and medical conditions that impact psychiatric/functional status; 2. Review of discharge criteria, discussion of progress towards discharge and review of barriers to discharge; 3. Review and revision, as indicated, of foci, objectives and interventions by the team (emphasizing the risks of substance use to an individual who has not used in 13 years, no revision of interventions to address violence even after the individual tossed a chair as she left the room); 4. Review of foci and objectives with input from the individual (instead, team members took turns reviewing with the individual their views of the individual's progress); 5. Data-based review of the individual's participation in PSR Mall activities; and

			6. Linkages within the IRP (foci, objectives and interventions) and between Mall activities and objectives in the IRP. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Provide a summary of all mentoring activities provided to the IRP teams during the review period relative to the engagement of individuals. Specify the participating disciplines in mentoring the teams and the mentoring process (didactic, observation, feedback to teams). 2. Ensure that team mentors address the process deficiencies outlined in other findings above. 3. Continue to provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. 4. Continue to monitor the individual's attendance and participation in the IRP conferences using process observation data based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 5. Present comparative data (mean %C for each indicator in current review period vs. last review period). 6. Implement the facility's CAP of October 7, 2010 relative to section V.B.
	V.B.2	treatment planning provides timely attention to the	Please see sub-cells for compliance findings.

<table>
<tr><td></td><td></td><td>needs of each individual, in particular:</td><td></td></tr>
<tr><td>MES</td><td>V.B.2.a</td><td>initial assessments are completed within 24 hours of admission;</td><td>Findings:
Using the Clinical Chart Audit tool, SEH reviewed an average sample of 13% of the initial psychiatric assessments (target sample was two IRPs per unit per month) and reported a mean compliance rate of 100% for the period of July and August 2010.

In addition, the facility used different tools to assess the timeliness of all disciplinary initial assessments. The following is a summary of the data:

<table>
<tr><th>Audit</th><th>Timeframe for completion</th><th>Average sample (%S)</th><th>Mean compliance (%C)</th></tr>
<tr><td>Comprehensive Initial Psychiatric Assessment</td><td>24 hours</td><td>19%</td><td>100%</td></tr>
<tr><td>Comprehensive Initial Nursing Assessment</td><td>8 hours</td><td>17%</td><td>72%</td></tr>
<tr><td>Initial Psychosocial Assessment Part A</td><td>5 days</td><td>12%</td><td>50%</td></tr>
<tr><td>Initial Psychosocial Assessment Part B</td><td>12 days</td><td>12%</td><td>64%</td></tr>
<tr><td>Social Work Assessment</td><td>5 days</td><td>20%</td><td>60%</td></tr>
</table>

SEH noted a decline in the compliance rates regarding several disciplinary assessments during this review period. However, the facility attributed this decline to technical issues related to entry of the assessments into AVATAR. Reportedly, the assessments of several disciplines were saved in “draft” status rather than “final” status and thus rated as not completed. Corrective action was developed.</td></tr>
</table>

			Other findings: This expert reviewed the charts of 10 individuals (HJ, CW, BJ, PC, BGW, TJ, JC, HAS, MB and BA) who were admitted during this review period. The review found that the initial assessments were completed within the required timeframe in all cases. Findings regarding other disciplinary assessments are addressed in corresponding sections of this report. **Compliance:** Substantial. **Current recommendations:** 1. Continue to monitor the timeliness of the initial disciplinary assessments during this review period. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). 3. Same as in VI.A.1 to VI.A.5.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Findings:** SEH reported self-assessment data using the Clinical Chart Audit (July and August 2010). The facility reviewed an average sample of 13% of IRP reviews to assess the timeliness of completion of the initial comprehensive treatment plan (by 7th day +/- 3 days since admission). Using this indicator, the mean compliance rate was 83% with this requirement.

			Other findings: This expert consultant reviewed the charts of 10 individuals (HJ, CW, BJ, PC, BGW, TJ, JC, HAS, MB and BA) who were admitted during this review period. The review found that the initial IRPs were completed as required in all cases. **Compliance:** Substantial. **Current recommendations:** 1. Continue to monitor the timeliness of the comprehensive IRPs based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average mean. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Findings:** SEH reviewed two IRP reviews per admission unit per month to assess timeliness of the IRP reviews (by 30 days, 60 days and every 60 days thereafter). Using the Clinical Chart Audit (July and August 2010), the facility reported a mean compliance rate of 86%. **Other findings:** This expert consultant reviewed the charts of 10 individuals who were admitted during this review period. The review found substantial compliance in eight cases (HJ, BJ, PC, BGW, TJ,

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>HAS, MB and BA) and partial compliance in two (CW and JC).

Compliance:
Substantial.

Current recommendations:
1. Continue to monitor the treatment plan reviews based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
2. Present comparative data (mean %C for each indicator in current review period vs. last review period).</td>
</tr>
<tr>
<td>MES</td>
<td>V.B.3</td>
<td>individuals are informed of the purposes and major side effects of medication;</td>
<td>Findings:
SEH continued the process of Consumer Satisfaction Survey. Based on surveys during this review period, the facility presented data relevant to this requirement. The following is a summary of the indicators and corresponding rates of agreement (or being neutral) and disagreement:

<table>
<tr><th>Indicator</th><th>Agreement (or neutral)</th><th>Disagreement</th></tr>
<tr><td>The doctor discussed the medication</td><td>70%</td><td>30%</td></tr>
<tr><td>Given information about side effects</td><td>62%</td><td>38%</td></tr>
<tr><td>Given choice about treatment options</td><td>72%</td><td>26%</td></tr>
</table>
</td>
</tr>
</table>

			The facility provided information regarding current groups that offer medication education. The following is an outline of the groups and corresponding discipline that provides education: 1. "Understanding Your Illness and Treatment" (Psychiatry); 2. "What's Up Doc?" (Psychiatry); 3. "Mental Health Teaching" (Psychiatry); 4. "Understanding Your Illness and Treatment" (Nursing); and 5. "Medication Education" (Nursing). The facility has yet to provide information regarding the number of groups scheduled and held, the number of individuals who were determined to be in need and the number of individuals who received medication education. SEH reported that plans were underway to implement a revised Psychiatric Update template (October 2010), including a prompt to address medication education concerning side effects of treatment. **Compliance:** Partial; improved compared to last review. **Current recommendations:** 1. Continue the process of Consumer Satisfaction Surveys and provide a summary of results. 2. Provide information regarding medication education groups provided during the interval, including number of groups scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education.

MES	V.B.4	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;	**Findings:** Same as in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5). During this review period, SEH implemented a self-assessment process using the Clinical Chart Audit (July and August 2010). Based on a 13% sample, the facility reported a mean compliance rate of 95%. The facility acknowledged that these data may not be reliable because most of the data were obtained prior to implementation of IRP training to IRP teams and auditors regarding the development of case formulation, foci, objectives and interventions. **Other findings:** Same as in V.D.1 to V.D.5. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Same as in V.D.1, V.D.2 and V.D.3. 2. Same as in V.D.4 and V.D.5. 3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 4. Present comparative data (mean %C for each indicator in current review period vs. last review period).

MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Findings:** SEH had an adequate process to implement this requirement. The Risk Manager reviews unusual incident reports and identifies individuals who were involved in three or more incidents of any type, including but not limited to the use of seclusion/restraints, during a 30-day period. The Risk Manager then notifies the Medical Director and the Director of Psychiatric Services of individuals who met this trigger/threshold. In these situations, the Director of Psychiatric Services is required to assess the events and document this assessment and recommendations in AVATAR. The information is then provided to the Risk Manager to ensure that the recommendations are communicated to psychiatrists and other disciplinary representatives for follow up. The facility presented documentation of review and assessment by the Director of Psychiatry of all individuals meeting the facility's threshold for this review (March to August 2010). **Other findings:** This expert consultant reviewed a sample of the reviews by the Director of Psychiatry of incidents involving three individuals: AA (March 25, 2010), GB (July 1 to July 26, 2010), and JW (August 10 to 30, 2010). This review found evidence of adequate assessment, including recommendations for corrective actions. **Compliance:** Substantial. **Current recommendations:** 1. *Continue to provide data regarding documentation of the review and assessment by the Director of Psychiatric*

			Services of individuals who reach high risk triggers/thresholds. 2. *Same as in XII.E.2.*
RB	V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	**Findings:** A review of the 10 most recent Forensic Review Board (FRB) submissions found over 90% compliance. This corresponds with the hospital's data indicating compliance rates between 90 and 100% since 12/09. Additional data indicates that the hospital is on track to have reviewed about 90% of these cases before the calendar year ends. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
MES	V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Findings:** Same as in V.E.3, V.E.4 and V.E.5. Same as in VIII. As mentioned earlier, SEH initiated a self-assessment process using the Clinical Chart Audit (July and August 2010). Reviewing an average sample of 13% of all IRP reviews scheduled each month, the facility reported a mean compliance rate of 64%. In addition, the facility used the Psychiatric Update Audit and reviewed an average sample of 9%. This audit contained the following indicators that were relevant to this requirement: 1. Is the subsection titled medication response accurately completed?

<table>
<tr><td></td><td></td><td></td><td>2. Does the Psychiatric Update accurately reflect the individual's progress/response to treatment?

Based on this audit, the facility reported mean compliance rates of 98% and 99%, respectively.

Compliance:
Partial; improved compared to the last review.

Current recommendations:
1. Same as in V.E.3, V.E.4 and V.E.5.
2. Same as in VIII.
3. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by comparative data to the last review and analysis of low compliance with plans of correction. Supporting documents should be provided.</td></tr>
<tr><td>MES</td><td>V.B.8</td><td>an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and</td><td>Findings:
SEH provided self-assessment data based on the Inter-Unit Transfer Audit (March to August 2010). The average sample was 47% of the transfers during each month. The following is an outline of the relevant indicators and corresponding mean compliance rates (items 9-16 apply to the psychiatric transfer assessment):

<table><tr><td>1.</td><td>Psychiatric transfer note present</td><td>42%</td></tr><tr><td>2.</td><td>Psychiatric acceptance note present</td><td>71%</td></tr></table></td></tr>
</table>

			3.	Social Work transfer note present	19%
			4.	Social Work acceptance note present	19%
			5.	Nursing transfer note present	65%
			6.	Nursing acceptance note present	77%
			7.	General Medical Officer transfer note present	58%
			8.	General Medical Officer acceptance note present	52%
			9.	Rationale for transfer	66%
			10.	Current behavior, treatment and response	65%
			11.	Anticipated benefits of transfer	71%
			12.	Brief course of treatment	65%
			13.	Risk factors	68%
			14.	Current diagnosis	74%
			15.	Discharge barriers	71%
			16.	Recommended plan of care	61%
			17.	IRP completed within 7 days of transfer	58%

The facility recognized that compliance rates were less than adequate and developed an oversight mechanism to ensure proper documentation of the assessments.

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

Initials	Dates of inter-unit transfer
SDG	4/2/10
EW	6/7/10
SK	7/9/10
EI	6/7/10
GD	8/25/10

			CD | 8/18/10 The review found substantial compliance in three charts (SDG, EI and CD) and partial compliance in three (EW, SK and GD). The main barrier to compliance was the lack of specific and adequate information regarding the course of treatment, current target symptoms and plan of care. **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically	**Findings:** The following is a summary outline of the current auditing tools at SEH, including sample size (in parenthesis) and status of implementation, including any changes since last review: 1. IRP Process Observations (two observations per unit per month): the tool was used during this review period (March to August, 2010) and modified in July 2010 to better reflect requirements of the Agreement; 2. Clinical Chart Audit (two IRPs per unit per month): the tool

		recognizes that peer review is not required for every patient chart.	was introduced in July 2010 and used for the period of July and August); 3. Comprehensive Initial Psychiatric Assessment (20% of admissions per month): the tool was used during this review period (March to August 2010) and modified to track each subsection of the mental status examination and risk assessment; 4. Psychiatric Update (two updates per psychiatrist per month): the tool was used during this review period (March to August, 2010) and revised to track each subsection of the mental status examination and include new indicator regarding diagnostic accuracy; 5. Inter-Unit Transfer (20% of transfers per month): the tool was used during this review period (March to August, 2010) with no changes made; 6. Tardive Dyskinesia (six cases per month): the tool was used during this review period (March to August, 2010) with no changes made; 7. Initial Psychological Assessments (20% of assessments per month): the tool was used during this review period (March to August, 2010) with no changes made; 8. Psychological Risk Assessments (one per practitioner per month): the tool was used during this review period (March to August, 2010) with no changes made; 9. Other Psychological Assessments (one per practitioner per month): the tool was used during this review period (March to August, 2010) with no changes made; 10. PBS plans/guidelines (100% sample per month): a different tool was introduced in May 2010 and used from May to August, 2010; 11. Initial Rehabilitation Services Assessment (20% of assessments per month): the tool was used during this review period (March to August, 2010), instructions were developed

			for use beginning in September 2010; 12. Nursing Initial Assessments (20% of admissions per month): the tool was used during this review period (March to August, 2010) with no changes made; 13. Nursing Update (four per unit per month): the tool was used during this review period (March to August, 2010) based on two per unit per month, a new tool is being developed to align better with the nursing assessments of changes in the status of the individuals; 14. Social Work Initial Assessment (20% of admissions per month): the tool was used during this review period (March to August, 2010), a revision (to track if family was invited to IRP conference) was developed to begin in September 2010; 15. Social Work Update (one per practitioner per month): the tool was used during this review period (March to August, 2010), a revision similar to that mentioned above was developed to begin in September 2010; 16. Social Worker Discharge Barriers follow Up: this audit was not used and will be discontinued as this area is now audited as part of the Clinical Chart Audit; 17. Seclusion/Restraints: the tool was modified to reflect policy changes: this audit was used (50% sample per month) in August 2010; 18. Nursing Side Rail Audit: this audit has yet to be implemented (100% of cases (as applicable) per month); 19. Discharge Record Audit: a different tool was introduced in April 2010 and used for April to August 2010 (10% of discharges per month) in lieu of the Adequacy of Discharge Interventions Audit; 20. Emergency Involuntary Medication audit: this tool has yet to be implemented (20% of individuals given involuntary medications per month); 21. Therapeutic Progress notes (one note per group

			leader/individual therapist per month): the tool was used during review period (March to August) and instructions were clarified in September 2010. 22. Group Facilitator Observation Audit (target one observation per group leader per quarter): this tool has yet to be implemented and 23. DMH Post Discharge audits (monthly): the tool was modified beginning in September 2010 to include whether DMH received discharge plan of care. For further information regarding each type of audit, please refer to the corresponding section of the Agreement. **Compliance:** Substantial. **Current recommendations:** 1. Present an outline of all current self-assessment tools, including sample sizes, status of implementation during the review period, any modifications made during the review period or planned for next review period. 2. Consolidate and simplify some of the auditing tools that address overlapping areas and that contain redundant indicators (e.g. Medication Monitoring Audit can be discontinued in favor of a more complete Psychiatric Update Audit and the Therapeutic Progress Notes tool can be simplified).

<table>
<tr><td></td><td colspan="3">C. Case Formulation</td></tr>
<tr><td></td><td></td><td>By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:</td><td>Please see sub-cells for findings and compliance.</td></tr>
<tr><td>MES</td><td>V.C.1</td><td>be derived from analyses of the information gathered including diagnosis and differential diagnosis;</td><td>Findings:
During this review period, SEH developed an IRP training module dedicated to Case Formulation. The facility revised the IRP manual to align with the training module. The manual and the module adequately address requirements of the Agreement. Competency-based training on this module was provided in August and September 2010. The following table summarizes the facility's data regarding this training (14 hours of training were provided to Clinical Administrators and 12 hours to other disciplines):

<table>
<tr><th>Discipline</th><th># attendees and attendance rate*</th><th># competent (of attendees)</th></tr>
<tr><td>Clinical Administrator</td><td>12 (100%)</td><td>12 (100%)</td></tr>
<tr><td>Psychiatry</td><td>21 (95%)</td><td>21 (100%)</td></tr>
<tr><td>Psychology</td><td>12 (86%)</td><td>11 (86%)</td></tr>
<tr><td>Nurse Manager</td><td>8 (100%)</td><td>8 (100%)</td></tr>
<tr><td>Social Work</td><td>12 (92%)</td><td>12 (100%)</td></tr>
<tr><td>Total</td><td>65 (94%)</td><td>64 (98%)</td></tr>
</table>
*of all employees required to attend

In July 2010, the facility initiated self-monitoring of this requirement based on the Clinical Chart Audit. This audit</td></tr>
</table>

			included adequate indicators and operational instructions regarding this requirement. Based on an average sample of 13% of all IRP reviews each month (July and August 2010), the facility reported a mean compliance rate of 71%. SEH reported that a new format of the Case Formulation that is consistent with the training module will be used in October 2010 and integrated into AVATAR. **Other findings:** This expert consultant reviewed the IRPs of 25 individuals (AB, AJS, AM, BE, CH, CU, DB, DB-2, DL, DLA, EM, HML, JA, JB, LD, MMB, RLS, JC, TL, BGW, HAS, FS, AS, MJ and TT). Most of these IRPs were developed in September and October 2010. In general, the reviews found a much improved format of the Case Formulation. However, the content of information was inadequate as follows: 1. In general, the Precipitating Factors section did not address factors that precipitated the individual's symptoms/ maladaptive behavior. Instead, this section was often limited to a rehash of the history of present illness; 2. The Previous Treatment and Response section often included vague and generic information about the individuals being "stabilized on medications in the past;" 3. The present status review of risk factors did not address important risks that were identified in the Comprehensive Initial Psychiatric Assessment (CIPA) (e.g. LD) or provided information that conflicted with the CIPA risk assessment (e.g. MMB); 4. The present status section regarding the review of individualized discharge criteria, progress towards discharge and barriers to discharge was either blank (RLS), included

			irrelevant information (JC) or provided criteria that were generic, not measurable and unattainable (TL); 5. In general, linkages between the case formulation and the foci, objectives and interventions of the IRP were inadequate. **Compliance:** Partial. **Current recommendations:** 1. Continue to provide aggregated data regarding competency-based training of IRP team core members regarding the Interdisciplinary Case Formulation. 2. Continue to monitor this requirement based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period). 4. Implement SEH CAP of October 7, 2010 relative to section V.C.
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Findings:** Using the above-mentioned auditing mechanism (July and August 2010), the facility reported a mean compliance rate of 49% for this requirement. **Compliance:**

			Partial. **Current recommendations:** Same as above.
MES	V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	**Findings:** The facility used the Clinical Chart Audit (July and August 2010) and reported a mean compliance rate of 99% with this requirement. **Other findings:** Chart reviews by this monitor found compliance rates lower than that provided by the facility. However, reviews of the plans of care as part of the Comprehensive Initial Psychiatric Assessment (see VI.A.5) found adequate pharmacological plans. **Compliance:** Substantial. **Current recommendations:** 1. Same as above. 2. Same as in VI.A.5
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Findings:** The self-assessment audit showed mean compliance rate of 85%. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.5	consider such factors as age, gender, culture,	**Findings:**

		treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	The facility reported a mean compliance rate of 74% based on the above-mentioned audit. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Findings:** The facility reported a mean compliance rate of 37% based on the above-mentioned audit. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.7	make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.	**Findings:** The facility reported a mean compliance rate of 52% based on the above-mentioned audit. **Compliance:** Partial. **Current recommendations:** Same as above.

<table>
<tr><td></td><td colspan="3">D. Individualized Factors</td></tr>
<tr><td></td><td></td><td>By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:</td><td>Please see sub-cells for findings and compliance.</td></tr>
<tr><td>MES</td><td>V.D.1</td><td>develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;</td><td>Findings:
During this review period, SEH developed an IRP module dedicated to IRP Foci, Objectives and Interventions. The IRP Manual was revised to align with this module. The module and the manual adequately addressed the requirements of the Agreement.

Competency-based training on this module was initiated in August 2010 and continued in September 2010. The following table summarizes the facility's data regarding this training (15 hours of training were provided to Clinical Administrators and 12 hours to other disciplines):

<table>
<tr><th>Discipline</th><th># attendees and attendance rate*</th><th># competent (of attendees)</th></tr>
<tr><td>Clinical Administrator</td><td>12 (100%)</td><td>12 (100%)</td></tr>
<tr><td>Psychiatry</td><td>21 (95%)</td><td>21 (100%)</td></tr>
<tr><td>Psychology</td><td>12 (86%)</td><td>12 (100%)</td></tr>
<tr><td>Nurse Manager</td><td>8 (100%)</td><td>8 (100%)</td></tr>
<tr><td>Social Work</td><td>12 (92%)</td><td>12 (100%)</td></tr>
<tr><td>Total</td><td>65 (94%)</td><td>65 (100%)</td></tr>
</table>
*of all employees required to attend

SEH reported that its TLC has enhanced the following core programs to address the special needs of individuals with</td></tr>
</table>

			cognitive impairments: 1. An online cognitive skill building program for individuals with mild impairments (Neuropsych online); 2. A "pen and pencil" cognitive skill building program for individuals with moderate impairments; and 3. A sensory enhancement/reminiscence/remotivation program for individuals with mental retardation and/or dementia. The enhancements included the following: 1. Delineation of candidates for the group based on three levels of cognitive functioning (programs #1-3); 2. Modifications in the group curriculum to align with the participants' functional level (program #2); and 3. Use of more material for individuals' with severe cognitive impairments to practice learned skills during group sessions (#3). In addition, various disciplines (psychiatry, rehabilitation, social work and psychology) have increased the range of groups provided by these disciplines (within the TLC) that include a cognitive remediation component. The facility reported that the number of all group sessions that address cognitive remediation has increased from 109 (53 groups) during the period of May to August 2010 to 254 (51 groups) as of September 2010. SEH did not respond to the recommendations made by this expert consultant to finalize and implement draft SEH policies regarding Emergency Medical Response (#116.1-09.), General Medical Services (#209-1), Seizure Management (#208-1) and

			Transfers of Individuals In Care (#111.2-08). These processes were relevant to the development and execution of goals/foci, objectives and interventions to address the identified needs of individuals who suffer from seizure and general medical disorders. During this review period, the facility developed a Clinical Chart Audit to assess compliance with this requirement. The tool included indicators and operational instructions that adequately addressed this requirement except for the lack of attention to the identified neurological and medical needs of the individuals at the facility. Using this tool (July and August, 2010), the facility reviewed an average sample of 13% of IRP reviews each month. The mean compliance rate was 68%. **Other findings:** Chart reviews by this consultant found that the facility has made improvements in the formulation of foci in some IRPs that were completed in September 2010. However, the facility has yet to correct the deficiencies that were mentioned in the previous reports in this section regarding the content of foci, objectives and interventions. The following are chart examples of overinclusive and generic formulations of the focus of hospitalization: 1. "Will manage mood stability and psychiatric symptoms through ongoing assessment and clinical intervention" (HJ); 2. "Will be able to maintain control of his paranoia and delusions, to be able to express himself without using threatening or destructive behaviors. He will be able to live in a group home and participate in employment" (MMB) and 3. "Had not been adherent to medications, was found without

			clothing, staring into space, talking to walls and had damaged his room. The goal is to manage his symptoms of psychosis by increasing his awareness of his symptoms and the importance of consistent medication adherence in order to maintain himself in the community" (HAS) In addition, this expert consultant reviewed the charts of individuals diagnosed with seizure (FS, AS, MJ, RM, ED and DT), cognitive (TT, ML, MH, RAH, JAN, VG, GAH and MA).and substance use (HAS, TL, CW, RLS, TJ CLT, and JC) disorders. The purpose of the review was to assess whether the IRP included appropriate diagnosis, foci, objectives and interventions to address the individuals' identified needs. These reviews found that the facility has strengthened progress in some areas as follows: 1. Review of the present status of individuals diagnosed with seizure disorders adequately addressed seizure activity during the interval in all charts reviewed (FS, AS, ED and MJ); 2. Review of the present status of some individuals diagnosed with dementing illness (RAH) included adequate review of cognitive status during the interval; 3. The IRPs included foci, objectives and interventions related to seizure disorders in most charts reviewed; 4. In some individuals with seizure disorders, the formulation of objectives was based on adequate learning outcomes and of interventions that aligned with these objectives (e.g. FS and AS); 5. In some individuals with both seizure and cognitive disorders, there was evidence of caution in the choice of anticonvulsant medications regarding the risk of further cognitive decline (TT);

			6. There was evidence of improved documentation of interventions that were appropriately tailored to the individual's level of cognitive functioning in some individuals diagnosed with dementing illnesses (RAH, and VG). The review found the following deficiencies: 1. Individuals diagnosed with seizure disorders (FS, AS, MJ, RM, ED and DT): a) The plans did not document foci, objectives and interventions that address seizure activity (DT); b) Some plans included evidence of objectives that were unattainable and inappropriate(AS, RM and ED); c) In general, the diagnosis of dementing illnesses was over-inclusive apparently due to technical difficulties with AVATAR . 2. Individuals diagnosed with cognitive disorders: a) The present status section of the case formulation did not include any (TT, ML) or adequate (MH) review of the cognitive status of the individuals); b) There was no documentation of a focus statement or objectives or interventions to address diagnoses of Dementia Due to Multiple Aetiology (TT) and Vascular dementia, Uncomplicated (VG); c) The IRPs of some individuals with dementing illnesses did not include any (ML) or adequate and specific (MH) interventions to address the cognitive impairment; d) Some the interventions that provided cognitive skill training (e.g. TT) were disconnected from the established objectives. 3. Individuals diagnosed with substance use disorders (HAS, TL, CW, RLS, TJ, CLT, and JC) received objectives and interventions that were not aligned with the stated stage of

change in the charts of HAS, TL, TJ and RLS or inappropriately listed as "not applicable" in the chart of JC. In two charts (CW and CLT), the objectives/interventions were properly aligned with the individuals' needs and stage of change

This expert consultant reviewed the charts of individuals who were transferred to an outside facility for medical care on eight occasions during this reporting period. The review focused on procedures that facilitate the delivery of medical care that meets the individual's physical needs. The following outlines these reviews:

Initials	Date of transfer	Reason for transfer
RJ	9/21/10	Bradycardia and hypotension
RM	5/26/10	Seizure disorder
CD	8/4/10	Lethargy and fecal incontinence
CD-2	5/24/10	Abnormal EKG (Bradycardia)
SS	1/4/10	Grand Mal Seizure
AWB	2/12/10	Unresponsiveness
YS	7/27/10	Vomiting R/O Bowel Obstruction
YS	8/10/10	Vomiting R/O Bowel Obstruction

The reviews found that the facility implemented (in September 2010) an adequate format to improve documentation of the medical assessment of individuals upon outside transfer.

The reviews also found a number of significant process deficiencies in nursing and medical care that require corrective actions. The following are examples:

1. The physician who assessed an individual upon return

			transfer from outside hospitalization was unable to find any documentation of records regarding the hospital stay (RJ). 2. The documentation by nursing of the occurrence of seizure activity in two individuals was generic and inadequate (CD and SS). 3. An individual was transferred to an outside hospital because of abnormal EKG showing significant bradycardia. When asked about the status of this individual, the treating physician, in a personal interview, stated that no medication change had occurred (prior to the change in the individual's status). However, review of the individual's records found evidence of a significant change in the individual's medications that may have contributed to his condition (CD-2). This individual was returned to SEH with a diagnosis of Bradycardia Secondary to Medication (change). 4. An individual (CD) who was diagnosed with Moderate Mental Retardation developed an episode of lethargy and fecal incontinence and was found, at the outside facility, to have both lithium toxicity and divalproex toxicity. However, these events were not reported or investigated by SEH as severe adverse drug reactions as required by the facility's policy regarding adverse drug reactions 5. An individual (YS) was transferred to an outside hospital on two occasions (July 27 and August 10, 2010) to Rule Out Bowel Obstruction. There was evidence of inadequate nursing reassessments and monitoring of the status of this individual during the intervening period between the two transfers. 6. In general, the nursing documentation of significant changes in the physical condition of individuals did not include the time of notification of the General Medical Officer (e.g. RJ). **Compliance:**

			Partial; improved compared to the last review (except for medical and nursing care). **Current recommendations:** 1. Develop and implement corrective actions to address the process deficiencies in medical and nursing care outlined above. Include an update regarding the status of implementation of the facility's policies and procedures regarding provision of medical care and seizure management. 2. Continue to provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/ Interventions. 3. Continue to monitor each requirement in V.D.1 to V.D.6 based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates and weighted average compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 4. Present comparative data (mean %C for each indicator in current review period vs. last review period). 5. Ensure that the self-report contains a summary outline of the following: a) Number and types of Cognitive remediation interventions that are currently provided and plans to increase these interventions and b) Specific information regarding the assignment of Mall groups to individuals based on initial cognitive screening of the individuals. 6. Implement the facility's CAP of October 7, 2010 relative to

			section V.D.
MES	V.D.2	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	**Findings:** The facility presented self-assessment data based on the Clinical Chart Audit. The mean compliance rate (July and August 2010) was 80%. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Findings:** SEH reported a mean compliance rate of 61%. **Other findings:** Chart reviews by this expert consultant found examples in a few charts of progress in the formulation of treatment/ rehabilitation objectives since the last review: 1. "Will identify at least one symptom of his illness as evidenced by being able to state it to the group facilitator at the TLC once per week for 30 days" (JB); 2. "Will learn effective ways to manage her psychosis and mood disturbance without resorting to physical aggression as evidenced by use of her comfort plan" (CW); and 3. "Will maintain cognitive functioning as evidenced by picking out his own clothes each night for the next day for the next six weeks (GAH). Overall, however, the review found persistent deficiencies in the content of treatment/rehabilitation objectives. The following

			are some chart examples: 1. "Will begin to have awareness of her difficulties in making decisions for herself and to care for herself independently as evidenced by considering the medication the doctor has recommended, cooperating with treatment" (LD); 2. "Will increase her ability to manage emotional outbursts, agitation and frustration when communicating with staff (with the help of interpreter and/or other supports) as evidenced by rounds, staff reports, discipline reports and case manager interactions" (HJ); 3. "Will evidence a decrease in paranoia as evidenced by participating in therapy groups, participate in discussion regarding his payee situation and verbalize some insight into his mental illness and the need for treatment adherence in the community" (MMB); and 4. "Will have a reduction in his symptoms of psychosis to include his not responding to internal stimuli or believing that other are out to get him or poisoning his food as evidenced by his taking prescribed medications and his being observed not moving his lips as if he were responding to voices and an improvement in appetite and connection with others" (BGW). **Compliance:** Partial. **Current recommendations:** Same as above.
MES and RB (PSR/	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Findings:** The Therapeutic Progress Note (TPN) form in Avatar has been improved so that the name of the group is automatically populated in the note.

Mall)

The hospital has begun to audit TPNs and results generally indicate scores around or above 90%, with the exception of indicators for the TPN indicating where the service occurred (87%) and for including the verbatim intervention from the most recent IRP (79%). Since May 2010, the hospital's data indicates that TPNs are being completed within the correct time frame over 90% of the time, indicating that the hospital has been able to effectively remove the barriers to timely completion of the TPN.

Using the Clinical Chart Audit (July and August 2010), the facility reported a mean compliance rate of 84%.

In addition, SEH used the Therapeutic Progress Notes Audit to assess the individuals' participation in group activities relative to established objectives and interventions. The average sample was 15% of therapeutic progress notes each month (March to August 2010**)**. These notes are completed by group leaders from various disciplines (Psychiatry, Psychology, Rehabilitation, Social Work or Nursing). The following is an outline of the relevant indicators and corresponding mean compliance rates:

1.	Notes completed timely	67%
2.	Objective documented from last IRP	87%
3.	Intervention documented from last IRP	79%
4.	Number of sessions scheduled/attended indicated appropriately	99%
5.	Individual's participation was described (in a manner that informs the IRP)	95%
6.	Appropriate progress relative to the established objective	94%

			The facility reported that training was provided to nursing staff and a tip sheet developed regarding the documentation of the notes. **Other findings:** A review of interventions in medical records continued to find broad variability in the formatting of interventions, and it is hoped that the current IRP training program will lead to an improvement in this finding over the next six months. This expert consultant found some examples of improved formulation of interventions as follows: 1. "RN will facilitate Medication Group in TLC room to teach about the names, purpose, side effects of medications and improve understanding of the need for psychopharmacological treatment" (TL); 2. "OT will facilitate occupational therapy on the unit to assist Mr. H with task completion which will assist him with following directions to pick out his clothes each evening" (GAH); and 3. "Will provide Sensory Enrichment group on the unit to assist her with attention and concentration as evidenced by remaining in the group for a minimum of twenty minutes" (MA). The following are examples of interventions that were generic, did not align with the individual's assessed needs and had poor linkage with the IRP foci and objectives: 1. "Assess and review psychiatric needs; dispense medication and educate patient on medication needs, potential side effects and expectations. Also will provide supportive

			counseling as needed" (HJ); 2. "Provide psychiatric management focused on evaluating and treating Mr. S's symptoms, with medication and therapy, monitor response, titrate as needed. Encourage participation in therapy groups on the ward and in the transitional TLC" (HAS); 3. "Psychological assessment to clarify diagnosis, cognitive deficits" (RLS and HAS); 4. "Provide an opportunity for the patient to discuss life goals, needs and concerns and to identify barriers to discharge and remaining in the community. Discuss his concerns regarding allowing someone else to be his payee. Encourage time to evaluation of pros and cons(nursing intervention)" (MMB) (in this chart, there was no documentation that this intervention was implemented and the documentation of nursing intervention was limited to the assisting the individual to take medications and follow regulations on the unit); and 5. "Relaxation group with a focus on exploring various methods of relaxation to utilize on the ward and upon return to the community" (LD). **Compliance:** Partial. **Current recommendations:** 1. Same as above. 2. Continue to monitor this requirement using the Clinical Chart Audit and the Therapeutic Progress Notes Audit. Present aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted averages of %C. The data should be accompanied by analysis of low

			compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period). 4. Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. Present auditing data for this instrument according to instructions in Cell V.B.9.
RB	V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and	**Findings:** The hospital has only begun to collect this data, so results were not available for this tour, but should be available for review in 6 months. **Compliance:** Partial. **Current recommendations:** 1. Track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
MES	V.D.6	provide that each treatment plan integrates and	**Findings:**

		coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	Same as in V.D.1 through V.D.5. **Compliance:** Partial. **Current recommendations:** Same as in V.D.1 through V.D.5.

<table>
<tr><td></td><td colspan="3">E. Outcome-Driven Treatment Planning</td></tr>
<tr><td></td><td></td><td>By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:</td><td>Please see sub-cells for findings and compliance.</td></tr>
<tr><td>MES</td><td>V.E.1</td><td>revise the objectives, as appropriate, to reflect the individual's changing needs;</td><td>Findings:
The facility's IRP training module regarding Foci, Objectives and Interventions and the revised IRP Manual include instructions regarding the revision of the objectives to address the changing needs of the individuals.

The facility conducted self-assessment based on the Clinical Chart Audit (July and August). This audit was focused on the content of the IRP. The average sample was 13% of IRP reviews each month. The mean compliance rate was 59%.

The facility also assessed the process of the revision of the objectives by the IRP team during the IRP conference. Using the Observation Monitoring Audit, the facility assessed if the team reviewed progress on objectives (March to June 2010) and reported a mean compliance rate of 7%. In July 2010, the monitoring indicator was revised to address if the team based progress reviews/revisions recommendations on clinical observation and data. Using this indicator (July and August 2010), the facility reported a mean compliance rate of 86%.

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

<table><tr><td>Initials</td><td>IRP reviews</td></tr></table></td></tr>
</table>

			<table><tr><td>HJ</td><td>7/14 and 8/30/10</td></tr><tr><td>BGW</td><td>5/11 and 5/20/10</td></tr><tr><td>MMB</td><td>7/23 and 8/20/10</td></tr><tr><td>BJ</td><td>10/1 and 10/27</td></tr><tr><td>HAS</td><td>9/21 and 10/21/10</td></tr><tr><td>RLS</td><td>9/7 and 9/22/10</td></tr></table> This review found substantial compliance in five charts (HJ, BGW, MMB, HAS and RLS) and partial compliance in one (BJ) **Compliance:** Substantial. **Current recommendations:** 1. Continue to monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period). 3. Implement the facility's CAP of October 7, 2010 relative to section V.E.
MES	V.E.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Findings:** During this review period, SEH revised its Psychiatric Update Audit instructions to ensure that the psychiatrist's review of the individual's progress considers medication response and

			psychiatric status as well as progress towards treatment goals and specific behavioral or psychodynamic issues affecting progress. This revision adequately addressed this requirement. Using the Psychiatric Update Audit (March to August 2010), the facility reviewed two updates per psychiatrist per month (9% of the reassessments). The mean compliance rate was 99%. The indicator assessed if the Psychiatric Update accurately reflected the individual's response to treatment/progress. **Other findings:** Chart reviews by this expert consultant verified the facility's compliance data. **Compliance:** Substantial. **Current recommendations:** 1. Same as in V.E.1. 2. Continue to monitor this requirement using the Psychiatric Update Audit based on an adequate sample. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	V.E.3	review the goals, objectives, and interventions more frequently than monthly if there are clinically	**Findings:** Using the Clinical Chart Audit (July and August 2010, 13%

relevant changes in the individual's functional status or risk factors;

sample), SEH reported a mean compliance rate of 86% with this requirement. Other reviews relevant to this requirement were addressed in V.B.5.

Other findings:
Chart reviews by this monitor found that the Psychiatric Updates did not adequately implement this requirement due to deficiency in the documentation of important developments during the previous interval (see VI.A.1 and VI.A.7).

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

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

Initials	S/R	IRP reviews
AJ	7/1/10	8/9/10
SJ	8/11/10	8/17/10
TB	7/2/10	8/11/10
AP	7/26/10	8/5/10
AW	8/5/10	8/18/10

This review found that the IRP reviews did not specifically address the use of seclusion/restraint during the interval. However, these plans documented adequate modifications of interventions in response to the use of S/R to minimize future

<table>
<tr><td></td><td></td><td></td><td>risk. These modifications included the use of comfort plans, referrals for behavioral interventions, modification of existing behavioral interventions, neurology consultations, and/or use of the involuntary medication process.

Compliance:
Partial; improved compared to the last review.

Current recommendations:
Same as in V.E.1.</td></tr>
<tr><td>MES</td><td>V.E.4</td><td>provide that the review process includes an assessment of progress related to discharge; and</td><td>Findings:
SEH developed an IRP training module dedicated to discharge planning. The revised IRP Manual and module provide adequate instructions regarding the implementation of this requirement.

The facility provided competency-based training to its IRP teams (August and September 2010) regarding discharge planning. The following is a summary of the data regarding results of this training (15 hours of training were provided to all disciplines):

<table>
<tr><th>Discipline</th><th># of attendees and attendance rate*</th><th># competent (of attendees)</th></tr>
<tr><td>Clinical Administrator</td><td>10 (83%)</td><td>10 (100%)</td></tr>
<tr><td>Psychiatry</td><td>21 (95%)</td><td>20 (95%)</td></tr>
<tr><td>Psychology</td><td>12 (86%)</td><td>12 (100%)</td></tr>
<tr><td>Nurse Manager</td><td>8 (100%)</td><td>8 (100%)</td></tr>
<tr><td>Social Work</td><td>12 (92%)</td><td>12 (100%)</td></tr>
<tr><td>Total</td><td>63 (91%)</td><td>62 (98%)</td></tr>
</table>
*of all employees required to attend</td></tr>
</table>

			Using the IRP Observation Monitoring Audit, the facility reviewed an average sample of 7% of all IRPs each month (March to June 2010) to assess compliance with this requirement. The following is an outline of the indicators and corresponding compliance rates (in parenthesis): 1. Discuss in phase I (of the IRP conference) discharge plans or step down (transfer to a less restrictive unit) at SEH (99%) and 2. Individual participated in discharge planning/step down discussions (88%). In July and August, the facility used a revised IRP Observation Monitoring Audit and reviewed an average sample of 10% of all IRPs each month. The mean compliance rate was 79% with an indicator that is well-aligned with this requirement. **Other findings:** This expert consultant reviewed the charts of six individuals (BJ, TL, CW, RLS, JC and LD) to assess documentation of the teams' review of the individuals' progress towards discharge. As mentioned earlier, the present status section regarding review of progress towards discharge (and barriers to discharge) was either blank (RLS and BJ), included irrelevant information (JC) or provided criteria that were generic, not measurable and unattainable (TL). In general, there was no adequate documentation of the team's discussion of the individual's progress or strategies to overcome barriers to discharge. The following are examples of inadequate discharge criteria that were found during this review: 1. "Good behavioral control" (TL); 2. "Sufficient reduction in psychotic symptomatology" (TL);

			3. "Will demonstrate effective ways to manage her mood and psychotic (disorder) as evidenced by consistent compliance with medical, psychiatric and psychosocial treatment" (CW); 4. "Increase in thought organization, decrease in persecutory/paranoid delusions and increased insight into her diagnosis and need for further treatment" (LD). **Compliance:** Partial. **Current recommendations:** 1. Continue to provide aggregated data regarding competency-based training of all core members of the IRP teams relevant to this requirement. 2. Monitor this requirement using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Findings:** Same as in Section V.A.1 to V.A.1.5, as in V.B.1 and as in V.E.4. Using the above-mentioned process of IRP Observation Monitoring, the facility provided self-assessment data that are summarized as follows:

			1. Team discussed if individual was benefiting from therapies (88%, March to June 2010); 2. If individual was not benefiting, team revised pertinent interventions (76%, March to June 2010) and 3. Team based progress reviews and revision recommendations on clinical observation and data collected (86%, July and August 2010). **Compliance:** Partial. **Current recommendations:** 1. Same as in Section V.A.1 to V.A.1.5. 2. Same as in V.B.1. 3. Same as V.E.4. 4. Monitor this requirement using both process observation and clinical chart audit tools based on an adequate sample. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 5. Present comparative data (mean %C for each indicator in current review period vs. last review period).

	VI. Mental Health Assessments		
MES and RB		By 18 months from the Effective Date hereof, SEH shall ensure that each individual shall receive, after admission to SEH, an assessment of the conditions responsible for the individual's admission. To the degree possible given the obtainable information, the individual's treatment team shall be responsible, to the extent possible, for obtaining information concerning the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and treatment plans in accordance with newly discovered information.	**Summary of Progress:** 1. SEH has made sufficient progress in the finalization of provisional psychiatric diagnoses. 2. SEH has made sufficient progress in the documentation of the admission risk assessments, as part of the Comprehensive Initial Psychiatric Assessment (CIPA) 3. SEH has made further progress in the organization and presentation of self-assessment data based on the CIPA, Psychiatric Update and Inter-Unit Transfer audit tools. 4. SEH is in the process of modifying the format for the Psychiatric Update to improve documentation of psychiatric reassessments. 5. The SEH Corrective Action Plan of October 7, 2010 contained adequate steps to assist the facility in achieving compliance with the requirements in this section. 6. Appropriate auditing tools and auditing data now exist for all psychological assessments. 7. Psychology Department auditing data indicates that completion of the Initial Psychological Assessment and Neuropsychological Assessments continue to fall below the best-practices threshold established by the hospital. 8. In most of the content areas of the Rehabilitative Services Assessment, substantial compliance has been achieved, although problems in timely completion of these assessments were noted. 9. Most of the content areas of the Social Work Initial Assessment show marked improvement, but problems persist in sections pertaining to the successful resolution of discrepancies in social history data. 10. Initial assessments for all disciplines need to recommend specific group treatment offerings from the online course catalogue.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Tyler Jones, MD, Director, Psychiatric Services Reviewed: 1. Charts of the following 49 individuals: AB, AO, BB, BGW, BJ, BW, CAM, CB, CL, CW, DT, DW, ED, FC, FF, GF, HAS, HH, HJ, ID, IJ, JC, JD, JF, JM, JT, LD, LF, LR, LT, MJ, MMB, MR, NT, OA, PC, PJJ, PS, RG, RH, RLS, TB, TJ, TL, TW, VS, WB, WHM and WW 2. Saint Elizabeths Hospital (SEH) Compliance (self assessment) Report, October 7, 2010 3. SEH Corrective Action Plan, October 7, 2010 4. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians 5. SEH Policy #602.1-08: Assessments, revised September 14, 2010 6. Comprehensive Initial Psychiatric Assessment Audit Form, March 11, 2010 7. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions May 1, 2010 8. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions September 1, 2010 9. Comprehensive Initial Psychiatric Assessment Summary Data March to August, 2010 10. Psychiatric Update Audit Form July 29, 2010 11. Psychiatric Update Audit Form September 1, 2010 12. Psychiatric Update Audit Operational Instructions, not dated 13. Psychiatric Update Audit Summary Data; March to August

			2010 14. Inter-Unit Transfer Audit Summary Data; March to August 2010 15. SEH Dementia NOS Review; 16. SEH Initial Psychological Assessment Audit summary data (March to August, 2010) 17. SEH Medication Monitoring Audit summary data (March to August 2010) 18. SEH outline of CME activities since January 2010 during this review period 19. SEH Psychiatry Caseload summary data September 21, 2010
MES	VI.A.1	By 24 months from the Effective date hereof, SEH shall develop and implement policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments, including a plan of care that outlines specific strategies, with rationales, adjustments of medication regimens, if appropriate, and initiation of specific treatment interventions;	**Findings:** During this review period, SEH revised its policy regarding Assessments (#602.1-08) to align with its Policy #601-02 regarding Medical Records. Both policies include the same timeframes for completion of psychiatric assessments and reassessments. These timeframes are in compliance with requirements of the Agreement. The facility used its Comprehensive Initial Psychiatric Assessments (CIPA) and Psychiatric Update Auditing tools to assess its compliance with the requirements regarding timeliness and content of the psychiatric assessments and reassessments (updates). The format of the Psychiatric Update was modified to improve the clinical flow of the document and the operational instructions were recently revised to improve alignment with requirements of the Agreement (e.g. regarding the reassessment of the individual's response to treatment/progress). In general, both audits included adequate indicators and operational instructions. Using the CIPA Audit, the facility reviewed an average sample of

19% of admissions during each month (March to August 2010). The following is an outline of the indicators and corresponding mean compliance rates:

1.	Completed within 24 hours of admission	100%
2.	Legal status	98%
3.	Psychiatric history	98%
4.	Information from prior treatment setting	84%
5.	History includes adverse reaction to medications	74%
6.	History of present illness	100%
7.	Medical history	91%
8.	Information about current medications	56%
9.	Substance abuse history	98%
10.	Substance abuse assessment reflects stage of change	95%
11.	Family history	79%
12.	Social and developmental history	79%
13.	Mental status examination (all components included)	88%-100%
14.	Consistency between diagnosis and clinical presentation	91%
15.	Strengths	86%
16.	Risk associated with medication regimen	86%
17.	AIMS test	77%

The following is a summary of the data derived from the Psychiatric Update Audit (March to August). The data were based on a target sample of two updates per Psychiatrist per month (average sample of 9% of the updates).

1.	Completed every 30 days	97%

			2.	Mental status examination (all components included but no data presented for the individual's affect and no explanation provided)	94% to 100%
			3.	Use of Stat medications or restraint/seclusion is addressed specifically if and how the benefits out weight the risks	68%
			4.	Adverse reactions noted, as appropriate	88%
			5.	Risk Assessment sections completed	95%
			6.	Response to treatment/progress completed	99%
			7.	Diagnosis reflects current clinical data or updated based on current data	98%
			8.	Documented justification for R/O or NOS diagnosis	82%
			9.	Current medication regimen accurately described	99%
			10.	There is rationale for use of anticholinergics for individuals with cognitive disorder	84%
			11.	Abnormal laboratory levels are addressed	95%
			12.	Pharmacological plan of care reflects diagnosis, mental status examination and response to treatment	99%
			13.	Rationale for use of benzodiazepines for individuals with substance use disorders	88%
			14	Explanation for the medication administered involuntarily	88%
			15.	Noted by attending physician if update completed by a trainee	85%
			Overall, the facility's data showed improvements in the content of the assessments/reassessments and the monitoring process. The facility presented an adequate review of compliance data compared to the previous reporting period and expects		

			improvement in compliance with all items as a result of further modification of the Psychiatric Update format as well as ongoing monitoring. **Other findings:** This expert consultant reviewed the charts of 10 individuals (JM, BGW, MMB, BJ, HAS, TL, CW, RLS, JC and LD). The reviews found that the assessments and reassessments were, in general, timely but the content of the assessments and reassessments still fell short of compliance with the requirements of the Agreement as illustrated by findings of deficiencies in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. 2. Continue to monitor the timeliness and content of psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period). 4. Implement SEH CAP of October 7, 2010 relative to the requirements in VI.A.2

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>MES</td><td>VI.A.2</td><td>By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;</td><td>Findings:
SEH presented an outline of different components of the risk assessment in the CIPA and the Initial Psychological Assessment (IPA) Audits. The IPA Audit was based on an average sample of 12% of the assessments (March to August 2010). The following is a summary:

<table>
<tr><td colspan="3">CIPA</td></tr>
<tr><td colspan="3">Were the following specific subsections of the risk assessment completed?</td></tr>
<tr><td>1.</td><td>Self-injury</td><td>98%</td></tr>
<tr><td>2.</td><td>Completed suicide</td><td>98%</td></tr>
<tr><td>3.</td><td>Physical aggression</td><td>100%</td></tr>
<tr><td>4.</td><td>Sexual aggression</td><td>100%</td></tr>
<tr><td>5.</td><td>Elopement</td><td>100%</td></tr>
<tr><td>6.</td><td>Appropriate precautions for each type of risk</td><td>95%</td></tr>
</table>

<table>
<tr><td colspan="3">Initial Psychological Assessment</td></tr>
<tr><td>1.</td><td>Assessment of Violence risk</td><td>100%</td></tr>
<tr><td>2.</td><td>Findings of violence risk</td><td>86%</td></tr>
<tr><td>3.</td><td>Assessment of suicide risk</td><td>96%</td></tr>
<tr><td>4.</td><td>Findings of suicide risk</td><td>89%</td></tr>
</table>

Other findings:
This expert consultant reviewed the Comprehensive Psychiatric Assessments in the charts of 10 individuals (JM, BGW, MMB, BJ, HAS, TL, CW, RLS, JC and LD). In general, the admission risk assessments were completed in a timely and adequate manner. The indicators of the risk assessment adequately address this requirement.</td></tr>
</table>

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

Current recommendations:
1. Same as VI.A.1.
2. Continue to monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
3. Present comparative data (mean %C for each indicator in current review period vs. last review period).</td>
</tr>
<tr>
<td>MES</td>
<td>VI.A.3</td>
<td>By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;</td>
<td>Findings:
SEH presented self-assessment data that were relevant to this requirement using the previously-mentioned CIPA and Psychiatric Update Audits (March to August 2010). The following summarizes the facility's compliance data:

<table>
<tr><td colspan="3">CIPA</td></tr>
<tr><td>1.</td><td>All (diagnosis) Axes completed</td><td>93%</td></tr>
<tr><td>2.</td><td>Diagnosis reflects the clinical presentation</td><td>91%</td></tr>
</table>

<table>
<tr><td colspan="3">Psychiatric Update</td></tr>
<tr><td>1.</td><td>Diagnosis accurately updated and completed</td><td>97%</td></tr>
<tr><td>2.</td><td>Diagnosis reflects current clinical data or changed/updated based upon change in current data</td><td>98%</td></tr>
</table>
</td>
</tr>
</table>

3.	All (diagnosis) Axes completed	97%
4.	Adequate justification for R/O or NOS diagnosis (Axis I)	82%

In addition, the facility presented results of the Medical Director's survey regarding the number of individuals receiving Axis I diagnosis listed as R/O, NOS or Deferred during this review period compared to the last review period.
The following is a summary:

Indicator	March 18, 2010	September 23, 2010
Total # of individuals in care	333	314
Total # with Axis I diagnosis	333	313
R/O diagnosis >90 days	7	4
NOS diagnosis >90 days	46	34
Deferred diagnosis >90 days	7	0

The data demonstrated a downward trend in the number of individuals receiving unspecified diagnosis since the last reporting period. In addition to these data, SEH conducted a special review of individuals diagnosed with Dementia NOS and Amnestic Disorder NOS. This review identified 14 individuals and found that only three of them were not evaluated by the departments of Neurology and/or Neuropsychology, these individuals were referred for neuropsychological assessment.

This expert consultant reviewed the charts of 25 individuals who have received diagnoses listed as NOS or R/O during this reporting period. The following is an outline of the reviews:

Initials	**Diagnosis**
IJ	Psychotic Disorder NOS finalized to

	Schizophrenia, Paranoid Type
WHM	Psychotic Disorder NOS finalized as Schizoaffective Disorder, Bipolar type
MR	Psychotic Disorder NOS finalized as Substance-induced Mood Disorder
AB	Psychotic Disorder NOS finalized to Schizophrenia, Paranoid Type
BW	Dementia NOS
FC	Dementia NOS
BB	Dementia NOS
TB	Dementia NOS
GF	Dementia NOS
RG	Dementia NOS
PS	Dementia NOS
DW	Cognitive Disorder NOS finalized as Vascular Dementia with Delusions
JC	Cognitive Disorder NOS (diagnosis for <90 day)
WW	Cognitive Disorder NOS and Moderate mental Retardation
JF	Cognitive Disorder NOS (neuropsychological testing recommended change to severe Mental Retardation)
LT	Cognitive Disorder NOS (diagnosis finalized as Dementia Due to Traumatic Brain Injury)
HJ	Impulse Control Disorder NOS changed to Intermittent Explosive Disorder
AO	Impulse Control Disorder NOS changed to Borderline Personality Disorder
LR	Impulse Control Disorder
MJ	Impulse Control Disorder changed to Borderline Personality Disorder
NT	Mood Disorder NOS (diagnosis for <90days),

	finalized to Bipolar Disorder With Psychotic Features NOS (AVATAR did not update diagnosis)
CAM	Mood Disorder NOS finalized to Mood Disorder Due to General Medical Condition (HIV)
VS	Depressive Disorder NOS
RH	Depressive Disorder NOS (diagnosis <90 days)
RG	Bipolar Disorder NOS (diagnosis for <90 days)
CB	Medication-induced Movement disorder NOS finalized as Neuroleptic-induced Tardive Dyskinesia

The review found substantial compliance in 20 charts (IJ, WHM, MR, AB, BW, FC, BB, GF, RG, PS, DW, JC, AO, LR, MJ, NT, CAM, VS, RH and CB) and partial compliance in five (TB, WW, JF, LT and HJ). The charts that did not meet substantial compliance included evidence of inadequate tracking of the cognitive functions of the individual using MMSE (LT), lack of follow up to update the individual's discharge diagnosis based on results of neuropsychological testing (JF), inadequate justification of medication regimen based on current diagnosis (WW, TB and HJ).

Chart reviews by this expert consultant found that only one individual had "no diagnosis" on Axis I. There was adequate justification for this diagnosis (DT).

Compliance:
Substantial.

Current recommendations:
1. Same as in VI.A.1 and VI.A.6.
2. Continue to monitor diagnostic accuracy in psychiatric

			assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period). 4. Provide an outline of the average number of individuals in each of the following categories (during the review period compared with the previous period): a) All individuals in care; b) Individuals with "no diagnosis" on Axis I; c) Individuals receiving Axis I diagnosis listed as Deferred for 90 or more days; d) Individuals receiving Axis I diagnosis listed as R/O for 90 or more days; and e) Individuals receiving Axis I diagnosis listed as NOS for 90 or more days. 5. Ensure timely updates of diagnoses on AVATAR.
MES	VI.A.4	By 18 months from the Effective Date hereof, SEH shall ensure that psychiatric assessments are consistent with SEH's standard diagnostic protocols;	**Findings:** Same as in V.A.3 **Compliance:** Substantial. **Current recommendations:** Same as in V.A.3.
MES	VI.A.5	By 12 months from the Effective Date hereof,	**Findings:**

		SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;	Same as in VI.A.1 to VI.A.3. **Other findings:** This expert consultant reviewed the charts of 10 individuals (JM, BGW, MMB, BJ, HAS, TL, CW, RLS, JC and LD) who were admitted during this review period. In general, the content of the assessments was adequate except for the lack of information (or follow up to complete this information) regarding the following: 1. Medical history; 2. Psychosocial history; and 3. Specifics regarding abnormalities of thought content. **Compliance:** Partial. **Current recommendations:** 1. Same as in VI.A.1 to VI.A.3. 2. Develop and implement corrective actions to address the deficiencies outlined in findings above.
	VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
MES	VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Findings:** Same as in VI.A.1 and VI.A.3. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1 and VI.A.3). **Current recommendations:**

<table>
<tr><td></td><td></td><td></td><td>Same as in VI.A.1 and VI.A.3.</td></tr>
<tr><td>MES</td><td>VI.A.6.b</td><td>all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments;</td><td>Findings:
SEH presented self-assessment data that were relevant to this requirement using the previously-mentioned CIPA and Psychiatric update Audits (March to August 2010). The following summarizes the facility's compliance data:

<table>
<tr><td colspan="3">CIPA</td></tr>
<tr><td>1.</td><td>CIPA is signed by the attending Psychiatrist.</td><td>100%</td></tr>
<tr><td>2.</td><td>If CIPA is completed by a resident, there is a note from the attending Psychiatrist</td><td>72%</td></tr>
</table>

<table>
<tr><td colspan="3">Psychiatric Update</td></tr>
<tr><td>1.</td><td>If completed by a resident, there is documented evidence that the update was reviewed by the attending Psychiatrist.</td><td>83%</td></tr>
<tr><td>2.</td><td>If completed by a resident, there is a note by the attending Psychiatrist.</td><td>85%</td></tr>
</table>

Although still short of compliance, the data showed positive trend since the last review.

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

Compliance:
Partial; improved compared to the last review.

Current recommendations:
1. Continue to monitor implementation of this requirement in</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>psychiatric assessments and reassessments based on adequate samples. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
2. Present comparative data (mean %C for each indicator in current review period vs. last review period).</td></tr>
<tr><td>MES</td><td>VI.A.6.c</td><td>differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and</td><td>Findings:
The facility's self-assessment data regarding this requirement were presented in VI.A.3.

Other findings:
The following is an outline of relevant CME education that was provided at SEH since January 2010:

<table>
<tr><th>Title</th><th>Speaker and Affiliation</th><th>Date</th></tr>
<tr><td>Schizophrenia, Treatment Resistance</td><td>Robert Conely, MD, University of Maryland</td><td>1/6/10</td></tr>
<tr><td>Psychiatric Disorders in HIV clinic</td><td>Glenn Treisman, MD, John Hopkins University</td><td>3/3/10</td></tr>
<tr><td>Recognizing and exploring dissociative processes</td><td>Richard Chefetz, MD</td><td>5/5/10</td></tr>
<tr><td>Treatment and management of sex offenders</td><td>Judith Becker, PhD, University of Arizona</td><td>6/2/10</td></tr>
<tr><td>Paranoia and violence</td><td>Phillip Resnick, MD</td><td>6/14/10</td></tr>
<tr><td>Psychiatric roles in</td><td>Bradley Johnson, MD,</td><td>7/7/10</td></tr>
</table>
</td></tr>
</table>

			<table><tr><td>treating sex offenders</td><td>Arizona Community Protection & Treatment Center</td><td></td></tr></table> **Other findings:** Same as in VI.A.3. **Compliance:** Substantial. **Current recommendations:** 1. Same as in VI.A.3. 2. Continue to provide documentation of CME training during the review period, including dates and titles of courses and names of instructors and their affiliation.
MES	VI.A.6.d	each individual's psychiatric assessments, diagnoses, and medications are clinically justified.	**Findings:** Same as in VI.A.1 through VI.A.6.a and VI.6.c. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1 through VI.A.6.a and VI.6.c). **Current recommendations:** Same as in VI.A.1 through VI.A.6.a and VI.6.c.
MES	VI.A.7	By 24 months from the Effective Date hereof, SEH shall develop protocols to ensure an ongoing and timely reassessment of the psychiatric and biopsychosocial causes of the individual's continued hospitalization.	**Findings:** During this review period, SEH modified its format for the Psychiatric Update (Reassessment) as described in VI.A.1. The facility used the Psychiatric Update Audit to assess compliance with this audit. In addition to the data provided in VI.A.1 and VI.A.3, the following data are also relevant to this requirement:

			1.	Subjective findings are completed and consistent with the relevant progress notes	100%
			2.	Target symptoms completed and accurate	95%
			3.	Medication response completed	98%
			4.	Psychopharmacological plan of care adequately addressed the monitoring /side effects of antipsychotic medications	90%
			5.	Psychopharmacological plan of care adequately addressed the use of > two antipsychotic medications and/or three or more psychiatric medications	88%
			6.	There is adequate justification for continued hospitalization	98%

In general, the Psychiatric Update data showed a positive trend since the last review.

In addition, the Medication Monitoring Audit by the Pharmacy Department was used as part of self-assessment. During this review period, the facility modified this audit. In August 2010, the facility audited samples representing medication records from each unit (instead of reviewing one unit's medication records each month). The average sample was 6% of the individuals served for at least one day each month (March to August 2010). This audit found that 2% of the individuals (three cases) received PRN medications during the review period contrary to the facility's policy. SEH reported that this practice was discontinued in two cases before they were discovered and in one case once it was discovered.

Other findings:
This consultant reviewed the most recent Psychiatric Update in the charts of the following individuals: LR, JD, TJ, CL, JT, MJ,

			WB, FC, PC, ID, BJ, FF, OA, PJJ, HH, VS, ED, TW and LF). These updates were completed by different practitioners. The review found general evidence of progress since the last review period. In particular, improvements were noted in the following areas: 1. Tracking results of rating instruments, when clinically indicated; 2. Specifics regarding current target symptoms; 3. Specifics regarding abnormalities of though content; 4. Review of the use of Stat medications; 5. Rationale for prescribed medications, including high risk treatment; 6. Review of specific behavioral/psychodynamic interventions, including consideration of behavioral interventions, when indicated; 7. Review of the individuals' progress towards treatment goals; 8. Review of risk factors; and 9. Plan of care based on a review of the individuals' progress. However, most of the reassessments lacked adequate information in the section titled Overall Assessment/ Changes in the Patient's Condition (since the last assessment). This section is a critical component of the update as it reflects the practitioner's review of significant developments during the previous interval in order. This review is essential to inform current diagnostic and treatment strategies. The facility's Director of Psychiatric Services was in the process of modifying the template to address this issue and to improve the overall flow of clinical data in this document. If properly implemented, the modified format can be sufficient to ensure compliance with this requirement.

			Compliance: Partial; improved compared to the last review. **Current recommendations:** 1. Implement corrective actions to improve the review of clinical developments during the interval and the clinical flow of data in the Psychiatric Update. 2. Same as in VI.A.1. 3. Continue to monitor this requirement using the Psychiatric Update and Medication Monitoring Audits based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 4. Present comparative data (mean %C for each indicator in current review period vs. last review period).

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Richard Gontang, Ph.D., Chief of Psychology Reviewed: 1. Medical Records: TL, HA-S, AB, JH, DJ, HM, CA, IB, MB, LH, RB, JD, JD2, LE, RE, FF, DH, RN, KP, TR, LC, JF, RG, WJ, LM, RM, PN, CP, AS, DT 2. Initial Psychology Assessment Audit Tool and Results 3. Psychology Evaluation Audit Tool and Results 4. Neuropsychological Evaluation Audit Tool and Results 5. Risk Assessment Audit Tool and Results
RB	VI.B.1	By 24 months from the Effective Date hereof, SEH shall ensure that individuals referred for psychological assessment receive that assessment. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, risk assessments and personality/differential diagnosis assessments, rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	**Findings:** Appropriate auditing tools and auditing data now exist for all psychological assessments (Initial Psychological Assessments [IPA], Focused Assessments, Risk Assessments and Neuropsychological Assessments). The hospital's auditing data showed that timeliness in completing the IPAs remained a problem, and this was verified by an independent review of 10 charts. This same problem was also apparent in the hospital's data regarding the timely completion of Neuropsychological Assessments, as only 33% were found to be completed within 45 days. An independent review also found that these assessments were frequently placed in the medical record without indicating the date on which the report was signed by the neuropsychologist. In contrast, the hospital's data showed that focused psychological assessments were routinely completed within 30 days over the last 6 months. Facility staff suggested that they lengthen the timelines for completion of neuropsychological assessments to 90 days, as a way to remedy

			this situation. The DOJ consultant does not believe that this is a viable solution to the problem as it would have the effect of delaying services to individuals in care beyond acceptable community standards and place individuals at risk for inappropriate or insufficient treatment. **Compliance:** Partial. **Current recommendations:** 1. Determine the barriers to the timely completion of IPAs, both Part A and Part B and the timely completion of neuropsychological assessments and implement appropriate corrective action plan. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
	VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments shall:	Please see sub-cells for findings and compliance.
RB	VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Findings:** The hospital's data indicated that only about 60% of focused assessments explicitly stated the purpose for which they are performed or the referral question, and the auditing form for neuropsychological assessments did not include this item. An independent review of recently completed focused and neuropsychological assessments found that 100% of them had accurately identified the purpose for which they were

			performed. **Compliance:** Partial, due to hospital data. **Current recommendations:** 1. Change the audit form for neuropsychological assessments to include an audit of the referral question/purpose of the assessments. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.b	be based on current and accurate data;	**Findings:** In all reviewed psychological assessments, it was independently found that they were based on current and accurate data. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

RB	VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Findings:** This requirement was met in all reviewed risk assessments. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Findings:** The IPAs do not routinely recommend specific treatment groups form the online course catalogue. On the basis of the hospital's data and an independent review, focused psychological assessments did not routinely provide answers to the referral questions, but neuropsychological assessments did provide such answers. **Compliance:** Partial. **Current recommendations:** 1. Identify barriers to providers directly addressing the referral question in focused psychological assessments and institute a corrective action plan. 2. Identify barriers to IPA providers recommending specific

			groups and institute a corrective action plan. 3. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Findings:** All reviewed assessments continued to include a summary of the empirical basis for conclusions. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	**Findings:** Completed **Compliance:** Substantial. **Current recommendations:**

			None needed.
RB	VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Findings:** Based on data provided by the Psychology Department, 96% of those individuals in care identified as needing a psychological assessment now have an up-to-date psychological assessment in their medical record. **Compliance:** Substantial. **Current recommendations:** None needed.
RB	VI.B.5	By 24 months from the Effective Date hereof, when an assessment is completed, SEH shall ensure that treating mental health clinicians communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.	**Findings:** The audit tool for neuropsychological assessments does not contain this item. The hospital's data indicated that there was evidence of the communication of the results of focused assessments in only 33% of audited cases. An independent chart review found that the signed form acknowledging receipt of focused and neuropsychological assessments could be located in about 80% of reviewed records, but in the majority of cases, the form was not checked off to indicate the treatment team's response to the recommendations of these assessments. **Compliance:** Partial. **Current recommendations:** 1. Determine barriers to completing the acknowledgement sheet and institute corrective action plan. 2. Develop a method for auditing these sheets for completeness.

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

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: Crystal Robinson, MT-BC, Director of Rehabilitation Services Reviewed: 1. Charts: TL, HA-S, AB, JH, DJ, HM, CA, IB, MB, LH 2. Rehabilitation Services Audit Tool and Results
RB	VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.	**Findings:** Both hospital data and data provided by an independent chart review found that completion of the RSA within the timelines indicated in policy occurred about 80% of the time. The Director of Rehabilitative Services has instituted a practice of reviewing all completed RSAs for timeliness with appropriately individualized corrective action plans as needed. **Compliance:** Partial. **Current recommendations:** 1. Continue with present corrective action plan. 2. Continue to present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	Please see sub-cells for compliance findings.

RB	VI.C.2.a	be accurate as to the individual's functional abilities;	**Findings:** Both the hospital's data and an independent review found that all RSAs achieved this standard. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Findings:** Both the hospital's data and an independent review found that all RSAs achieved this standard. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Findings:** Both the hospital's data and an independent review found that all RSAs achieved this standard. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
RB	VI.C.2.d	provide specific strategies to engage the individual in appropriate activities that he or	**Findings:** While strategies were provided in all reviewed RSAs, these

		she views as personally meaningful and productive.	tended to be generic and not individualized. For example, recommendations frequently said: "Provide Music Therapy, Dance Therapy and Art Therapy" without any indication as to how this would specifically benefit the individual based on his/her current level of functioning. The Director of Rehabilitative Services indicated that the fact that clinicians now have access to the online course catalogue will help improve the RSAs in this area. **Compliance:** Partial. **Current recommendations:** Continue to present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.C.3	By 24 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at SEH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, if indicated, referred for an updated rehabilitation assessment.	**Findings:** This has been accomplished. **Compliance:** Substantial. **Current recommendations:** None needed.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Harriet Moore, LICW, Social Work Supervisor 2. Maura Gaswirth, LICSW, Social Work Supervisor Reviewed: 1. Medical Records: TL, HA-S, AB, JH, DJ, HM, CA, IB, MB, LH 2. Social Work Initial Assessment Audit Tool and Results
RB	VI.D	By 18 months from the Effective Date hereof, SEH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors	**Findings:** The hospital's data found that the SWIA is not being routinely completed in a timely manner, although about 80% of those independently reviewed were found to have been completed within the 5-day timeframe, which appears to reflect the success of corrective action plans developed by the SW Department, and the fact that there is currently only one SW vacancy. Many parts of the SWIA demonstrate increased compliance based on both the hospital and independent reviewer data (at or above 80%). Problems continue to exist with the resolution of inconsistencies in the social history, however, as the hospital's data found compliance with this provision of the Settlement Agreement to average about 50% over the last 3 months, and an independent review found that these sections of the SWIA were frequently left blank. In such cases, it is not clear if this is meant to indicate that no discrepancies were found or if the social worker completing the assessment had simply skipped this section. The social work supervisors presented an acceptable corrective action plan for providing ongoing supervisory support and education to social workers who were having trouble achieving an acceptable level of compliance in completed SWIAs. Additionally, the hospital has increased the

			requirements for social workers such that all must be licensed. **Compliance:** Partial. **Current recommendations:** 1. Continue with current corrective action plan. 2. Specify in the directions for the SWIA that the section on discrepancies must contain an entry, even if the entry is "No discrepancies were identified." 3. Continue to present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	VII. Discharge Planning and Community Integration		
MLS		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The hospital has continued to reduce its inpatient census. 2. Since the last review, there has been progress in addressing the needs of individuals with housing and/or nursing home barriers and the number of individuals considered "resistive to discharge." 3. The "Community Integration Meetings" where personnel from DMH, SEH and Community agencies review "discharge ready individuals" with regard to roles, responsibility and communication have been significantly improved. 4. The hospital continues to struggle with discharge planning at the point of admission. There needs to be a stronger connection between diagnosis and assessment and the development of specific interventions documented in the IRP that will result in community integration and discharge. There has been improvement regarding the arrangement of community services and supports for discharge ready consumers between SEH social workers, DMH and community agencies (CSAs). 5. SEH has given its Social Work department significant attention with regard to sufficient staffing levels, orientation concerning community resources, support in mitigating barriers to discharge for consumers, and improved communication with community providers. 6. The process for resolving clinical disagreements between hospital and community agencies with regard to discharge planning/community placements and for reviewing individuals with multiple admissions needs to be strengthened. 7. A number of positive revisions have been made to reporting/monitoring/audit tools which are adequate. IRP training occurred in summer, 2010.
MLS			**Methodology:** <u>Interviewed</u>:

			1. Jana Berhow, Director of Integrated Care, DMH 2. Steve Lerch and staff of New Directions 3. Sean Favretto, McLendon Center 4. Harriet Moore, Social Work Supervisor, SEH 5. Clo Vidoni-Clark, Director of Treatment Programs, SEH 6. Maura Gaswirth, Social Work Supervisor, SEH 7. Andres Marquez-Lara, Director of Consumer Affairs, SEH 8. Katrina Carter, Social Worker, SEH 9. Sheila Stone, TLC Administrator, SEH 10. Denise Brown, Social Worker, SEH 11. ACT Team, clinical and administrative staff at Green Door, CSA <u>Reviewed</u>: 1. The charts of current and discharged consumers: BR, JC, CM, JM, JH, BW, AH, JA, HH, MJ, RH, TS, JR, JS, AS, EW, HL, OA, CW, DT, JF, and KB. 2. SEH Compliance Report Tab #1, IRP Training Outlines and Data 3. SEH Compliance Report Tab #7, Clinical Formulation Update Avatar Report Forms and Instructions 4. SEH Compliance Report Tab #8 IRP Monitoring Observation Audit Tools (Feb 10 and July 10 versions)/Instructions 5. SEH Compliance Report Tab #9 IRP Monitoring Observation Audit Results 6. SEH Compliance Report Tab #31 Social Work Initial Assessment (SWIA) Avatar Report Form and Instructions 7. SEH Compliance Report Tab #32 Social Work Initial Assessment (SWIA) Audit Tool/Instructions 8. SEH Compliance Report Tab #33 Social Work Audit Results (both for initial assessment and update) 9. SEH Compliance Report Tab #34 Social Work Update Avatar Report Form and Instructions 10. SEH Compliance Report Tab #35 Social Work Update Audit Tools 11. SEH Compliance Report Tab #36 Audit Sample Plan

			12. SEH Compliance Report Tab #42 List of Vacancies Approved to Be Filled 13. SEH Compliance Report Tab #44 Therapeutic Progress Note Avatar Report Form and Operational Instructions 14. SEH Compliance Report Tab # 45 Therapeutic Progress Note Audit Tool/Instructions 15. SEH Compliance Report Tab #47 Wellness and Recovery Guide (Handbook for Individuals in Care) 16. SEH Compliance Report Tab #67 Discharge Audit Tool with Instructions 17. SEH Compliance Report Tab #68 Discharge Audit Results 18. SEH Compliance Report Tab #69 TLC Catalogue and Ward Based Activities 19. SEH Compliance Report Tab #72 Discharge List Planning Log 20. SEH Compliance Report Tab #73 DMH, Division of Integrated Care Hospital Post Discharge Care Audit Results 21. SEH Compliance Report Tab #79 List of Individuals in Care Attending Community Day Treatment Programs 22. SEH Compliance Report Tab #81 Revised Hospital Discharge Plan of Care Instructions 23. SEH Compliance Report Tab #83 DMH, Division of Integrated Care, Discharge Process Protocol/Practice Standards 24. SEH Compliance Report Tab #84 Grand Rounds Training Schedule 25. SEH Compliance Report Tab #164 "Working Together: A Partnership for Community Integration" 26. SEH Compliance Report 6 27. SEH Corrective Action Plan <u>Observed</u>: 1. DMH-SEH Community Integration Meeting 2. Team Meeting of Annex B for IRP review of ED 3. Team Meeting of Unit 1E for IRP review of TS 4. Therapeutic Learning Center (transitional) during active period

			(late morning) 5. Annex A/B 6. Visited Green Door, New Directions and McLendon Day Center 7. Visited off-grounds transitional apartment program
MLS	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Current Findings:** 1. There have been improvements to the IRPs. However, the IRPs and record documents reviewed do not clearly reflect a focus on the specific interventions that will support discharge; the focus continues to rely primarily on reduction of psychiatric symptoms. (JS, JM, BW, KB, DT) **Compliance:** Partial **Current Recommendations:** 1. The hospital should continue to monitor the IRP process utilizing existing quality assurance and audit tools and identify staff in need of coaching. 2. The hospital should continue to focus training on identifying factors at point of admission that bear on discharge planning.
MLS	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Current Findings:** 1. The IRP includes a section that documents the identification of an individual's strengths, preferences, and personal goals. 2. The two IRP meetings and a majority of records reviewed included the consumer's preferences and personal goals. The IRPs and records were not as strong when documenting consumer strengths. (EW, JC, JH) **Compliance:** Partial **Current Recommendations:** 1. See VII.A

			2. IRP training and coaching should focus on identifying an individual's strengths and how to incorporate them into specific interventions that will lead to discharge. 3. Implement Corrective Action Plan, Action Step regarding the establishment of multidisciplinary conferences.
MLS	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Current Findings:** 1. SEH focuses on individual symptoms of mental illness; it is a strong component of the IRP team process. 2. The history of sexual assault and/or physical abuse was tangentially referenced and not incorporated into the IRP process. (TS, KB) **Compliance:** Partial **Current Recommendations:** 1. See VII.A. and VII.A.1 2. The IRP process can be improved by better integrating a comprehensive assessment and diagnosis, including symptoms of mental illness, into identifying specific behavioral and clinical interventions that ready individuals for transitioning to the community and discharge planning.
MLS	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Current Findings:** 1. The hospital and DMH have improved its processes for identifying barriers to discharge including revisions to the Community Integration Meeting, hiring an additional social work supervisor and consolidation of multiple discharge lists. 2. An October 5th training bringing together hospital social workers, DMH and community staff was a good first step in increasing the knowledge of community resources. 3. There appears to be no formal internal process for identifying and reviewing the clinical histories of individuals with multiple hospitalizations. This expert reviewed the record of an individual recently hospitalized with more than 25 admissions; there was no

			documentation indicating a review of prior history. (KB) 4. Records reviewed did not reflect an understanding of what precipitants (other than medication compliance) led to rehospitalization. (KB, DT, JF) **Compliance:** Partial **Current Recommendations:** 1. The hospital should implement the additional planned hospital/community seminars in order to increase understanding of community resources and the skills necessary for a consumer to be successful. 2. The hospital should consider implementing a process to review the clinical and discharge needs of individuals with multiple admissions. 3. SEH Corrective Action Plan, Action Steps should be implemented and monitored.
MLS	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Current Findings:** 1. According to the hospital's own report and based upon this consultant's observations and record reviews, IRPs do not reflect interventions that will support discharge. Hospital data indicate poor documentation and/or provision of transitioning assistance and psychosocial rehabilitation to support successful skills for community living. (RH, OA, EW, JF) 2. There have been significant revisions to the transitional TLC structure that target curricula to specific functional needs. The curricula needs continual refinement; at one cognitive skill building class, the material was far too advanced for the consumers in attendance. (RH) 3. DMH is in the process of establishing a community based apartment program to help in skill development and to facilitate discharge planning. 4. SEH has increased the number of transitional and community

			groups within its transitional TLC. **Compliance:** Partial **Current Recommendations:** 1. SEH should continue to refine matching individual's functional skills with the revised TLC curricula. 2. Working with DMH and community agencies, SEH should identify and expedite transitional activities in the community for individuals considered discharge ready. These activities should include attending day programs, public transportation training, visiting potential housing programs, visiting the community, establishing therapeutic relationships pre-discharge, etc. A specific community integration plan that increases the consumer's involvement in community services and supports over time could be developed to expedite successful discharge. 3. Continue to implement and monitor the SEH Corrective Action Plan.
MLS	VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	**Current Findings:** 1. The hospital has made progress in incorporating the individual into the IRP process with regard to their personal goals and treating the individual with respect and dignity. **Compliance:** Substantial **Current Recommendations:** 1. Continue to maintain this progress through ongoing monitoring.
MLS	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Current Findings:** 1. The IRP contains a section (Focus 6) entitled Community Integration. The objectives are not written in measurable, specific activities with specific timelines. The interventions should directly correlate with the treatment objectives that lead to discharge.

			(RH, EW, JF, JS) SEH monitoring reports document a lack of active participation by social work staff in the IRP process. **Compliance:** Partial **Current Recommendations:** 1. Continue to implement and monitor the Corrective Action Plan. 2. Focus social work staff and individual social work supervision meetings on IRP participation and process.
MLS	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Current Findings and Recommendations:** 1. See VII.C **Compliance:** Partial
MLS	VII.C.2	the persons responsible for accomplishing the interventions; and	**Current Findings:** 1. Records and data reviewed and IRP meetings observed indicate that specific staff are identified. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor to ensure compliance.
MLS	VII.C.3	the time frames for completion of the interventions.	**Current Findings:** 1. Avatar includes timeframes of 30 and 60 days for completion of IRP planning. Specific interventions are open ended with an assumption that that they will occur sometime between the last team meeting and the next. They are open ended and default to the IRP process rather than creating a time frame that is specific to the intervention. This does not create a momentum by the team or individual members to meet specific interventions sooner. There is no sense of urgency in the implementation of interventions to

			expedite community discharges. IRP meetings and a review of documents do not include an anticipated date of discharge. (OA, MJ) 2. The social work self-assessments documented a decline in interventions that are specific to their frequency. **Compliance:** Noncompliance **Current Recommendations:** 1. Each intervention should be measurable with a specific timeline. 2. SEH should establish a working discharge date for individuals who are on the discharge ready list. 3. Implement and monitor the Corrective Action Plan. The CAP should be modified to include "social workers to identify specific recommendations/interventions" that have specific timelines for completion.
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. There have been significant revisions to the transitional TLC curricula including the addition of community groups and cognitive/skill building groups. 2. There is a revised discharge monitoring tool. The results indicate a low (mean of 22%) percentage of evidence of transition assistance. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the Corrective Action Plan.
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	**Current Findings:** 1. The AVATAR system does not document whether a copy of the discharge plan was provided to the consumer upon discharge. 2. The hospital's discharge audit results do not reflect a positive

		acceptance of the individual for the services, and the discharge of the individual.	improvement/trend with regard to post-hospital services arranged. **Compliance:** Partial **Current Recommendations:** 1. Implement and monitor the Corrective Action Plan. 2. Consider adding a note in the clinical record that consumer was provided a copy of discharge plan.
MLS	VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	**Current Findings:** 1. DMH has developed and implemented a system of monitoring of individuals 30, 60 and 90 days post discharge. This process commenced in January, 2010 and continues. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor progress.
MLS	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Current Findings:** 1. A monitoring system has been developed by DMH to follow individuals 30, 60 and 90 days post discharge. This monitoring is triggered based on DMH receiving a completed discharge plan of care. **Compliance:** Substantial **Current Recommendations:** 1. Continue to monitor progress.
MLS	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Current Findings:** 1. There is a sufficient number of staff to implement monitoring/quality assurance activities within SEH.

			Compliance: Substantial **Current Recommendations:** 1. Continue to monitor progress.

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Progress:** 1. SEH has maintained substantial compliance with the requirement regarding psychiatric staffing levels. 2. The facility has made sufficient progress in reducing the use of high risk medications including benzodiazepines and anticholinergics in vulnerable populations and certain types of polypharmacy. 3. SEH has made sufficient progress in the review of Stat medication use and the adjustment of regular treatment based on this review. 4. SEH completed an adequate Drug Utilization Evaluation (DUE) that reflected current needs of the facility. 5. SEH has improved its performance regarding the documentation of medication administration variances. 6. SEH has made sufficient progress in updating its current individualized medication guidelines and initiating new guidelines. The updates and the new guidelines comport with current generally accepted standards. 7. SEH has made further progress in the organization and presentation of self-assessment data that address medication practices. 8. SEH Corrective Action Plan of October 7, 2010 contained adequate steps to assist the facility in achieving compliance with the requirements in this section. 9. The hospital has made important progress in providing appropriate behavioral treatment to many individuals in care, with some notable positive results. 10. Training in the principles of positive behavior support has been successfully completed by over 90% of clinical staff. 11. A disconnect has prevented some Risk Management data regarding individuals in care with frequent aggressive episodes from being forwarded to the Psychology

			Department for follow up. 12. Mall programming on the Transitional Mall continues to go well, but such programming on the Intensive Mall appears to be hampered by the fact that this mall serves two distinct populations, one of which is not engaged in treatment. 13. On unit programming appears to be failing to engage a large percentage of individuals in care. 14. SEH has reached substantial compliance in VIII.D.1, VIII.D.5, VIII.D.6, and VIII.D.10.a. 15. All relevant variables are now included in nursing staffing reports. This should support systematic evaluation of nursing staffing adequacy and inform decision making in this area. 16. SEH has decided to increase RN staffing to a 40% RN skill mix. This is consistent with requirements for both care and supervision of care provided by non-licensed nursing care providers. 17. SEH has reached substantial compliance in VIII.D.1, VIII.D.5, VIII.D.6., and VIII.D.10.a 18. All relevant variables are now included in nursing staffing reports. This should support systematic evaluation of nursing staffing adequacy and inform decision making in this area. 19. SEH has decided to increase RN staffing to a 40% RN skill mix. This is consistent with requirements for both care and supervision of care provided by non-licensed nursing care providers.

	A. Psychiatric Care		
MES		By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Clotilde Vidoni-Clark, PhD, Director of Treatment Services 3. Ermias Zerilassie, Chief Pharmacist 4. Sheila Stone, Program Administrator of Therapeutic Learning Center 5. Sylvia Atdjian, MD, Director of Clinical Training and Consultation, Office of Medical Affairs. 6. Tyler Jones, MD, Director of Psychiatric Services Reviewed: 1. Charts of the following 33 individuals: AJ, AP, AS, AW, BW, CC, CLT, CS, CW, FC, FH, GW, JAR, JM, JRH, JW, LT, MT, OB, PG, PSS, PW, RM, RMN, SJ, SM, TB, TJ, WD, WW, WW-2, YL and YS 2. SEH Compliance (Self-Assessment Report), October 7, 2010 3. SEH Corrective Action Plan of October 7, 2010 4. SEH Policy (draft), High Risk Indicators, Review and Tracking, September 10, 2010 5. SEH database regarding individuals receiving benzodiazepines 6. SEH database regarding individuals receiving anticholinergic treatments 7. SEH database regarding individuals receiving polypharmacy 8. SEH database regarding individuals receiving treatment with New Generation Antipsychotic medications 9. SEH regarding individuals diagnosed with Tardive Dyskinesia 10. Comprehensive Initial Psychiatric Assessment Audit Form, March 11, 2010 11. Comprehensive Initial Psychiatric Assessment Audit

			Operational Instructions May 1, 2010 12. Comprehensive Initial Psychiatric Assessment Audit Operational Instructions September 1, 2010 13. Comprehensive Initial Psychiatric Assessment Summary Data March to August, 2010 14. Psychiatric Update Audit Form July 29, 2010 15. Psychiatric Update Audit Form September 1, 2010 16. Psychiatric Update Audit Operational Instructions, not dated 17. Psychiatric Update Audit Summary Data; March to August 2010 18. SEH Medication Monitoring Audit summary data (March to August 2010) 19. SEH Medication Guidelines, revised September 6, 2010. 20. SEH Drug Utilization Evaluation (DUE): Effect of Atypical Antipsychotic Agents on Hemoglobin A1C 21. SEH DUE: Long-term Benzodiazepine Use in Certain populations, May 18, 2010 22. SEH Adverse Drug Reaction (ADR) Incident Report September 2009 to August 2010 23. SEH summary data regarding ADRs, March to August 2010 24. SEH ten completed ADR Incident reports 25. SEH Reported Medication Variance Incidents, Updated September 23, 2010 26. SEH ten completed Medication Variance Incident reports 27. SEH Medication Administration Documentation data report 28. SEH Co-occurring Disorders summary data, March to August 2010 29. SEH list of all current psychiatrists at SEH with their case loads and FTE status 30. SEH Tardive Dyskinesia (TD) Audit summary data, March to August 2010 31. Minutes of the SEH P&T Committee meetings, March 10, May 12, June 9 and July 14, 2010

			32. SEH Pharmacy and Medication Reports, April, May and June, 2010 33. SEH template for Transfer for Medication Evaluation, September 2010 34. SEH template for Seizure Observation Form, May 17, 2010 35. SEH Pharmacy Drug Interventions and Recommendations, March to August 2010 36. SEH Pharmacy Drug Alert, Lamotrigine: Risk of Aseptic Meningitis, August 27, 2010 37. SEH Mortality Review documents regarding AL, DA and REH
MES	VIII.A.1	By 24 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the provision of psychiatric care. In particular, policies and/or protocols shall address physician practices regarding:	Please see sub-cells for findings and compliance.
MES	VIII.A.1.a	documentation of psychiatric assessments and ongoing reassessments per the requirements of this Settlement Agreement;	**Findings:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c. and VI.A.7 **Compliance:** Partial, improved compared to the last review (this rating considers findings in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments and VI.A.7 regarding psychiatric updates (reassessments). **Current recommendations:** 1. Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a, VI.A.6.c. and VI.A.7. 2. Implement SEH CAP of October 7, 2010 relative to this section.

MES	VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	**Findings:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7. Refer to the facility's data regarding the following indicators: 1. Addressing Stat medications, seclusion and/or restraints; 2. Adequate completion of the risk assessment; 3. Reflecting the individual's response to treatment/progress; 4. Completion and adequate update of diagnosis; 5. Appropriate follow up and response to abnormal labs; 6. The pharmacological plan of care reflecting the diagnosis, mental status examination and response to treatment; 7. The pharmacological plan of care reflecting ongoing monitoring of adverse reactions of antipsychotic medications; and 8. Review of reassessments, if completed by a trainee. In addition, the facility reported the following compliance data that are relevant to this requirement: 1. If standing medication is being administered involuntarily, there is adequate explanation why (88%); 2. Appropriate adverse reactions are noted in the subsections regarding antipsychotic medications (88%); and 3. The Update reflects a current and accurate list of the barriers to discharge (99%). Overall, the data showed improvement compared to the last review period. **Other findings:** Partial, improved compared to the last review (this rating considered findings in VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7).

			Compliance: Partial, improved compared to the last review 9this rating considered findings in VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7). **Current recommendations:** Same as in VI.A.1, VI.A.2, VI.A.3, VI.A.4 and VI.A.7.
MES	VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Findings:** The facility presented self-assessment data relevant to this requirement as part of the Psychiatric Update Audit (see VI.A.3). In addition, the following data addressed this requirement: 1. The Update reflects the individual's response to treatment/progress (99%); 2. The pharmacological plan of care reflecting the diagnosis, mental status examination and response to treatment (99%); and 3. The Update includes an integration of behavioral and psychiatric interventions (97%). Overall, the data showed improvement compared to the last review period. **Other findings:** Same as in VI.A.1, VI.A.3, VI.A.4 and VI.A.7. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1, VI.A.3, VI.A.4 and VI.A.7). **Current recommendations:** Same as in VI.A.1, VI.A.3, VI.A.4 and VI.A.7.

MES	VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Findings:** The facility's data are presented in VI.A.1 and V.A.7. The following are the relevant indicators: 1. CIPA Audit: Risks associated with prescribed medication regimen. 2. Psychiatric Update Audit: a) Addressing Stat medications, seclusion and/or restraints; b) Documentation of adverse reactions of antipsychotic medications; c) Rationale for using high risk medications (anticholinergics); d) Addressing abnormal laboratory results; e) Ongoing monitoring of adverse reactions of antipsychotic medications; f) Rationale for polypharmacy; and g) Rationale for using high risk medications (benzodiazepines). The data showed positive trend since the last review. The facility recognized the need to improve its performance in addressing the use of Stat medications and benzodiazepines. **Other findings:** Same as in VI.A.1 and VI.A.7. **Compliance:** Partial; improved compared to the last review (this rating considered findings in VI.A.1 and VI.A.7). **Current recommendations:** Same as in VI.A.1 and VI.A.7.

MES	VIII.A.1.e	assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Findings:** Same as in V.B.5, VI.A.2 and VI.A.7. The relevant indicators are as follows: 1. CIPA Audit: Completion of risk assessment and 2. Psychiatric Update Audit: a) Completion of risk assessment; b) Addressing Stat medications, seclusion and/or restraints; c) Addressing involuntary medications; and d) Completion of risk assessment. Overall, the data showed improvement compared to the last review period regarding completion of the risk assessment. The facility recognized the need to improve its performance in addressing the use of Stat medications and seclusion/restraints. **Other findings:** Same as in V.B.5, VI.A.2 and VI.A.7. **Compliance:** Partial, improved compared to last review (this rating considered findings in V.B.5, VI.A.2 and VI.A.7). **Current recommendations:** Same as in V.B.5, VI.A.2.and VI.A.7.
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Findings:** Same as in VI.A.1 and VI.A.7. Overall, the data showed improvement compared to the last review period. The relevant indicators are the following: 1. CIPA Audit: Risks associated with prescribed medication

			regimen; and 2. Psychiatric Update Audit: a) Documentation of adverse reactions of antipsychotic medications; b) Addressing abnormal laboratory results; and c) Ongoing monitoring of adverse reactions of antipsychotic medications. In addition, the update reflects that laboratory levels were obtained (92%). **Other findings:** Same as in VI.A.1 and VI.A.7. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1 and VI.A.7). **Current recommendations:** Same as in VI.A.1 and VI.A.7.
MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Findings:** The facility assessed its compliance with this requirement using the previously mentioned Psychiatric Update and Medication Monitoring Audits. The Psychiatric Update data relevant to this requirement were presented in VI.A.1 and VI.A.7. Overall, the data showed improvement compared to the last review period. The relevant indicator was the use of three or more antipsychotic medications or three or more psychiatric medications of different classes. Using the Medication Monitoring Audit, the facility found no evidence of use of three or more antipsychotic medications and

			one case of using four different psychiatric medications without documented rationale (of 137 cases reviewed). **Other findings:** Same as in VI.A.1, VI.A.7 and VIII.A.2.a.i. **Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.1, VI.A.7 and VIII.A.2.a.i). **Current recommendations:** 1. Same as in VI.A.1 and VI.A.7. 2. Continue to monitor this requirement regarding the use of polypharmacy based on an adequate sample. Present a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	VIII.A.1.h	timely review of the use of "pro re nata" or "as-needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	**Findings:** The facility's data based on the Psychiatric Update Audit were presented in VI.A.1 and VI.A.7. The data showed positive trend since the last review. The following are the relevant indicators: 1. Addressing Stat medications and seclusion/restraints (68% for both items combined); 2. Addressing involuntary medications (88%); and 3. The pharmacological plan of care addressing diagnosis, mental

			status examination and response to treatment (99%). As mentioned in VI.A.7, the Medication Monitoring Audit found that three individuals received PRN medications during the review period contrary to the facility's policy. SEH reported that this practice was discontinued in two cases before they were discovered and in one case once it was discovered. In addition, SEH reported that Stat medication use is monitored as part of the facility's high risk indicator process (see V.B.5). In this process, any use of Stat medication is rated as of the unusual incidents when tracking triggers (three or more unusual incidents of any type during a 30 day period). **Other findings:** This expert consultant reviewed the charts of five individuals (AJ, SJ, TB, AP and AW) who experienced the administration of Stat medications during this review period. The review found that the facility has made progress since the last report regarding the review (and face-to-face assessment) by the treating psychiatrists of the Stat medication use within 24 hours of their use and modifications of treatment based on this review (including adjustments of the doses of regular medications, referrals for behavioral interventions and the use of the involuntary medication process). **Compliance:** Substantial. **Current recommendations:** 1. Same as in VI.A.1 and VI.A.7. 2. Provide monitoring data (Psychiatric Update/Medication Monitoring Audits) based on adequate samples. Present a

			summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
MES	VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a.i	clinically justified;	**Findings:** During this review period, SEH assessed its compliance with this requirement by monitoring the use of high risk medications using the Psychiatric Update Audit. The data were presented in VI.A.1 and VI.A.7. The following are the relevant indicators: 1. Anticholinergics for individuals with cognitive impairment; 2. Benzodiazepines for individuals with substance use disorder; 3. Use of three or more antipsychotic medications or three or more psychiatric medications of different classes; and 4. Ongoing monitoring of antipsychotic medication use. The above data showed significant improvement in all indicators

since the last review.

The facility reported data regarding the number of individuals receiving complex/high risk medication regimens as of September 20, 2010. The data showed that the facility has made progress in reducing the use of high risk medications since the last review. The following is an outline of the data:

High risk/complex medication regimen	#individuals
Three or more antipsychotic medications	15
Four or more psychiatric medications of different classes	27
Benzodiazepines (>90 days) in presence of cognitive impairment	10
Benzodiazepines (>90 days) in presence of substance use disorder	8
Benzodiazepines (>90 days)	24
Anticholinergics (>90 days) in presence of cognitive impairment	1
Anticholinergics (>90 days)	30

In addition, the facility used the previously mentioned Medication Monitoring Audit. This audit included other relevant indicators but used a different method of data presentation and the mean compliance rates were difficult to interpret. However, the facility provided an adequate narrative explanation of the data, including comparisons with the last review period. The following is a summary:

1. Polypharmacy: Same as in VIII.A.1.g.
2. Benzodiazepines (lorazepam, clonazepam, diazepam or alprazolam):
   a) Percentage of individuals prescribed benzodiazepines and

			suffering from substance use disorders decreased from 19% to 13% (of all individuals taking benzodiazepines regardless of duration); b) Percentage of individuals prescribed benzodiazepines and suffering from cognitive disorders increased from 11% to 13% (of all individuals taking benzodiazepines regardless of duration); c) Documentation of rationale (risks vs. benefits) for using these medications has improved from 24% to 53% (of all individuals taking benzodiazepines regardless of duration); and d) Documentation of a current valid indication for use was maintained at a high rate (97% compared to 98% in the previous period) (of all individuals taking benzodiazepines regardless of duration). 3. Anticholinergics (benztropine, trihexyphenidyl or diphenhydramine): a) The use of medications for individuals with cognitive disorders has decreased from 6% to 3% (of all individuals taking anticholinergics regardless of duration); b) The documentation of rationale (risks vs. benefits) of treatment has increased from 40% to 100%; c) The use for individuals with a diagnosis with tardive dyskinesia has decreased from 8% to 6%; and d) The documentation of side effects of treatment that support the use has improved from 27% to 32%. 4. New generation Antipsychotics (clozapine, olanzapine, risperidone and quetiapine): a) The monitoring of weight (BMI) by the IRP team has improved from 64% to 93%; b) Percentage of individuals receiving these medications and diagnosed with Diabetes Mellitus has increased slightly from 17% to 19%;

			c) Percentage of individuals receiving these medications and having BMI of >30 has increased from 35% to 41% (this may reflect better tracking of BMI); and d) Laboratory testing as per facility's medication guidelines has increased from 88% to 95%. 5. Medication use in geriatric individuals: a) Percentage of individuals receiving medications that can cause delirium has decreased from 26% to 13%; and b) Laboratory monitoring (creatinine clearance) has decreased from 93% to 83% (this data reviewed the use of creatinine clearance even when it was not necessarily indicated). With few exceptions, the above data indicated positive trends in the use of high risk medications and monitoring individuals for the risks of this practice. **Other findings:** This expert consultant reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic Medications for individuals diagnosed with cognitive disorders and/or tardive dyskinesia; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. This expert consultant reviewed the charts of 14 individuals receiving the above types of medication uses. The following is an outline of these review followed by findings regarding compliance (diagnoses are listed only if they signified conditions that

increase the risk of use). These findings were based on documentation of the justification for use, monitoring the individuals for the risks of use, attempts to use safer medication alternatives and risk benefit analysis of the use.

Benzodiazepine use

Individual	Medication(s)	Diagnosis
TJ	Lorazepam	Alcohol Dependence, Cocaine Dependence
CLT	Clonazepam	Cocaine Abuse
JRH	Clonazepam	Cannabis Abuse

This review found compliance in two charts (CLT and JRH) and partial compliance in one (TJ). However, due to the limited number of individuals receiving this high risk treatment, the facility appears to have made sufficient progress in this area.

Anticholinergic use

Individual	Medication(s)	Diagnosis
PW	Benztropine and diphenhydramine	Cognitive Disorder NOS
CS	Benztropine	Cognitive Disorder NOS
WD	Benztropine	Mild Mental Retardation
GW	Benztropine	Neuroleptic-induced Tardive Dyskinesia

This review found compliance in two charts (WD and GW) and partial compliance in two (PW and CS). However, due to the limited number of individuals receiving this high risk treatment, the facility appears to have made sufficient progress in this area.

Polypharmacy use

Individual	Medication(s)	Diagnosis
AS	Clonazepam, olanzapine, citalopram, trifluoperazine and carbamazepine	
PG	Clozapine, quetiapine and lorazepam	Cannabis Dependence
YS	Clozapine, quetiapine, lithium, lorazepam and benztropine	
WW	Risperidone, ziprasidone, olanzapine, divalproex and benztropine	
WW-2	Clozapine, ziprasidone, clonazepam and topiramate	
MT	Olanzapine, risperidone, ziprasidone, divalproex, lorazepam, zolpidem and diphenhydramine	

This review found compliance in three charts (PG, YS, WW and WW-2) and partial compliance in two (AS and MT). This finding indicates progress since the last review.

This expert consultant reviewed the charts of 14 individuals who were receiving treatment with new generation antipsychotic medications, most of whom were diagnosed with metabolic disorders. The reviews are outlined as follows:

Individual	**Medication(s)**	**Diagnosis**
SM	Clozapine	Diabetes Mellitus, Hyperlipidemia and Obesity

FH	Clozapine	Hypercholesterolemia
RMN	Clozapine	No diagnosis
PG	Clozapine and quetiapine	No diagnosis
YL	Olanzapine	Diabetes Mellitus
RM	Clozapine and quetiapine	No diagnosis
MT	Olanzapine, risperidone and ziprasidone	Diabetes Mellitus and Hypertension
RS	Olanzapine	Diabetes Mellitus
BW	Olanzapine	Diabetes Mellitus
CC	Risperidone	Diabetes Mellitus and Hyperlipidemia
JM	Risperidone and quetiapine	Diabetes Mellitus
FC	Risperidone and quetiapine	Diabetes Mellitus
GW	quetiapine	Morbid Obesity
CS	quetiapine	Diabetes Mellitus

This review found general evidence of adequate monitoring of the individuals in the following areas:

1. Laboratory monitoring of the blood counts and vital signs in individuals at risk;
2. Laboratory monitoring of serum glucose and lipid profile as well as monitoring of weight for individuals receiving high risk medications; and
3. Documentation of specific risks associated with high risk medications in the psychiatric reassessments.

In addition, the facility has improved the monitoring of

			individuals diagnosed with Diabetes Mellitus and receiving high risk agents (using Hemoglobin A1C as an indicator of diabetic management). However, there were several deficiencies that must be corrected to ensure sufficient progress in this area. The following are examples: 1. The order for monitoring vital signs was inadequate to ensure proper and proactive monitoring of an individual who was recently started on clozapine (PG). 2. The facility did not have a standard to ensure adequate monitoring of vital signs, including temperature, for individuals receiving clozapine. 3. There was no documentation of serum lipids in the past year in an individual receiving clozapine (RMN) 4. There was no evidence of laboratory monitoring for endocrine dysfunction in female individuals receiving long-term treatment with high risk agents, including risperidone (MT and CC). 5. The frequency of monitoring for serum lipids during the past year for an individual receiving olanzapine and diagnosed with Diabetes Mellitus was inadequate (YL). **Compliance:** Partial; improved compared to the last review. **Current recommendations:** 1. Implement corrective actions to correct the deficiencies outlined by this consultant regarding the monitoring of individuals receiving new generation antipsychotic medications. 2. Continue to monitor this requirement regarding high risk

			medication uses (Psychiatric Update and Medication Monitoring Audits), based on an adequate sample during the review period. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Continue to provide information regarding the number of individuals receiving high risk medication uses during the review period compared to the last review period. Provide average number of individuals during the review period and address the following types of medication uses: a) Intra-class polypharmacy (two or more antipsychotics); b) Inter-class polypharmacy(four or more); c) Anticholinergics > 90 days for individuals age 65 or above; d) Anticholinergics > 90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias); e) Benzodiazepines >90 days for individuals diagnosed with any substance use disorder; and f) Benzodiazepines >90 days for individuals diagnosed with cognitive impairments (Borderline Intellectual Functioning, Cognitive Disorder NOS, Mental Retardation or Dementias).
MES	VIII.A. 2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.

MES	VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	Same as above.
MES	VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	Same as above.
MES	VIII.A.2.a.v	evaluated for side effects; and	Same as above.
MES	VIII.A.2.a.vi	documented.	Same as above.
MES	VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	Same as above.
MES	VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Findings:** During this review period, the facility updated its medication guidelines regarding the use of clozapine, New Generation Antipsychotic (NGA) medications other than clozapine, and Stat medications. The revised guidelines included the following: 1. Individualized monitoring standards (monitoring cue card) regarding the risks associated with various NGAs and mood stabilizers; 2. Sample titration schedule of clozapine dose; 3. Detailed clozapine monitoring chart (hematological); 4. Relative adverse effects of NGA medications; 5. Common drug interactions of NGA medications; 6. Indications for closer monitoring of serum prolactin levels; 7. Conversion chart regarding the use different forms of divalproex; and 8. Triggers for review of the IRP based on Stat medication use. In addition, the facility added new individualized guidelines to

			address the use of the New generation Antipsychotic medications asenapine and paliperidone, First Generation Antipsychotics, lithium, divalproex, topiramate, carbamazepine and lamotrigine. **Other findings:** This expert consultant reviewed the facility's current guidelines. The guidelines addressed the following medication uses: 1. Clozapine; 2. First generation and new generation antipsychotics (other than clozapine); 3. Mood stabilizers; 4. Benzodiazepines; 5. Stat medications; 6. Anticholinergics; 7. Polypharmacy; and 8. Treatment of the elderly. This review found that the guidelines comported with current generally accepted standards and that SEH has made sufficient progress regarding this requirement. **Compliance:** Substantial. **Current recommendations:** 1. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience. 2. Provide a summary of updates in these guidelines.
MES	VIII.A.	develop and implement a procedure	**Findings:**

	2.b.ii	governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;	Same as in VIII.A.1.h. **Compliance:** Substantial. **Current recommendations:** Same as in VIII.A.1.h.
MES	VIII.A.2.b.iii	establish a system for the pharmacist to communicate drug alerts to the medical staff; and	**Findings:** SEH presented data regarding one drug alert (for lamotrigine) that was issued between August 2009 and February 2010. This alert was posted on the intranet and communicated to the facility's Pharmacy and Therapeutics Committee. In addition, the facility presented data regarding other Pharmacy interventions that were communicated to the medical staff between March and August 2010 (see VIII.C) **Compliance:** Substantial. **Current recommendations:** 1. Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the prescribing practitioners. 2. Present documentation of review by the P&T Committee of drug alerts.

MES	VIII.A.2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Findings:** During the period of March to August 2010, a total of 42 ADRs were reported compared to 30 during the period of September 2009 to February 2010. SEH acknowledged that underreporting of ADRs continues and that its efforts in this area have not proven to be effective. As a corrective action, the facility recently initiated a process of reviews by its Chief Pharmacist of the 24 hour nursing report in order to identify ADRs that result in medical response. The facility recognized that this process is geared more towards identification of serious ADRs. In addition, the Medical Director has continued reviews of this issue during monthly meetings of the medical Staff. The facility's data regarding disciplines that reported ADRs showed that the majority of the reactions (#34) were reported by psychiatrists and that nursing staff reported no reactions. However, the facility did not present analysis or corrective actions to address a clear pattern of lack of identification and/or reporting of ADRs by its nursing staff. The facility provided an adequate classification of ADRs using probability and severity scales. During this review period, no ADR was classified by SEH as severe and consequently no intensive case analysis was performed. Although minutes of the Pharmacy and Therapeutics Committee reflected a review of ADRs, there was no evidence of adequate analysis of patterns and trends and of corrective actions based on this analysis. Chart reviews by this expert consultant (see V.D.1) found that one individual was diagnosed at an outside hospital as having both lithium toxicity and divalproex toxicity. However, the facility did not report this event as an ADR and did not conduct an intensive case analysis, which should have been done given the severity of the condition.

			During this review period, SEH conducted a DUE that addressed the relationship between the use of new generation antipsychotic (NGA) medications and laboratory monitoring of hemoglobin A1C levels. The significant findings included the following: 1. Twenty-eight percent of individuals who were diagnosed with Diabetes Mellitus while receiving these agents had developed new onset Diabetes during treatment; 2. Ninety percent of individuals receiving NGAs had A1C levels of less than 7%; and 3. Twelve percent of all individuals receiving these medications had levels greater than of equal to 6.5%. This DUE employed adequate methodology and included appropriate recommendations for corrective actions. In addition, the facility presented an adequate follow-up regarding the Benzodiazepine DUE that was mentioned in the previous report. SEH improved its system of aggregating and presenting its data regarding medication variances. The facility reported a total of 70 variances (41 potential and 29 actual) during this review period compared to 141 (71 potential and 70 actual) during the previous period. While the relative increase in capturing potential vs. actual variances was a step in the right direction, the overall number of potential variances indicated the need for further corrective actions to increase reporting of these variances. In a personal interview, the facility's Medical Director, Director of Psychiatry and Chief Pharmacist reported a variety of current and planned corrective actions to improve capturing of variances, including educational and oversight components.

			The facility presented an adequate classification of variances by type (category), critical breakdown points and outcome of the variances. Most of the variances and critical breakdown points occurred in the categories of administration, dispensing and prescribing. The facility presented adequate review of positive trends in documentation variances and adequate tracking by the Pharmacy and Therapeutics Committee of the reported variances in all categories. However, no analysis or corrective actions were presented regarding the patterns of administration, dispensing and prescribing variances during this review period. During this review period, the facility's Mortality and Morbidity Committee reviewed the deaths of two individuals who expired between March and August 2010. Both mortalities occurred at outside hospitals following transfers from SEH for specialized medical care. One mortality (AL) occurred more than two months following the transfer (for evaluation of left leg and hip pain). The cause of death was related to post-surgical complications; the mortality review was completed and death determined to be expected. The second mortality (DA) occurred approximately a week after transfer to the outside hospital (to R/O leg fracture following a fall). The individual expired approximately one week later after he suffered intracranial bleed following a fall at the outside hospital. This review has yet to be completed but the case was not referred for an external independent review. The circumstances of this mortality are such that an external review should be completed. In addition, the facility conducted follow-up on a mortality review (REH) that was initiated during the previous reporting period. The facility's internal reviews and recommendations for corrective actions were addressed in the previous report. During this review period, an external independent review was completed

			and results of the final post-mortem examination were received. The facility conducted a final review that incorporated results of these processes but this review was untimely. **Compliance:** Partial. **Current recommendations:** 1. Implement corrective actions to address under-reporting of ADRs. 2. Continue to provide summary data regarding Adverse Drug Reactions (ADRs) including: a. Total number of ADRs reported during the review period (specify dates) compared with the number during the previous period (specify dates); b. Classification of ADRs by probability category (doubtful. possible, probable and definite) compared with the number during the previous period; c. Classification of ADRs by severity category (mild, moderate and severe) compared with the number during the previous period; d. Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved; e. Clinical information regarding each ADR that was classified as "not recovered and/or unresolved;" f. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following: i. Date of the ADR; ii. Brief Description of the ADR; iii. Outline of ICA findings and recommendations;

			and iv. Outline of actions taken in response to the recommendations. g. Analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns. 3. Continue to provide summary of Drug Utilization Evaluations (DUEs) during the review period, including the following information: a. Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. b. Date of each DUE; c. Description of each DUE including methods used; d. Outline of each DUE's recommendations; and e. Outline of actions taken in response to the recommendations. f. Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns. 4. Improve mechanisms to capture medication variances, including potential variances; 5. Continue to provide data regarding Medication Variance Reporting (MVR), including: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs.

			actual, with totals during the review period compared with the last review period; c. Number of variances by critical breakdown point with totals during the review period compared with the last review period; d. Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved; e. Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; Also provide summary outline of each analysis including the following: i. Date of the variance; ii. Brief Description of the variance; iii. Outline of ICA findings and recommendations; and iv. Outline of actions taken in response to the recommendations. f. Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances; g. Evidence of corrective actions to address patterns and trends identified in medication variances. 6. Provide data regarding Mortality reviews of all unexpected deaths during the review period and ensure completion of an external review of all unexpected mortalities and integration of results of the independent external medical mortality review and post-mortem examinations in the final level interdisciplinary review in a timely manner.
MES	VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time	**Findings:** The facility presented data regarding current psychiatric staffing that demonstrated continued compliance with this

		psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.	requirement. **Compliance:** Substantial. **Current recommendations:** Continue to provide information to confirm continued compliance with this requirement in all acute care and long-term care units in the facility.
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Findings:** Same as in V.A.2.e and VI.A.7. **Compliance:** Partial; improved compared to the last review (this rating considered findings in V.A.2.e and VI.A.7). **Current recommendations:** Same as in V.A.2.e and VI.A.7.
MES	VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	Same as above.
MES	VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	Same as above.
MES	VIII.A.4.c	integrate psychiatric and behavioral treatments.	Same as above.
MES	VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness	**Findings:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.

		of the medication treatment.	**Compliance:** Partial, improved compared to the last review (this rating considered findings in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2). **Current recommendations:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2.
MES	VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Findings:** During this review period, SEH has increased the number and range of groups offering substance use education, including the assignment of individuals to these groups based on screening and evaluation of their stages of change and level of cognitive functioning. During May 2010, the facility provided 37 groups (47 sessions). By September 20, 2010, the groups were increased to 42 groups (66 sessions). The following is an outline of the current groups, by stage of change (*refers to groups that are further stratified by two levels of cognitive screening): 1. Precontemplation/Contemplation: a) Anger Management for Co-occurring Disorders (COD) b) Stress Management for COD c) Soothing to the soul for COD d) Healthy Choices e) Learning about Healthy Living (Smoking Cessation part I)* f) Stage of Change* 2. Preparation: a) Same as a to f above b) Substance Abuse Education 3. Action/Maintenance: a) Same as a to f above

b) Self-Management and Recovery Training*
c) Practicing Refusal Skills*
d) Living Sober*
e) Relapse Prevention Education*
f) Supportive Psychotherapy for individuals with COD
g) Quitting Smoking*
h) Alcoholics/Narcotics Anonymous*
i) Double trouble in Recovery*
j) Art Therapy-Recovery & Recovery Prevention

In addition, the facility provided specialized groups for individuals with trauma history/risk for victimization. The following is an outline:

1. Women's Recovery and Empowerment;
2. Sexual Safety and Sobriety; and
3. Sexual Issues for Women.

Using the CIPA Audit, SEH presented the followings data that were relevant to this requirement:

1.	Substance abuse assessment was completed and, if not, the reason was clearly provided	98%
2.	The assigned Stage of Change (SOC) reflected results of the Substance Abuse Assessment	95%

The above data showed significant improvement since the last review.

In addition, the facility used the Co-Occurring Disorders Audit (March to August 2010) to assess compliance; the average sample ranged from 7% to 11% of individuals with diagnosis of substance use disorder. The following is a summary of the data:

1.	The IRP addressed both the identified mental illness and substance use disorder	80%
2.	The IRP reflected the SOC with respect to substance use disorder	70%
3.	If #2 is yes, the intervention is appropriately linked to the documented SOC	59%
4.	The IRP has discharge criteria regarding substance us disorder	23%
5.	If #4 is yes, criteria is individualized and written properly	100%

SEH reportedly provided training to address inadequate compliance with most of the indicators above.

Other findings:
See this monitor's findings in V.D.1 regarding the evaluation and management of substance use disorders at SEH. In addition, this expert consultant observed a group session for individuals in the pre-contemplative stage. The lesson plan was relevant to the individual's needs and the group leader made appropriate efforts to engage the individuals and used appropriate practice materials to facilitate their participation.

Compliance:
Partial; improved compared to the last review.

Current recommendations:
1. Implement corrective actions to improve alignment between the individual's Stage of Change and IRP Objectives/Interventions and the formulation of proper discharge criteria regarding substance use disorders.
2. Continue to monitor this requirement (CIPA and Co-occurring

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>Disorders Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
3. Present comparative data (mean %C for each indicator in current review period vs. last review period).
4. Same as in V.D.1 and VI.A.5.</td>
</tr>
<tr>
<td>MES</td>
<td>VIII.A.7</td>
<td>By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia (“TD”). SEH shall ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.</td>
<td>Findings:
SEH identified 38 individuals as having a diagnosis of Tardive Dyskinesia (as of August 31, 2010). Using the CIPA Audit, the facility reported a 77% compliance rate with the completion of AIMS test as part of the CIPA.

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

<table>
<tr><td>1.</td><td>There is evidence of at least semi-annual AIMS</td><td>95%</td></tr>
<tr><td>2.</td><td>There is evidence of a Neurology Consultation</td><td>76%</td></tr>
<tr><td>3.</td><td>There is evidence of consideration in medication choices</td><td>95%</td></tr>
<tr><td>4.</td><td>There are IRP interventions targeting TD</td><td>76%</td></tr>
<tr><td>5.</td><td>Are first generation antipsychotics prescribed?</td><td>41%</td></tr>
<tr><td>6.</td><td>If #5 is yes, there is justification in the monthly notes?</td><td>87%</td></tr>
<tr><td>7.</td><td>Anticholinergics are prescribed</td><td>51%</td></tr>
<tr><td>8.</td><td>If #7 is yes, is there justification in the monthly notes?</td><td>95%</td></tr>
</table>
</td>
</tr>
</table>

			Overall, the data showed a positive trend since the last review. **Other findings:** This monitor reviewed the charts of seven individuals (YL, JAR, JW, OB, PSS, CW and LT) who had current diagnoses of Tardive Dyskinesia (TD). This review found evidence of adequate practice as follows: 1. The admission AIMS were completed for all individuals who were admitted since July 2009 (the admission AIMS for individuals who were admitted prior to July 2009 were not available for review). 2. The periodic AIMS tests were completed in accordance with policy, as applicable, in the charts of YL, JR, JW, PS, CW and LT. 3. The psychiatric progress notes provided adequate tracking of AIMS testing in the charts of YL and JAR. 4. The IRP documented a diagnosis of TD in all the charts reviewed. 5. The IRP included objectives and interventions related to TD in all the charts of individuals who had current diagnosis of TD. 6. There was no evidence of unjustified long-term use of anticholinergic medications in the charts of YL, JAR, DC, CW and LT. 7. The charts of JA and JW contained evidence of consideration of safer antipsychotic medications, as indicated. However, there continued to be a number of deficiencies that must be corrected to ensure sufficient progress in compliance with this requirement. The following are examples:

			1. The psychiatric progress notes did not provide adequate and specific information in the tracking of the status of TD in some charts (e.g. JW and PSS). 2. The IRP did not include focus or interventions to address the diagnosis of TD in the chart of LT. 3. The IRP objectives related to TD were unattainable for the individuals and did not include learning outcomes in most charts reviewed (YL, JAR, JW and PSS). 4. The periodic AIMS tests were not documented as required in the chart of JW. **Compliance:** Partial. **Current recommendations:** 1. Continue to monitor this requirement (CIPA and TD Audits) based on adequate samples. Present a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Present comparative data (mean %C for each indicator in current review period vs. last review period).

	B. Psychological Care		
RB		By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological supports and services to individuals who require such services.	**Methodology:** Interviewed: 1. Richard Gontang, Ph.D., Chief of Psychology 2. Richard Boesch, Ph.D., PBS Psychologist 3. Bernard Arons, M.D. Director of Medical Affairs 4. Harriett Moore, LICSW, Social Work Supervisor, Longterm Units 5. Maura Gaswirth, LICSW, Social Work Supervisor, Admission Units Reviewed: 1. Medical Records: MP, GS, KP, AJ, PW, TJ, LM, CO, CK, LH, CW, AA, RJ, DT, SL, JS, FW, MK, CL, JC, CW2, JC2 2. PBS, Behavior Guidelines and Initial Behavioral Interventions Audit Tools 3. Fidelity Check Form 4. PBS Training Data and Curriculum
RB	VIII.B.1	By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	Please see sub-cells for findings and compliance.
RB	VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and	**Findings:** Currently the PBS team has 4 of the 5.5 FTEs that have been allocated to it. There continues to be uncertainty when the nurse member of the team will be on board, which is a problem that was identified at the time of the last tour as well. The

		self-harm, treatment refractory individuals, and individuals on multiple medications;	presence of a nurse on the PBS team ensures that PBS philosophy and associated competencies are emphasized at the level of care. The PBS director has decided that a 0.5 RN position in conjunction with a full time RA position will permit adequate training of staff at the level of care, and the DOJ consultant is open to see how this approach works in practice. Both the hospital's data and an independent chart review found that the IPA is consistently providing a good screening of behavioral interventions and an adequate assessment of the appropriateness of a referral for the development of a PBS plan. Additionally, individuals with frequent utilization of restrictive interventions had been appropriately referred for the development of behavioral interventions. However, due to an apparent disconnect in the provision of Risk Management data to the Psychology Department, many individuals in care with frequent episodes of aggression have not been appropriately referred for behavioral interventions. The team psychologists also continue to make appropriate use of Initial Behavioral Interventions (IBI – referred to in the last report as Initial IRP Behavioral Interventions (IIRPBI). The format for IBIs has been standardized and auditing of these interventions has begun, with data showing an upward trend toward compliance. **Compliance:** Partial. **Current recommendations:** 1. Complete the formation of the PBS team. 2. Ensure that Risk Management data on individuals in care with frequent aggressive episodes is routinely made available to

			the Psychology Department for follow up. 3. Continue to present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B. 1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement;	**Findings:** An appropriate audit tool has now been developed for behavioral interventions and data indicates that results are trending toward compliance with this provision of the Agreement. Additionally, the more formally developed PBS plans and Behavior Guidelines (BG) demonstrated excellent functional/structural assessments. **Compliance:** Partial. **Current recommendations:** Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B. 1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;	**Findings:** While this factor is audited, one IBI was found that contained the use of a restrictive intervention. When this was discovered and brought to the attention of the Chief of Psychology and the

			PBS team leader, it was immediately rectified. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
RB	VIII.B. 1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	This cell repeats cell VIII.B.1.a
RB	VIII.B. 1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Findings:** An appropriate audit tool has now been developed for behavioral interventions and data indicates that results are trending toward compliance of this provision of the Agreement. Additionally, a format for doing fidelity checks has been developed but not yet implemented. **Compliance:** Partial. **Current recommendations:** Implement fidelity checks.
RB	VIII.B. 1.f	ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment	**Findings:** According to the hospital's report, there remains only one psychology vacancy; however, two psychologists are currently on maternity leave. The hospital has requested three additional

		programs.	psychology positions for FY 2011 depending on funding availability. It is likely that an increased number of filled psychology positions will also help with the timeliness of psychology assessments. **Compliance:** Partial. **Current recommendations:** Fill current psychology department vacancies and proceed with plans for three new positions.
RB	VIII.B.2	By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.	**Findings:** The initial assessments completed by Psychology, Social Work and Rehabilitation Services still do not routinely make recommendations for specific mall groups from which individuals may benefit. An IRP rounds process has been developed that includes representatives from the treatment teams and mall staff to review individual progress in mall groups and facilitate reassignment to more appropriate groups when necessary. **Compliance:** Partial. **Current recommendations:** 1. Take steps to insure that all initial assessments (RSA, IPA, SWIA and Nursing Assessment) specifically indicate recommended groups from the online course catalogue, and that the auditing of these assessments includes monitoring for this item. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S),

			indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B.3	By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.	**Findings:** All individuals except those newly admitted now attend the treatment mall programs for at least half day increments. Additional, on-unit programming is being provided on the admission and geriatric units, but observation during the recent tour found that over 50% of individuals in care were not attending on-unit programming while it was occurring. Finally, Rehabilitative Services now regularly offers evening and weekend programming. The transitional mall continues to be well run, and over 90% of individuals assigned to this mall were routinely engaged in active treatment during mall hours that were observed during the tour. More individuals on the intensive mall were observed to be not involved in active treatment. Discussion with treatment mall staff led to a general agreement between the reviewer and SEH staff that this mall is serving two distinct populations: an engaged population of individuals eager to be involved in treatment and a significantly less engaged population for which enhanced strategies will need to be developed. Staff indicated that an effort is made to engage at least briefly with each individual who is refusing treatment to see if alternatives can be developed and discussions have begun about enlisting the aid of the PBS team to help in the development of incentives that might motivate increased engagement. It will be important for the hospital to continue monitoring this issue and develop creative solutions to the problem of engagement, including the possibility of splitting the intensive mall into two malls, with one

			focusing specifically on engagement and making use of motivational interviewing techniques. A monitoring tool has been developed that will permit discipline chiefs to audit the groups facilitated by their clinicians to ensure that treatment is being provided as represented in the online course catalogue. **Compliance:** Partial. **Current recommendations:** 1. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 2. Continue to develop mechanisms to increase patient engagement on the intensive treatment mall.
RB	VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
RB	VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	**Findings:** See cell VIII.B.1.c **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.

RB	VIII.B. 4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Findings:** Substance abuse programs continue to be offered in both of the treatment malls. **Compliance:** Substantial. **Current recommendations:** Maintain current level of practice.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Findings:** In 70% of the reviewed cases, the Discharge Plan of Care included the cognitive disorder among the patient's diagnoses at discharge. However, over 40% of these cases did not have specific discharge recommendations that addressed the cognitive disorder. Where such recommendations were present, they reflected good thinking, e.g., "need for structured activities to assist with deficits in executive functioning (CL)." **Compliance:** Partial. **Current recommendations:** 1. Provide staff training to ensure that Discharge Plan of Care accurately reflects all of the patient's diagnoses and that specific recommendations are in place for the treatment and/or support needed for individuals with cognitive disorders. 2. Audit the Discharge Plan of Care as part of the Clinical Chart Review or Chart Review process.
RB	VIII.B.	programs are developed and implemented for	**Findings:**

	4.d	individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;	Appropriate programs exist for post-trial forensic patients, and attendance at one treatment team demonstrated how a forensic individual was making substantial progress toward discharge. **Compliance:** Substantial. **Current recommendations:** Maintain current level of progress.
RB	VIII.B. 4.e	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;	**Findings:** The hospital's own data indicated that this criterion was only being met by 64% of audited IRP conferences, and this reviewer only observed this occurring in one of the three observed IRP conferences. **Compliance:** Partial. **Current recommendations:** Continue to present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B. 4.f	clinically relevant information remains readily accessible; and	**Findings:** This requirement is being routinely met. **Compliance:** Substantial.

			Current recommendations: Maintain current level of practice.
RB	VIII.B.4.g	staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.	**Findings:** The hospital's data indicated that 96% of clinical staff have received training in the principles of positive behavior support. However, fidelity checks for formal PBS plans have not yet been implemented. **Compliance:** Partial. **Current recommendations:** 1. Institute fidelity checks. 2. Present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

<table>
<tr><td></td><td colspan="3">C. Pharmacy Services</td></tr>
<tr><td>MES</td><td></td><td>By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:</td><td>Methodology:

<u>Interviewed</u>:
1. Bernard Arons, Medical Director
2. Ermias Zerilassie, Chief Pharmacist

<u>Reviewed</u>:
1. SEH Pharmacy Drug Interventions and Recommendations, updated September 24, 2010
2. SEH Worx Intervention Category Definitions</td></tr>
<tr><td>MES</td><td>VIII.C.1</td><td>pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and</td><td>Findings:
SEH presented data regarding recommendations made by pharmacists during this review period (March to August 2010) compared with the last review period (September 2009 to February 2010). The data showed a significant decrease in the number of recommendations during this review period (48 compared to 121). In a personal interview, the facility's Chief Pharmacist reported that staffing issues were the main reason for this reduction and acknowledged the need for corrective actions. The following is an outline of these recommendations

<table>
<tr><td>Type of recommendation</td><td>Number</td><td>% of total</td></tr>
<tr><td>Drug allergy</td><td>5</td><td>10%</td></tr>
<tr><td>Interaction</td><td>2</td><td>4%</td></tr>
<tr><td>Dosage issues</td><td>1</td><td>2%</td></tr>
<tr><td>Indications</td><td>1</td><td>2%</td></tr>
<tr><td>Medication procurement off hours</td><td>5</td><td>10%</td></tr>
<tr><td>Order clarification</td><td>10</td><td>21%</td></tr>
<tr><td>Order entry</td><td>12</td><td>25%</td></tr>
<tr><td>Patient monitoring</td><td>2</td><td>4%</td></tr>
</table>
</td></tr>
</table>

			<table><tr><td>Polypharmacy</td><td>3</td><td>6%</td></tr><tr><td>Side effects</td><td>1</td><td>2%</td></tr><tr><td>Other drug information (at physicians' request)</td><td>6</td><td>13%</td></tr></table> The facility reported only one recommendation during this review period to which there was no response by the physician. During the investigation of this incident, the facility found evidence of appropriate follow-up by the physician regarding the recommendation and that the pharmacist did not update the entry in the system in a timely manner. The facility provided adequate definitions of the types of recommendations. **Compliance:** Partial. **Current recommendations:** 1. Implement corrective actions to address the significant drop in the pharmacy interventions/recommendations since the last review. 2. Continue to provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department, with comparisons to the previous review period. 3. Provide clear operational definitions for all categories of the recommendations.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Findings:** Same as above. **Compliance:**

			Substantial. **Current recommendations:** Same as above.

	D. Nursing and Unit-Based Services		
LDL		SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	**Methodology:** Interviewed: 1. Michele Richardson RN 2. Mierrien Davis RN 3. Olagunwa Adurata RN 4. Linder Derdre RN 5. Christianah Awosika RN 6. Oluyemisis Ihaza RN 7. Juliana Arkku LPN 8. Harold McKnight RA 9. Ibeh Godwin RN 10. Erdine King RN 11. Siom Mukan RN 12. Tamisha Boddie LPN 13. Bartholomew Nwachukwu LPN 14. Nigist Letema LPN 15. Caroline Ibijemilusi RN 16. Folugbemi Iunmilayo RN 17. James Brown FPT 18. Mildren Kromah RN 19. Juliana Arku LPN 20. Antoinette Saunders RA 21. Olah Andurota RN 22. Joeann Farmer RA 23. Sumayya Lane RN, Nurse Educator 24. Michael Spencer, Program Analyst to CNE 25. Laverne Plater RN, Nurse Educator 26. Shirley Quarles RN , Director of Nurse Education and Research 27. Michael Hartley, RN, Chief Nurse Executive 28. Malcomb Cook RN, Infection Control Officer

			29. Dr. Gupta, Infection Control Committee Chairman 30. Dr. Bernard Arons, Director of Medical Affairs 31. Dr. Shalita Snyder, Training Director 32. Martha Pontes RN, Assistant Chief Nurse Executive <u>Reviewed</u>: 1. SEH Compliance Report 6 and Corrective Action Plan (October 7, 2010). 2. SEH and Nursing Reports, Policies, Procedures, Forms, and Training Curriculums relevant to the provisions in Section VIII.D and provided in advance of visit. 3. Documents provided during the visit that included training sign-in sheets, examples of staffing reports, one week of nursing staffing for all units/shifts (9/1/10 – 9/7/10); unit nursing assignment sheets; unit program schedules; Investigation of Unusual Incident Report (10/28/10); table showing Healthcare Associated Infections. 4. Records of the following 27 individuals in care: SL, YS, EB, DH, HJ, RH, MH, RC, PW, RJ, DU, DL, MB, RM, GR, TW, DR, GS, DN, NT, BM, KH, MR, CG, JW, AJ, WM <u>Observed</u>: 1. IRPs: OA and VS (60 day); CB (Comprehensive) 2. Various nursing functions on units: 1A, 1C, 1D, 1E, 2A, 2B 3. Change of shift report – 1E 4. Transitional and Intensive TLCs
LDL	VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications,	**Findings:** SEH has developed a clear description of the structure, content, and processes for the nursing education program including orientation and annual training requirements. The content meets the requirements of this agreement and includes relevant curriculum and competency measures. In addition, the data

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

			Other findings: Evidence that nursing staff have been trained in new/revised policies and procedures was provided, consistent with information that emerged from a staff interview. As in the previous tour, the DNER described several creative ideas that have potential to maximize learning opportunities for existing staff who are often unable to leave active units. In addition to the self-study packet that has been developed, SEH would like to develop brief training fliers that could be used on the units to enhance knowledge in high priority areas such as mental health diagnoses. SEH also discussed implementing an "annual training day" format to make it easier for staff to complete all required annual update competencies on one day. This format is an efficient approach that has been effectively utilized in other hospitals. Immediate implementation of these ideas would be likely to improve annual competency achievement. This could be done on an interim basis while CNE pursues his goal of one educator for each 50 beds in order to implement a more individualized training approach. The current nurse educators provide both nursing department specific as well as hospital-wide orientation and annual update. The frequency of high priority education offerings has been increased in an effort to increase the number of staff who meet annual mandatory training requirements. The SEH hospital-wide education program now contains clear descriptions of orientation and annual update programs that include objectives, course outlines, and teaching strategies. This also represents substantial improvement. However, the SEH report on annual mandatory training requirements reflects that all relevant personnel have not been trained or achieved

			competency in high priority areas. Actions to address this are being implemented. **Compliance:** Substantial **Current recommendations:** 1. The October 7, 2010 SEH Corrective Action Plan (CAP) goals relative to nursing training appear to have been met. Compliance should be maintained. 2. The CAP contains adequate steps to address continued hospital wide training program development as well as improved employee attendance at competency based annual updates. 3. The CNE should consider and implement approaches to ensure that contract nursing personnel demonstrate competency consistent with the functions they are authorized to perform.
LDL	VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Findings:** A new *Nursing Assessment* policy (Number SDR 300.2; effective 9/20/10) was developed that provides the general structure, framework, and scope of the initial and annual nursing assessments. Accountability and steps are well outlined. The Nursing Annual Assessment form (Attachment A to policy) contains some prompts that should result in documented data synthesis and evaluation of progress. (Note: the new Nursing Assessment policy referenced above had not been implemented during the period of time for which audit data were provided.) Based on low findings in Comprehensive Initial Nursing Assessment (CINA) audits, SEH implemented a plan that involves designating one Registered Nurse (RN) to conduct the majority of the CINAs. The plan was implemented in August and although

			it is early to evaluate the effectiveness of this action, it is notable that the findings relative to the development of nursing interventions (questions #33, 34, and 36) were 100%. This audit finding was consistent with the findings in the records that were reviewed during the tour and represents considerable improvement. Nevertheless, despite earlier progress reports indicating that RNs would be able to directly enter IIRP interventions by mid-April, the "recommended" nursing interventions were still not included in the IIRPs. Currently, the RN still cannot enter these interventions but rather must "recommend" the interventions to the physician who develops the IIRP. This is not appropriate. An RN is legally responsible to delegate/give ***direction*** for nursing care through nursing interventions. The RN *may* make ***recommendations*** for specific other disciplines' consideration or for inter-disciplinary review. This issue needs to be resolved immediately. Once resolved, the initial nursing interventions need to be prioritized and individualized. The CNE indicated that he plans to separate the CINA into two parts: the first part must be completed within eight hours and the second part must be completed within 24 hours. Draft screens were provided and some feedback shared with the CNE. Chart reviews revealed fewer blank boxes in the CINA, although there continues to be unresolved conflicting information. Neither the CINA nor the admission narrative note reflect synthesis of the data that are gathered and subsequent implications for nursing care. SEH audit findings for the Nursing Update Assessment (NUA) (March – August) show considerable variability, although the data are not really comparable due to revisions in both update

			assessments and audit tools. The mean for all criteria (some of which are new) for the review period was 78%. In the records reviewed during the tour, Nursing Updates were not timely and did not meet quality standards. The Nursing Progress Update (to take the place of the NUA) has been recently revised. Those that were reviewed in records did not contain information relevant for a progress update but rather a repeat of admission information. It is not clear if form guidelines exist. If they do, they should be reviewed to ensure that they are aligned with the new form and focused on the purpose of a progress note. An alternative approach would be to reconsider the existing form prompts and provide more focus and specificity to support RNs to document the required content. The *Nursing Documentation* procedure (Number 4.2; new issuance 10-15-10) provides a comprehensive framework for nursing documentation. However, some of the language, and possibly process, do not seem to be fully aligned with SEH policies e.g. references "problems" as opposed to foci, seems to describe paper documentation. Record review revealed that aspects of this procedure are not consistently followed. For example, notes are rarely organized in a "SOAP" format, there are not consistent notes for 72 hours following a significant event, and it is not clear which forms remain in hard copy and which should be electronic. The latter issue, i.e. the combination of hard copy and electronic records (including forms that are in AVATAR) compromises accurate and timely communication about the chronology of important events involving the individual, his or her treatment responses, and current status. Nursing documentation in the records continues to be redundant e.g. both RN and RA write a note with the same content for the

			exact same two-hour time period. Notes rarely add information that relates to the IRP or that provides an enhanced understanding of the individual and his/her progress in treatment. As in the past, documentation relevant to agitated, threatening, or aggressive behavior tends to be detailed, especially when the individual in care did not respond to "redirection". Documentation in these circumstances continues to reflect highly personalized responses to challenging behaviors, a tendency to view these behaviors as "willful", and a lack of understanding of behaviors associated with mental illness. It is quite likely that the findings relative to documentation, as well as observations made during unit tours, are directly related to the fact that unit work is not well organized, accountability is diffuse, and there is inadequate supervision. This is partially influenced by the fact that the single RN assigned to the unit/shift was either not on the unit observing staff, or was present but did not address issues. Other influences include: a pre-printed nursing assignment Sheet that does not provide clear accountability for specific unit functions or for each individual in care; assignments were not consistently completed at the start of the shift by an RN; accountability for critical nursing functions such as q 30 minute checks was not clear. Observations revealing a lack of supervision included the fact that materials with individuals' names were left uncovered on the top of an open desk that was readily accessible to individuals, soiled linens were shaken in the hall and/or carried down the hall to a dirty linen bag, soiled adult incontinence briefs were carried down the hall to a distant trash can, and individuals' first and last names were literally shouted when they were due to receive medication. Although some staff demonstrated and verbalized a caring attitude toward individuals, others were entirely disengaged, often milling back and forth between work areas and areas where

			individuals were sitting. The SEH IRP Monitoring Audit Results (July, August) revealed that RN's were present at 88% of the IRP meetings. In the IRPs that were observed, RNs were consistently present, participated, and generally provided relevant information. The RA was also frequently present and sometimes provided relevant information. The change of shift report that was attended was thorough and included important information relative to behavioral and physical status. IRPs were generally not referenced, though group attendance was reported. **Other findings:** The Nursing Leadership minutes that were reviewed documented non-specific references to audit reviews. The documentation did not adequately reflect all processes associated with performance improvement e.g. specification of the data presented, trend analysis, identification of actions to address trends, monitoring of the effectiveness of the actions taken. It is likely that an orderly discussion that includes these processes would build capacity within the nursing department to achieve necessary improvements. **Compliance:** Partial **Current recommendations:** 1. The SEH CAP (V Treatment Planning; VIII, Treatment Services; and V.VIII, X regarding integrating skill acquisition and house based interventions) contain some actions that will support nursing to meet this provision. Others are needed that address unit operations.

			2. Develop a mechanism for the RN to enter relevant nursing interventions into the IIRP. Train the designated RN to prioritize and individualize interventions. 3. Develop a structure and process for nursing leadership to analyze audit findings, document actions to address findings, and evaluate the effectiveness of those actions. 4. Revise the existing assignment sheet to be aligned with a recovery oriented environment and to ensure enhanced engagement with individuals including EARN implementation. 5. Train all charge RNs and Nurse Managers on using a new assignment sheet to organize work flow and enhance accountability. 6. Train RNs on how to write a progress note.
LDL	VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	**Findings:** Documentation of medically necessary routine and non-routine measurements/information was inconsistently present in the records that were reviewed. For example, there was documentation to reflect that an individual was "underweight" and at risk for "electrolyte imbalance" (GS), however this was not addressed in the IRP and there was no evidence of consistent monitoring by nursing. Other examples include: tachycardia noted in a nursing progress note without subsequent evidence of nursing monitoring and follow-up (RM); inconsistent description of wound or dressing status involving MRSA infection (WM); no evidence of monitoring bowel functions or assessing for dehydration in an individual who went to the ER twice in a two-week period (for evaluation of vomiting and finding of constipation) (YS); inconsistent evidence of assessment/monitoring of an individual with abdominal pain and an elevated temperature and pulse (SL). The Nursing procedure, *Assessing Change in Patient Condition* (Number 3-99; new issuance 10/18/2010) is not well aligned with

			the hospital General Medical Services policy. For example, it does not address important information including the need to assume "…that all physical complaints or observations that could indicate medical/surgical conditions shall be regarded as symptoms of a physical condition until ruled out by a physician or nurse practitioner" (hospital policy). It also does not incorporate physician notification timelines that are based on the level of urgency of the presenting problem. Based on the records reviewed, it is unlikely that the *Change in Condition Form* contains sufficient prompts to support nurses to complete the required assessment and documentation. Guidelines for completion of this form were not provided. Although guidelines are an alternative approach to prompts on the form, in emergent or urgent situations an RN is not likely to consult form guidelines. Form prompts provide real-time structure to the assessment. In the records that were reviewed (involving changes in physical status that resulted in transfer to/return from the ED), RN assessments were incomplete e.g. did not consistently contain basic vital signs, did not contain pain assessment or a description of the pain, did not contain abdominal palpation and auscultation when symptoms required those actions (YS, SL). In addition, there was not appropriate consideration of the potential relationship/implications involving the medications the individual was taking (Clozaril and Lithium) and the presenting problems that included vomiting, constipation, and dehydration (YS). There was inconsistent documentation of the time and name of MD notified. Transfer and return times were inconsistently documented. IRPs did not address physical problems, including following an individual's transfer to an ER twice in a two-week period for the same issues (YS). SEH provided an Input and Output Form (Tab 110) that is

			undated and does not include space to document urinary output. There was no accompanying policy/procedure or form guideline and it is not clear if this is a revised form in response to previous recommendations. SEH has a *Transfers of Individuals in Care* policy (number 11/2/08; revised May 6, 2010). This policy establishes requirements for the transfer of an individual to a medical hospital. The Nursing Procedure, *Patient Transfer to and Return from Outside Facility for Evaluation* (no number, effective 10/01/2010) is aligned with this policy, as is the *RN Transfer Form* (policy attachments A and C). Guidelines for form completion were not provided. The guidelines should direct where the RN is expected to document information that will assist the receiving facility to work effectively with the individual e.g. effective approaches, special considerations. Likewise, since return forms must include physical assessment data that are related to the reason for transfer, direction will be needed relative to where to document such data. A section titled "Baseline Mental Status" is included on both forms. It is not clear if this means *baseline* status or mental status *at the time* of transfer and/or return. The latter is critical information and based on assessment findings, it would be necessary to compare current to "baseline" mental status. This needs to be clarified. SEH reports that audit tools for this provision are under development with implementation targeted for late November or early December. The CAP does not specify actions to support SEH to meet the requirements of this provision. **Other findings:** The physician reviewer reported that in the records reviewed

			involving individuals with seizure disorders, nursing documentation did not align with the *Seizure Management* policy (number 209-10; May 17, 2010) and there was no evidence that the *Seizure Observation Report* had been implemented (policy Exhibit 2). **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. Align the nursing policy for assessing change in individual condition with the hospital policy addressing medical services. 3. Consider revising the template to document nursing assessments for physical status change so that it provides prompts to support nurses to conduct and document assessments necessary for the particular physical status change. 4. Immediately provide training to all RNs on how to assess individuals whose physical status changes. 5. Develop/revise the monitoring instrument and include qualitative criteria; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. 6. Identify and take actions to resolve barriers to consistent documentation of interventions for physical care.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Findings:** SEH has made modifications to the medication administration environment such as improving accessibility of refrigerator locks, location of towel dispensers etc. SEH reported that the nursing leadership group will work with pharmacy to improve first dose response documentation in November. A first dose auditing tool

			has been developed. It is a very long tool and contains criteria not directly related to first-dose documentation and may need to be re-considered in the interests of efficiency. Several direct observations of medication administration were conducted on different units and in the TLCs. Numerous variations from standards were observed that have potential to jeopardize the health and safety of individuals in care. These included preparing insulin doses in a room different from the room that contained the eMAR screen that specified the exact order i.e. insulin type and dose. Although it was clear that the involved RNs were attempting to provide privacy for the individual receiving insulin, all medications need to be prepared in the area where the written order for the medication can be reviewed and verified. Other variations from standards included: inadequate verification of insulin by a second nurse; inconsistent use of two patient identifiers; narcotic keys were passed between nurses without counting; medications were administered at times inconsistent with policy requirements (i.e. at 5:15 AM when the policy indicates 7 AM and allows only one-hour variance in either direction); inconsistent practice around the steps/checks required to ensure that an individual receives medication according to the standard "rights" e.g. right medication, right dose, right route etc. First dose response was inconsistently documented as was the reason for and response to prn or STAT medications. The CAP does not specify actions to support SEH to meet the requirements of this provision. **Other findings:** The e-MAR for a sliding-scale insulin order contained directions

			which were confusing and pose high risk for error. The fact that this order appeared on the e-MAR reflects a breakdown in physician, nurse, and pharmacy systems involving physician medication orders. The specific issue was brought to the attention of the CNE and the Director of Psychiatric Services. **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. Identify and resolve barriers to consistent documentation of medication administration. 3. Develop audit criteria and establish a process to regularly audit medication administration. 4. As an interim measure, the CNE should consider reviewing the proper medication administration practices with all Nurse Managers so that they can increase their own monitoring of medication administration. They may need to be relieved of other duties/routine reports to do this.
LDL	VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	**Findings:** SEH no longer authorizes "certified medication givers" to administer medication. Course outlines for medication administration are comprehensive. In addition, all nursing staff have been trained and achieved 100% competency in medication administration. This, coupled with the observation that the findings in VIII.D.4 involved management level nurses as well as nurses who have been employed at SEH for many years, suggests that the identified issues may be associated with a practice culture that merits review, rather than training per se.

			Other findings: None **Compliance:** Substantial **Current recommendations:** The CAP goals relative to competency based medication administration training have been met. Additional goals and strategies may be necessary relative to the actual practice on the unit. See VIII.D.4
LDL	VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors;	**Findings:** SEH has successfully focused efforts on decreasing the rate of missed documentation for routinely scheduled medications. Monthly reports show reductions in rates of missing documentation from a high of 1.22% in May to 0.57% in August. In addition, SEH is monitoring missing documentation at both the unit and practitioner-specific levels, noting that 48% of the nurses had no missing documentation in August. The success of this effort suggests that SEH will be able to take other effective actions to address findings in VIII.D.4. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	VIII.D.	Ensure that staff responsible for medication	**Findings:**

	7	administration regularly ask individuals about side effects they may be experiencing and document responses;	During medication observations, no staff were observed to ask individuals about side effects. However, this content will reportedly be included in medication education groups that nursing conducts as well as informal interactions. The SEH Compliance Report reflects that this area is an upcoming focus for nursing leadership. eMARS were not reviewed for this item during this review visit. **Other findings:** None **Compliance:** Partial **Current recommendations:** See VIII.D.4
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:** During unit observations that included staff interviews and change of shift report, it was evident that staff knew the general status of the individuals in care. However, they did not know the specific objectives and interventions in the IRP, and did not know the content of behavior plans (though they knew the individual had a behavior plan). This included staff who were performing 1:1 observations. See VIII.D.2, VIII.D.3, and VIII.D.9 **Other findings:** None **Compliance:** Partial

			Current recommendations: See VIII.D.2, VIII.D.3, and VIII.D.9
	VIII.D.9	Ensure that each individual's treatment plan identifies:	Please see sub-cells for findings and compliance.
LDL	VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Findings:** See VIII.D.2, and VIII.D.3 SEH reported that for July and August 91% of the records reviewed met this provision. However, with the exception of identifying TLC groups, nursing interventions were rarely specified in the records that were reviewed during the tour. Although the IRPs specified groups that the individual should attend, the groups were sometimes not linked to objectives. Objectives were often extremely long e.g. actually contained six to eight objectives within one objective, and were not written in behavioral terms. In addition, IRPs were notably silent on nursing interventions related to physical health status. SEH reported that intensive training was provided to treatment teams, including nursing staff, in August and September. Results will be monitored during the upcoming review period. **Other findings:** A new nursing procedure that includes screening and assessment tools was developed to address dysphagia and choking risk. This procedure, *Dysphagia Assessment and Management* (NCP 600.5; revised 11-01-10), is more orderly than previous procedures, and specifies steps and levels of assessment. However, the language is still not fully aligned. SEH will need to monitor whether or not this impacts implementation and documentation. The draft CINA did not include screens referenced in the above procedure.

			In the records that were reviewed, risk for choking or dysphagia was identified, but not addressed in the IRP. There was sometimes conflicting documentation about whether or not certain risk conditions e.g. those associated with dental status, resulted in precautions. Choking precautions were inconsistently documented. In the TLC, three staff who were observing individuals in the dining area did not identify the individual who was on choking precautions. **Compliance:** Partial **Current recommendations:** 1. The CAP contains adequate steps to meet the IRP requirements of this provision. 2. Provide competency based training to staff regarding the new policy/procedure that addresses dysphagia and/or choking. 3. Monitor policy implementation, identify trends, take action to address trends, 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, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a. The SEH clinical chart audit for July and August found that 80% of the records reviewed met this provision. In the records that were reviewed during the tour, the symptoms and target variables to be monitored by nursing were rarely documented in the IRP. **Other findings:** None **Compliance:** Partial

			Current recommendations: See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Findings:** See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a The SEH clinical chart audit for July and August found that 77% of the records met this provision. In the records that were reviewed during the tour, the frequency by which staff needed to monitor symptoms was rarely included. **Other findings:** None **Compliance:** Partial **Current recommendations:** See VIII.D.2, VIII.D.3, VIII.D.4, VIII.D.8 and VIII.D.9.a
	VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	Please see sub-cells for findings and compliance.
LDL	VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Findings:** SEH is actively collecting routine surveillance data for appropriate types of Hospital Associated Infections, patients with Multi-Drug Resistant Organisms, and patients cultured for MRSA on admission. They are also collecting data on Hand Hygiene Compliance. SEH has begun to collect data relevant to employee infections that includes work restrictions due to a communicable disease, blood borne pathogen exposure, numbers of employees receiving influenza vaccine, and employees with a PPD conversion. SEH is in the process of developing a working database relative to monitoring PPD status.

			SEH conducted two focused reviews/special studies: Hep C screening and treatment; and an employee exposure to Blood Borne Pathogens. Both reviews revealed relevant data assessment, trend identification, determination of actions, and a plan for ongoing monitoring to determine the effectiveness of those actions. **Other findings:** Tables and reports that identified "conversion" were clarified. There were no actual PPD conversions. This will be corrected in future reports. Additional table corrections are needed (see "Mean – C" columns). In an effort to clarify previously discussed alternative methods to accomplish Hep B, C, and HIV data reviews, it was apparent that the Infection Control Officer (ICO), Infection Control Committee Chair (ICCC), and Director of Medical Affairs understood both requirements and recommendations. **Compliance:** Substantial **Current recommendations:** SEH CAP includes adequate actions to address PPD tracking. Since the proposed system relies on the Nurse Manager (NM), SEH will need to closely monitor the effectiveness of the plan. SEH may need to consider alternative approaches that are not reliant upon NM data entry.
LDL	VIII.D. 10.b	assess these data for trends;	**Findings:** Although some special studies included trend assessment, there was not consistent documentation reflecting assessment of other data. Infection Control Committee (ICC) minutes are the typical locus for documentation of such assessments, although SEH may

			determine another documentation mechanism. As noted by SEH, ICC minutes were not available for the majority of the review period. The CAP does not specify actions to support SEH to meet the requirements of this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. SEH is encouraged to follow through with planned actions to ensure that the IC requirements in VIII.D.10.c- e are documented and are accurately represented in the minutes. SEH may also determine an alternative approach to ensure the consistent documentation of these required functions. 2. SEH should consider developing a plan to address this provision in the next CAP.
LDL	VIII.D.10.c	initiate inquiries regarding problematic trends;	**Findings:** Although some special studies included inquiries into problematic trends, there was not consistent documentation reflecting inquiries for other data. The CAP does not specify actions to support SEH to meet the requirements of this provision. See VIII.D.10.b **Other findings:** None

			Compliance: Partial **Current recommendations:** 1. See VIII.D.10. b 2. SEH should consider developing a plan to address this provision in the next CAP.
LDL	VIII.D. 10.d	identify necessary corrective action;	**Findings:** Although corrective actions were identified in some special studies, there was not consistent documentation of corrective actions for other data. The CAP does not specify actions to support SEH to meet the requirements of this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2.See VIII.D.10.b
LDL	VIII.D. 10.e	monitor to ensure that appropriate remedies are achieved;	**Findings:** Although some special studies included a plan to monitor that appropriate remedies were achieved following trend identification, there was not consistent documentation of this monitoring for other data. The CAP does not specify actions to support SEH to meet the requirements of this provision.

			Other findings: None **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. See VIII.D.10. b
LDL	VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Findings:** The SEH Compliance Report stated that the ICO represents the ICC on the Performance Improvement Committee. However, the linkages are not specified in the Performance Improvement section of the Infection Control Policy (10.0). **Other findings:** None **Compliance:** Partial **Current recommendations:** Specify the linkages between the ICC and hospital-wide Quality Assurance/Performance Improvement in Section 10 (Performance Improvement) of the Infection Control policy.
LDL	VIII.D. 10.g	ensure that nursing staff implement the infection control program.	**Findings:** There was some documentation in the records indicating that nursing staff implemented special precautions. However, the fact that the IRP does not reference relevant special precautions is likely to pose some barrier to ensuring consistent documentation in nursing progress notes.

			SEH reported that orders for special precautions went "live" in AVATAR in September and that nursing staff will now use the e-MAR to "respond" to such orders. If the e-MAR will be used to document implementation of precautions, it will be critical that training and ongoing monitoring ensure a mechanism to describe individuals' status as necessary e.g. wound status. See VIII.D.2 for issues relative to handling soiled items on the units. The CAP does not specify actions to support SEH to meet the requirements of this provision. **Other findings:** The ICO has developed templates for IRP interventions for Hep/HIV and MRSA. These templates are designed to provide a resource for RNs, enabling them to consistently integrate relevant infection control interventions into the IRP. However, the templates still do not align with the language that SEH uses for the IRPs e.g. reference "problems" rather than foci. Aligning the templates with the IRP framework will strengthen their utility. Based on ongoing surveillance, it may be useful to develop additional templates to support the RNs' to develop IRP interventions to address individuals' health and wellness. **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. Identify and resolve barriers to consistent documentation of infection control program implementation. 3. Continue to develop a menu of IRP objectives and

			interventions to support staff to include IC matters in the IRP as relevant.
LDL	VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services.	**Findings:** The CNE has developed a *Plan for the Provision of Care* that addresses relevant content including the target levels for Nursing Care Hours Per Patient Day (NCHPPD; 6.0) and RN Skill Mix (40%). These targets are consistent with the SEH individuals' requirements for nursing care as well as for supervision of non-licensed nursing care providers. SEH reported completing an analysis of the number of positions required to meet the SEH staffing plan (NCHPPD as well as required skill mix). SEH reportedly is working with the Department and the CFO's Office to identify new positions and funding to meet the required NCHPPD as well as a 40% RN skill mix. SEH is to be commended for this undertaking. In the interim, SEH is also to be commended for several efforts designed to reduce RN paperwork so that the existing RNs can be more fully focused on direct care and supervision. SEH has developed a mechanism to monitor the NCHPPD and RN mix through a report that also specifies the variance. Beginning in September, this report also included 1:1s (which were appropriately removed from the NCHPPD calculations) as well as use of overtime and contract employees. SEH has noted a reduction in unscheduled absences as a result of supervisory follow through and the addition of part time positions to assist with weekend staffing needs. Subsequently, they are beginning to see a reduction in the number of occasions when staff are required to move from their home unit to cover another unit. This will provide one platform for unit staff to increase their knowledge of individuals' IRPs.

			SEH reported that all shifts and units have had at least 1 RN on duty for this review period. SEH further reported an average of 5.4 NCHPPD and 25% RN mix from May through August. This generally aligns with the one week unit/shift staffing that SEH provided for review. SEH has reported an adjustment in the RN workload in terms of paperwork and reporting requirements. This is commendable and should continue. It may also be useful to review the functions and reports that may not add value at this time, or that may detract from the Nurse Managers' ability to provide active clinical and operational supervision on the units. See VIII.D.2 regarding unit operations. **Other findings:** None **Compliance:** Partial **Current recommendations:** The CAP contains adequate steps to address this provision. Conducting and documenting regular staffing evaluations during the nursing leadership meetings would strengthen management integration.

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

	X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications		
LDL		By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	**Summary of Progress:** 1. SEH seclusion and restraint use remains below national benchmarks. 2. SEH has reached substantial compliance in X.B.4, and X.C.1 – 5.
LDL			**Methodology:** Interviewed: See VIII.D Reviewed: See VIII.D Observed: See VIII.D.
	X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	Please see sub-cells for findings and compliance.
LDL	X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Findings:** SEH reported that policy/procedure alignment was completed. One nursing procedure was compared with the hospital policy to validate this report. It was noted that the nursing procedure, *Padded Mitten Utilization* (Number 3-102; new issuance 10/18/10) conflicts with the hospital policy *Medical or Protective Measures, Devices, and Techniques* (Number 101.2-08; revised March 30, 2010). For example, the hospital policy requires RN assessment every 15 minutes, specifying that safety, circulation and comfort be included in the assessment. The nursing procedure calls for

			this assessment to occur every hour. SEH also reported that alignment of form content is "ongoing" and changes in two key forms (*Doctor's Order form for Seclusion and Restraint* and *Level of Observation Flow Sheet)* are pending Avatar redesign. During the last review these forms were also awaiting revision. During several prior visits, it was evident that SEH had successfully eliminated prone restraint. However, during this review period there was one instance of prone restraint. The incident was appropriately investigated and relevant follow up occurred at the practitioner/staff specific level. However, there was no evidence that SEH considered the possibility that the use of prone restraint was a systemic "red flag". Since the involved staff were not new to SEH, and since there was some evidence that at least one staff member raised the issue that prone restraint was prohibited, it is quite likely that the use of prone restraint is a symptom of a larger issue within the hospital. The larger issue relates to the failure to ensure that staff remain competent in related annual mandatory training requirements (see X.A.2), the increase in violence and staff injuries, as well as the failure to adequately address clinical risks for violence in the IRP. The latter is likely to be influenced by the fact that there are rarely debriefings following seclusion or restraint use, excellent comfort plans are generally not integrated into IRPs, and there is no documented evidence that IRPs are reviewed or adjusted when individuals with especially challenging behaviors meet established frequency/intensity thresholds that require review. Notably, the Clinical Administrator on one unit consistently ensures that information from comfort plans is included in the IRPs. It would be useful to explore how this is accomplished, and whether or not it is helpful in addressing violence. The CAP does not specify actions to support SEH to meet the

			requirements of this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. Methodically review all policies (hospital and nursing) addressing restraint/seclusion, protective devices, and emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards. 3. Ensure that the content on all forms is consistent with policies/procedures and supports staff to complete required documentation.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Findings:** Both the Non-Violent Crisis Intervention (NVCI) and the Restraint and Seclusion (R/S) competency based training for new hires is at 100%. However, a significant number of existing staff are not current with training requirements in these areas. Specifically, SEH reports that only 59% of the employees required to take NVCI training (every two years), and 72% of the staff required to take R/S training (annually) are current with requirements. Further, despite the fact that as a 24/7 discipline nursing staff have the most opportunity to intervene with potential for violence, only 55% of them are current in NVCI and only 70% are current in R/S (one of the highest risk procedures in psychiatric mental health care). The NVCI competency based training is the main curriculum used

			by SEH to teach content that is key to reducing violence. This content includes: how staff can identify cues in advance of behavioral emergencies; how staff behavior and choice of words influences the potential for violence; and how staff can safely manage behavioral emergencies. However, designated staff are only required to attend this training every **two** years. The two-year interval merits re-evaluation in light of the current level of violence. The fact that an appreciable number of clinical staff, as well as security staff, have not maintained competency, is likely to be an important influence on the current rate of violence and staff injuries at SEH. Of note, a special study conducted by SEH about psychiatric emergencies revealed that four of the six categories of common stressors and precipitating factors directly relate to the quality of staff interactions and/or their ability to recognize early cues to agitation. **Other findings:** None **Compliance:** Partial **Current recommendations:** The CAP contains adequate steps to address the need for improved employee attendance at competency based annual updates.
LDL	X.A.3	the use of side rails on beds, including a plan:	**Findings:** In the record that was reviewed relative to the use of side rails, documentation was thorough, associated issues were addressed in the IRP, and efforts were made to minimize side rail use. Based on the difference between Compliance Report 6 (no side rails used during review period) and an October 19, 2010 letter from

			SEH (identifying three patients involved in side rail use), it is apparent that SEH is continuing to improve the accuracy of side rail use reports. **Other findings:** None **Compliance:** Partial **Current recommendations:** Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken.
LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Findings:** See X.A.3 **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.3
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.	**Findings:** See X.A.3 **Other findings:** None **Compliance:**

			Partial **Current recommendations:** See X.A.3
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;	The CAP contains adequate steps to address the need for improved employee attendance at competency based annual updates.
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:** Unit/house based schedules were provided that included evening and weekend programming. However, unit based groups that were scheduled during the day were not occurring when the houses were visited. One staff member quickly started a group (different from the one that was scheduled) and individuals were engaged during the group activity. There continue to be significant numbers of individuals on units rather than TLCs, not engaged with staff, and sleeping during the day. The CAP does not specify actions to address the issues that influence the ability of SEH to meet the requirements of this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:**

			1. SEH should consider developing a plan to address this provision in the next CAP. 2. Evaluate EARN implementation. 3. Determine and resolve barriers to unit based groups as well as TLC attendance.
LDL	X.B.3	are not used as part of a behavioral intervention; and	**Findings:** See VIII.B.1.c **Other findings:** See VIII.B.1.c **Compliance:** Substantial **Current recommendations:** See VIII.B.1.c
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Findings:** SEH audit findings show that this provision was met in 100% of the situations that were audited. In the charts that were reviewed during the tour the findings were the same. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.

LDL	X.C.1	the specific behaviors requiring the procedure;	**Findings:** SEH reports that audit findings from March – August revealed that the order specified the behaviors requiring R/S in 94% of the situations reviewed. 100% of the charts reviewed during the tour met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.2	the maximum duration of the order;	**Findings:** SEH reports that audit findings from March – August revealed that 100% of the records reviewed met this requirement. 100% of the charts reviewed during the tour also met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	**Findings:** SEH reports that audit findings from March – August revealed that 88% of the records reviewed met this requirement. 100% of the charts reviewed during the tour met this requirement. **Other findings:**

			None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Findings:** SEH reports that audit findings from March – August revealed that in 100% of the records reviewed (that involved an ordering physician different from the attending physician) met this requirement. 100% of the charts reviewed during the tour met this requirement. **Other findings:** None **Compliance:** Substantial **Current recommendations:** Maintain compliance.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;	**Findings:** SEH reports that audit findings from March – August revealed that 71% of the records reviewed met the requirement to re-inform the individual every 15 minutes (SEH policy requirement). This requirement was not applicable to the charts reviewed during the tour because the individuals were released. **Other findings:** None **Compliance:**

			Substantial **Current recommendations:** Proceed with plan to adjust audit tool to align with the provision and maintain compliance.
LDL	X.C.6	ensure that immediately following an individual being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	**Findings:** SEH reports that audit findings from March – August revealed that 18% of the records reviewed met this requirement. None of the charts reviewed during the tour met this requirement, including those that involved individuals with several s/r episodes (for example: NT; KH). **Other findings:** None **Compliance:** Partial **Current recommendations:** The CAP adequately addresses this issue. 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 from March – August revealed that 63% of the records reviewed met this requirement. 50% of the records reviewed during the tour met this requirement. **Other findings:** None **Compliance:** Partial

			Current recommendations: Continue monitoring.
LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	**Findings:** See X.A.2 **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.2
LDL	X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	**Findings:** The SEH Compliance Report indicated that they will cross-check information extracted from the physician's order for restraint and seclusion incidents with the daily nursing report. They have eliminated the requirement that S/R be reported on an UI. In addition, they reported that they are developing a system to specifically monitor and report emergency involuntary psychotropic medications. **Other findings:** None **Compliance:** Partial **Current recommendations:** Ensure that the variables currently available in STAT medication reports are included in the new emergency involuntary medication monitoring system.

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 "high performance" in this indicator (100% for one individual from March – August). The records reviewed during the tour did not consistently reflect adherence to this requirement. (For example, see KH). **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.1 and X.B.1
	X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	Please see sub-cells for findings and compliance.
LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Findings:** SEH has made changes in physician's orders and nursing documentation of STAT meds in an effort to develop a database to evaluate emergency involuntary psychotropic medication use. SEH also reported to be in the process of developing a mechanism to specifically monitor use of emergency involuntary psychotropic medication. It is anticipated that this will be operational in advance of the next review visit. The Pharmacy and Therapeutics committee will be responsible to review these data. An audit tool was developed and projected to be implemented in October. A review of the records indicated that a number of individuals received emergency involuntary medications over the course of several weeks without evidence of review or adjustment to the

			IRP. **Other findings:** None **Compliance:** Partial **Current recommendations:** Monitor the use of emergency involuntary psychotropic medication administration.
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 In the records that were reviewed, there was generally evidence of physician assessment. However, the exact time could not always be determined. **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	**Findings:** See X.F.1 In the records that were reviewed this requirement was not consistently met. Although it was reported that this provision will be tracked in the upcoming audits, the CAP does not specify

		revised plan, as appropriate.	actions to support SEH to meet the requirements of this provision. **Other findings:** None **Compliance:** Partial **Current recommendations:** 1. SEH should consider developing a plan to address this provision in the next CAP. 2. Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes.
LDL	X.G	By 18 months from the Effective Date hereof, SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Findings:** See X.A.2 Emergency involuntary psychotropic medication use has been integrated into the competency based training on restraint and seclusion. The Training Director and the DNER are currently planning to develop a separate module for physicians and nurses since they are most consistently involved in emergency involuntary psychotropic medication use. **Other findings:** None **Compliance:** Partial **Current recommendations:** See X.A.2

	XI. Protection from Harm		
BJC		By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.	**Summary of Progress:** 1. The new hospital has been designed to provide a safe physical environment. Comfort rooms are available, providing a space where individuals in care can move away from the activities on the unit and find quiet space. Crowding and its potential for aggression is diminished with the availability of two common sitting and television viewing areas on each unit. Bedrooms and bathrooms are designed to minimize the risk of self-harm. Wardrobes have sliding doors rather than hinged doors, and bathrooms provide privacy through curtains hung from ceiling tracks. Furniture in the courtyards is bolted to the patio, so that it cannot be used as a weapon. 2. The hospital's policies clearly articulate the responsibility of all staff members to report allegations of abuse and neglect. They state further that staff who fail to report are subject to disciplinary action. Reporting responsibilities are also covered during orientation training and in annual A/N/E reporting training. The Risk Manager has been the sole investigator of allegations of A/N/E during much of the review period, however, recently the hospital hired an investigator to assist the Risk Manager in the timely completion of investigations. 3. As stated in earlier reports, the review of criminal background checks is completed by the licensing body for all licensed staff members. This practice has not changed.

	XII. Incident Management		
BJC		By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	**Summary of Progress:** 1. The hospital hired an investigator to assist the Risk Manager in the timely completion of investigations at the end of September. 2. Following the close of the review period, the hospital revised the policy that governs the removal of staff members named in A/N/E allegations, Unusual Incident Investigation (302.4-09). Implementation of this policy should standardize practices for removing staff. 3. Two policies related to Incident Management (301-01 and 302.1-03) were revised so that they cite the same definition of neglect. 4. The hospital has recently expanded the UI (Unusual Incident) database to include recommendations made at the close of the investigation, the staff member responsible for implementation and a status report on movement toward effective implementation.
BJC			**Methodology:** <u>Interviewed</u>: 1. S. Bergmann, Director Performance Improvement Department 2. A. Kahaly, Risk Manager and Principal Investigator 3. J. Taylor, Director of Policy and Procedures 4. P. Canavan, Psy.D, Executive Director <u>Reviewed</u>: 1. Policy 301-01: Reporting A/N/E of Individuals in Care 2. Policy 302.1-03: Unusual Incident Reporting and Documentation 3. 11 investigation reports 4. A/N/E annual training dates for 19 staff members

			5. Aggregate incident data from PRISM 6. Aggregate assault data 7. Study of Psychiatric Emergencies (Code 13) 8. Treatment of Personality Disorders workgroup document 9. Violence Reduction/Safety Committee minutes
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:** Presently, the hospital's policies which address various aspects of incident management are comprehensive and consistent. During much of the review period, the Risk Manager was the sole investigator of allegations of A/N/E. This resulted in the lack of timely completion of many of the investigation reports reviewed. Other issues that surfaced during the review of investigations are discussed in the succeeding cells. **Compliance:** Partial **Current recommendations:** 1. Monitor the timely implementation of the Incident Management policies.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Findings:** In response to an observation made by this monitor, Policy 302.1-03: Unusual Incident Reporting and Documentation was revised on site on November 1, 2010 to include the same definition of Neglect as is used in Policy 301-01: Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care. Presently, both policies define Neglect as "any actual, alleged, or suspected action or failure to act by an employee or contact worker that impairs, or creates a substantial risk of impairment to the physical, mental or emotional condition of an individual in care, and includes failure to adequately supervise an individual in care,

			regardless of whether injury results." The Unusual Incident Reporting and Documentation policy defines the use of restraint and seclusion and elopements as major unusual incidents. **Other findings:** The investigation of the prone restraint of an individual in care on 7/26/10 determined the order by the physician to constitute abuse. The use of prone restraint is prohibited by SEH policy. The hospital reported that the physician was verbally counseled by the Director of Medical Affairs and the Director of Psychiatric Services. The counseling included review of the policy Seclusion and Restraint for Behavioral Reasons. Additionally, the Director of Psychiatric Services e-mailed a reminder to all psychiatrists directing them to the policy, the prohibition of prone restraint and the rationale for the prohibition. The issue was also discussed at an all psychiatrists meeting. **Compliance:** Substantial **Current recommendations:** 1. 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 audits investigations and identifies staff members who fail to report allegations of A/N/E in a timely manner. Data covering the period September 1, 2009-August 1, 2010 identifies delayed reporting in nine A/N/E incidents. Five of the nine incidents were allegations of neglect and four were allegations of physical abuse.

			Other findings: Data on the timeliness of reporting A/N/E allegations for the period 3/1/10-8/30/10 provided by the hospital indicates that in March, 2 of 3 A/N/E incidents were reported within one day; in April, 1 of 3; in May 1 of 5; in June 1 of 3; in July 2 of 5; and in August 4 of 5. This aggregate data is accompanied by a narrative describing the reason for the delay for each case. Delays ranged from 3to 81 days. Delays are calculated from the date of the incident (not the date it is reported) to the day the incident report is completed. Thus, if an incident occurred on May 1, but the allegation was not made by the victim until May 10 and the incident report was written on May 10, the reporting is nonetheless considered 10 days delayed. The Unusual Incident Reporting and Documentation policy of the hospital (302.1-03) requires that major unusual incidents (which include A/N/E) must be verbally reported within one hour of the incident (or of learning of the incident) to the Risk Manager. The completed and signed report must be submitted by the end of the shift. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice of identifying failure to report allegations of A/N/E in the manner prescribed in policy.
BJC	XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged	**Findings:** In 9 of the 11 investigations reviewed, an alleged staff perpetrator was named. In one of the nine, both Yes and No were checked in response to the question on the face sheet asking if the staff member was removed. In half of the remaining eight

		perpetrators from direct contact with individuals pending the investigation's outcome;	investigations, the named staff member was removed. **Other findings:** The policy that addresses the removal of staff members named in A/N/E allegations, Unusual Incident Investigation (302.4-09), was revised after the review period on October 20, 2010. This may account for the variability in the findings from the investigations sampled. The revised policy calls for the named staff member to be "immediately removed from any individual in care areas, assigned to other duties pending the outcome of the investigation, or placed on administrative leave consistent with any collective bargaining agreement or DC law." The exception to the above occurs in the following circumstance: Upon the written request of the employee's supervisor, the Assistant Director of Nursing or applicable Executive Staff member shall consult with the Risk Manager and determine whether the staff member may be permitted to provide clinical services. In the event that the applicable Executive Staff member concludes the employee does not need to be reassigned from clinical duties or placed on administrative leave, he or she shall ensure that the employee does not have contact with the putative victim." **Compliance:** Partial **Current recommendations:** 1. When a staff member named in an allegation of A/N/E is not removed under the exception in Policy 302.4-09, the investigation should include documentation of this circumstance.
BJC	XII.A.4	adequate training for all staff on recognizing	**Findings:**

and reporting incidents;

As indicated by the asterisk following the training date, six of the 19 employees sampled had not completed annual A/N/E training in the last year.

Staff member	Date of most recent annual A/N/E training
_F	2/11/09 *
_W	3/19/10
_I	4/2/10
_M	3/30/10
_R	4/2/10
_Y	1/5/10
_P	3/18/09 *
_R	3/18/09 *
_Y	3/3/10
_A	2/11/09 *
_M	3/16/10
_O	4/27/10
_D	3/30/10
_M	6/8/10
_B	3/22/10
_B	3/29/10
_M	3/18/09 *
_S	3/30/10
_P	2/24/09 *

Only last initials are provided to protect confidentiality.

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

			competency, according to the hospital. **Compliance:** Partial **Current recommendations:** 1. Take the measures outlined in the hospital's CAP to address staff training—both for orientation training for new employees and for recurring training for current employees. These measures adequately address the provision of training provision and monitoring of participation.
BJC	XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	**Findings:** Training on the obligation to report allegations of A/N/E is part of orientation training for all new employees. Additionally, this responsibility is clearly stated in policy, as are penalties for failure to report and protections from retaliation for reporting. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Findings:** In each of the units visited, a statement of rights of individuals in care in both Spanish and English was posted in a common area. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.

BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Findings:** The face sheet of each investigation report includes the question of whether an arrest was made in the case. In several incidents, the there was documentation that persons were referred to law enforcement. Specifically, JJ was arrested for arson after he lit his mattress in March 2010. In May, EI was transferred to jail on charges related to his attacks on individuals in care and staff members. A nurse filed sexual assault charges with the Metropolitan Police Dept. against an individual in care related to a March incident. **Compliance:** Substantial **Current recommendations:** 1. Continue to address the question of law enforcement referral in each investigation of A/N/E and whenever criminal activity is involved.
BJC	XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Findings:** Policy 301-01: Reporting Suspected A/N/E of Individuals in Care states that any employee, individual in care or other person who reports suspected A/N/E shall be free of retaliatory action by SEH, DMH, or the government of the District of Columbia as a result of reporting. **Other findings:** In the investigation of the alleged exploitation of LM and CW, the staff member reporting the incident said she feared she would be fired for reporting the incident. She was reassured by the Assistant Director of Nursing that she would not lose her job, provided the allegations were valid and not made with malicious intent.

<table>
<tr><td></td><td></td><td></td><td>No other investigations reviewed raised the question of retaliation or bribery.

Compliance:
Substantial-based on a limited sample.

Current recommendations:
1. Continue current practice of reinforcing with staff the responsibility to report incidents and the protections available to them for good-faith reporting.</td></tr>
<tr><td>BJC</td><td>XII.B</td><td>By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:</td><td>Findings:
Policy 302.4-09 Unusual Incident Investigation, revised on October 20, 2010 does not set timeframes for the completion of investigation reports. For investigations in institutional settings, timelines generally require completion by 30 days after the report of the incident unless there are extenuating circumstances. In the sample of 11 investigations, six were closed nearly 90 days or more after the report of the incident.
The completion of investigations was hampered during the report period by the insufficient number of trained investigators. The Risk Manager lost his assistant investigator at the end of June and the position remained vacant until the end of September. This left the Risk Manager as the sole investigator of all allegations of A/N/E. During the period, March 1-August 31, 2010, 19 investigations were closed. The Risk Manager was also responsible for ensuring the completion of Follow-Up reports for those incidents that did not require a full investigation. With the hiring of the additional investigator, the hospital expects that investigations will be completed in a timely manner.

<table>
<tr><th>Incident Type
Incident Date</th><th>Reported to Risk Management</th><th>Closed</th></tr>
</table>
</td></tr>
</table>

			Neglect Allegation 5/31/10	6/1/10	6/25/10
			Allegation of A/N/E— Inappropriate relationship 7/21/10	8/13/10	9/16/10
			Abuse Allegation 7/18/10	7/19/10	10/30/10
			Abuse Allegation 7/1/10	7/2/10	10/30/10
			Abuse Allegation 8/8/10	8/8/10	10/30/10
			Neglect Allegation 8/20/10	8/20/10	10/30/10
			Allegation of neglect 4/19/10	4/22/10	10/29/10
			Neglect/Exploitation Allegation 5/21/10	5/21/10	10/31/10
			Allegation of sexual abuse 6/4/10	6/4/10	10/28/10
			Allegation of Neglect 5/12/10	5/12/10	6/22/10
			Allegation of Physical Abuse 7/26/10	7/30/10	10/28/10
			Compliance: Partial **Current recommendations:** 1. Identify in policy the hospital's expectations regarding timeliness in completing A/N/E investigations. 2. Take any measures possible to expedite the complete and		

			timely investigation of incidents.
BJC	XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Findings:** Investigations of allegations of A/N/E are completed by staff members of the Performance Improvement Department. These staff members are independent and have no affiliation with any residential unit or treatment location. Several investigations reviewed identified a staff member's failure to follow nursing policies. **Other findings:** Please see XII.B.3. **Compliance:** Partial **Current recommendations:** 1. Provide close supervision of investigation to ensure their completeness and compliance with hospital policy.
BJC	XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	**Findings:** Both the Risk Manager and his recently hired Investigator have completed competency-based training in investigations as evidenced by copies of certificates of completion of training. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with	**Findings:** Several findings listed below indicate that not all of the

		investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	investigations reviewed were thorough and complete: • In none of the investigations reviewed, except in the investigation of the physical abuse of HS (8/8/10), were individuals in care interviewed unless they were the alleged victim, although in several investigations the circumstances of the incident suggested that individuals in care would likely have seen or heard the incident under investigation. • In one investigation reviewed, a staff member was named on the investigation report face sheet as an "identified witness" but was not interviewed. Specifically, in the investigation of the physical abuse allegation made by KH (7/1/10), the Supervisory Psychiatric Nurse is listed as an identified witness, but the investigation report does not include an interview of her. • In the investigation of the allegation of exploitation made on behalf of LM and CW (5/21/10), the staff member alleged to have financially exploited the two individuals in care was not interviewed. Additionally, the two individuals in care were not interviewed to learn if they had given money to the named staff member and had not received the goods for which they allegedly paid. • In the 11 investigations reviewed, there was no documentation in the investigation reports of face-to-face or telephone interviews with a total of 20 persons listed on the investigation report face sheets as having been interviewed. In most of these instances, the investigation report contained the written statements of these persons. Most commonly, in the investigation reports reviewed, when a face-to-face interview or telephone interview was conducted it was identified as such. Thus the lack of this documentation for these 20 persons should indicate that they were not interviewed by

			the investigator either in person or via the phone. See the portion of the UI Investigation policy cited below that specifically addresses the hospital's expectation that persons who provide written statements will also be interviewed. **Other findings:** One reading of the language in Policy 302.4-09 Unusual Incident Investigation indicates the expectation that individuals in care who may have witnessed an incident should be interviewed. Specifically, the policy states the investigator is to: Interview the individual-victim, and all other staff, co-workers, witnesses and potential witnesses, including all people who have previously submitted written statements. **Compliance:** Partial **Current recommendations:** 1. Ensure that all persons who may have witnessed an incident are interviewed and a summary of the interview is included in the investigation report.
BJC	XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations.	**Findings:** The revised policy, Unusual Incident Investigation, addresses the implementation of recommendations from investigations. It places responsibility on the "Executive-level Director to immediately implement any recommendations that have been approved by the Director of Performance Improvement, at the location or department at which the incident occurred while waiting for the development of any system-wide changes."

			Seven staff members in the 11 investigations of allegations of A/N/E reviewed were found to have engaged in misconduct. Human Resources Dept. reported that all received some form of discipline or resigned before discipline or disciplinary action is being prepared. **Other findings:** At the conclusion of the investigation of an inappropriate relationship between an individual in care and a staff member, the investigator found that several staff members had suspected that something was amiss, but did not report their suspicions. The investigation report concludes with the recommendation that all staff on the unit receive training on the timely reporting of incidents. I was advised by unit leadership that this recommendation was implemented by the nursing supervisor during the August 3-5 staff meeting. Review of the nursing supervisor's notes of that meeting contain only a reference to "be familiar with the Abuse policy. " This does not adequately implement the recommendation that they be trained. Please also see XII.C. **Compliance:** Partial **Current recommendations:** 1. Implement the plan reportedly still in place to assign Quality Improvement Coordinators to specific houses and disciplines to ensure recommendations made in incidents reach the responsible staff members and to facilitate implementation.
BJC	XII.C	By 24 months from the Effective Date hereof,	**Findings:**

		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.	Presently the Performance Improvement Director keeps a log of systemic recommendations coming from incident investigations and committee recommendations. This log identifies the incident type or the committee, the specific issue (e.g., safety, not performing duties, accountability for individuals in care), the recommendation and the status of implementation at follow-up. The log current at the time of the visit identified 35 recommendations. Eight of the recommendations are listed as completed or the narrative reads as if the recommendation has been implemented. Several narratives in the status section state that the recommendation will be implemented in the future, e.g., PID plans to begin auditing security check sheets in December. Other narratives provide no assurance that the problem has been addressed. For example, a June investigation of neglect recommended "Nursing Department should ensure that the Nursing Supervisor is conducting regular rounds to all Houses during the evening and night shifts " The status section answered: This is "part of the routine duties and expectations of the off shift supervisor." Presumably, rounds were part of the duties of the supervisor when the neglect occurred, so reiterating that this is an expectation without providing any evidence of a monitoring strategy is not a satisfactory remedy for the problem. **Other findings:** The hospital has recently expanded the UI (Unusual Incident) database to include recommendations made at the close of the investigation, the staff member responsible for implementation and a status report on movement toward effective implementation. **Compliance:** Partial

			Current recommendations: 1. Ensure that responses to recommendations provide an assurance that the issue has been addressed and monitoring will occur to ensure that implementation has been effective.
BJC	XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	**Findings:** The hospital's Unusual Incident database is able to identify individuals in care and staff members who appear in incidents. Each month the PRISM report states the number of unique individuals involved in incidents. For example, in August 2010, 115 individuals were involved in incidents, 66% in one incident, 19% in two incidents, and 2% in 6-10 incidents. The investigation reports reviewed included a review of the incident history of the individual in care and the named staff member in most instances. The exception was in the investigation of the physical abuse of AP. This investigation did not include a review of the physician's incident history. **Other findings:** The Unusual Incident database has recently been expanded to include the disposition of the investigation (substantiated or not substantiated) and the recommendations made at the close of investigations. The hospital will begin populating these fields shortly. During the review period, this data was kept on a log which included the incident type and date, the name of the alleged victim, the named staff member, the outcome/disposition and the initial administrative actions taken. **Compliance:** Substantial

			Current recommendations: 1. Add disposition and recommendations to the UI database, as planned.
BJC	XII.E	By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:	**Findings:** As identified in the cells below, the hospital tracks incidents by several variables, including type and location. The frequency in which individuals are named in incidents is also tracked, as is the frequency of delayed reporting. The level of peer assaults and assaults on staff is a matter of concern to the hospital. [Please see XII.E.1.a]. Several committees are reviewing this data. The Violence Reduction Committee and the Safety Committee met jointly for several months beginning in June to identify possible contributing factors and offer suggestions for initiatives to reduce the level of violence. Additionally, the hospital completed a study of Code 13 events (call for additional assistance to deal with an individual's behavior) and made findings regarding possible contributing factors. The Treatment of Personality Disorders workgroup report also addresses findings related to the reduction of factors that contribute to, if not foster, aggression. The work of various committees and studies have identified likely factors contributing to the aggression seen on the living units. These include: • In the new hospital, the integration of staff who formerly worked on civil units with those who formerly worked on forensic units has not always been smooth. Forensic staff tend to prefer tight rules and schedules. The mix of staff has led to inconsistent application of unit rules. • The lack of outdoor space for individuals on units in the upper storey units of the hospital means that staff must accompany some individuals outside. There are times when there are not a sufficient number of staff to

			accommodate the individuals' requests. • There were instances where front-line staff were making decisions to rescind an individual's privileges. This action can now be taken only with the approval of the treatment team. • Three individuals were responsible for a disproportionate number of injuries to others. One of these individuals has been discharged and the other two were separated into different units • Unit staff are not making effective use of comfort plans when individuals begin to show signs of agitation/escalation. In response, a binder was being prepared with each individual's comfort plan for each unit. This made the plans accessible quickly without staff having to go into the individual's clinical record to locate it. • Staff lack skills in identifying warning signs and employing calming techniques. • Treatment needs to be enhanced for individuals with Axis II diagnoses. **Other findings:** The Violence Reduction Initiative has been in the planning stages for over a year. The Committee chair made a presentation to the full staff meeting on October 6. "One is Too Many" stickers (meaning one violent incident) were provided to staff. In mid-December, buttons with this slogan and logo will be available. Early in December, the initiative will conduct a poetry and poster contest with prizes for the individuals whose works are chosen and for their units. Suggestion boxes were distributed to units and optional forms to complete for individuals' suggestions on ways of reducing violence. The use of Non-violent Crisis Intervention trainers as staff members on selected units to

			model de-escalation and prevention techniques has been suggested for implementation sometime in December. It is unclear whether the Crisis Intervention initiative has yet been approved by hospital leadership. **Compliance:** Partial. The hospital has been tracking and analyzing data, but no documentation was presented of actions (beyond those described above) taken in response or of a review of the effectiveness of any actions taken. **Current recommendations:** 1. Plan and present a timetable listing specific actions to reduce violence, such as increased recreational activities, incentives to houses that reduce violence, formation of a Peacemaker's group among individuals in care. Implement the actions as resources become available. The specific actions are suggestions only; the hospital should adopt activities that fit its needs and resources. 2. Continue current practice of tracking and trending incidents. Include the tracking of corrective measures, as planned.
BJC	XII.E.1	Track trends by at least the following categories:	Please see sub-cells for findings and compliance: The hospital has demonstrated its ability to track and trend data and present it in a useful format. Additionally, various hospital committees and studies have made recommendations for decreasing violence based on this data. It is not yet clear which of these recommendations will be implemented.
BJC	XII.E.1.a	type of incident;	**Findings:** The hospital provided data on incidents by type. A selected sample is shown below:

			<table><tr><th>Incident type</th><th>Sept.09-Feb 2010 (from UI Feb 10 report)</th><th>March-Aug 2010</th></tr><tr><td>A/N/E</td><td>35</td><td>24</td></tr><tr><td>Assault/Altercation</td><td>171</td><td>215</td></tr><tr><td>Contraband</td><td>34</td><td>56</td></tr><tr><td>Death</td><td>6</td><td>2</td></tr><tr><td>UL/Disappearance</td><td>31</td><td>22</td></tr><tr><td>Crime</td><td>3</td><td>5</td></tr><tr><td>Restraint/Seclusion</td><td>26</td><td>27</td></tr><tr><td>Total</td><td>306</td><td>351</td></tr></table> The increase in the number of incidents of assault (physical and sexual) raises concerns about the safety of individuals in care and staff. In the period October 09-September 10, the hospital averaged 1.1 assaults per day. In the period September 09-February 10, the hospital averaged 30 assaults a month. This rose to 35 assaults a month in the following six months, March-August 2010. **Compliance:** Substantial--for collecting and distributing data. **Current recommendations:** 1. Continue current practice collecting and analyzing incident data.
BJC	XII.E.1.b	staff involved and staff present;	**Findings:** In the nine investigation reports reviewed where a specific staff member was named as the alleged perpetrator, the incident history of the named staff member was documented in five. **Compliance:**

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>Partial

Current recommendations:
1. Consistently review the incident history of named staff members in incident investigation reports to assist in identifying patterns of behavior.
2. Just as the hospital creates a listing of individuals involved in multiple incidents, create a similar list of staff members involved in multiple incidents on a periodic basis.</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.c</td>
<td>individuals involved and witnesses identified;</td>
<td>Findings:
In each of the 10 investigations of A/N/E reviewed where a specific individual in care was named, the incident history of that individual/victim was provided.

Other findings:
The hospital tracks the number of individuals involved in multiple incidents on a monthly basis. A sample of this data below indicates that the number and percentage of individuals involved in four or more incidents has been rising since May.

<table>
<tr><td>Month</td><td>Feb 10</td><td>March</td><td>April</td><td>May</td><td>June</td><td>July</td><td>A</td></tr>
<tr><td>#</td><td>7</td><td>5</td><td>4</td><td>12</td><td>9</td><td>16</td><td>17</td></tr>
<tr><td>%</td><td>7%</td><td>5%</td><td>4%</td><td>10%</td><td>10%</td><td>15%</td><td>15</td></tr>
</table>

SEH data on the role of individuals in care in incidents shows an increasing number in the role of aggressor as shown below. The data shows a 108% increase in August over the February figure:

<table>
<tr><td>Month</td><td>Feb</td><td>March</td><td>April</td><td>May</td><td>June</td><td>July</td></tr>
<tr><td># in aggressor role</td><td>36</td><td>35</td><td>46</td><td>53</td><td>53</td><td>63</td></tr>
<tr><td># in victim</td><td>35</td><td>32</td><td>34</td><td>29</td><td>23</td><td>27</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><td>role</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Compliance:
Substantial-for the collection and distribution of data.

Current recommendations:
1. Hospital leadership, after considering the recommendations aimed at reducing violence presented by the various committees and as a result of studies (see XIIE), should develop an action plan for implementation of those they believe are do-able in the near future and likely to be effective.
</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.d</td>
<td>location of incident;</td>
<td>
Findings:
The hospital provided data on the location of incidents by unit beginning in May with the move to the new hospital. This data indicates that three units were the scene of a considerably greater number of incidents than other hospital units. The table provides the monthly mean number of incidents for the four month period May-August for the seven units/locations whose mean was 10 or greater. Eight locations/units had a mean of less than 10.

<table>
<tr><td>Unit</td><td>Monthly mean/incidents</td></tr>
<tr><td>1F-Shields</td><td>34</td></tr>
<tr><td>1E-Hayden</td><td>22</td></tr>
<tr><td>1D-Dix</td><td>20</td></tr>
<tr><td>2D-Franz</td><td>17</td></tr>
<tr><td>1A-Allison</td><td>16</td></tr>
<tr><td>Annex A</td><td>10</td></tr>
<tr><td>TLC-Transitional</td><td>10</td></tr>
</table>
</td>
</tr>
</table>

			The Violence Reduction/Risk Management meeting of July 15 reviewed assault data for the month of June. The data shows that of a total of 27 assault incidents, 12 (44%) were from two pre-trial houses, 1F and 1G. House 1F accounted for 7 of the 12 incidents. Persons suffered injuries as a result of three of these seven incidents. **Compliance:** Substantial—for the collection and distribution of data. **Current recommendations:** 1. Implement plans to provide teams with house-specific incident data on a regular periodic basis.
BJC	XII.E.1.e	date and time of incident;	**Findings:** The analysis of assault data for June 2010 finds that 15 of the 27 incidents (56%) occurred during the day shift while 10 (37%) occurred during the evening shift. The night shift accounted for two incidents. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice of identifying factors that contribute to aggression and characteristics of incidents of aggression.
BJC	XII.E.1.f	cause(s) of incident; and	**Findings:** The July 15 review of June assault data in the Violence Reduction/Risk Management meeting identified factors/triggers. • The assaults in 10 incidents were unprovoked. • In five incidents individuals felt they were touched or

			spoken to a disrespectful manner. • Telephone use factored in two incidents. • In two incidents individuals became upset when asked to move to another area. • Single incidents were related to a variety of everyday experiences, such as individuals tripping over others' feet, individuals bumping into each other or being poked, arguing over who would sit in a chair, arguing over a pair of sneakers and someone cutting in line. **Compliance:** Substantial—for analysis of incident data to identify causes/factors. **Current recommendations:** 1. Continue the work of identifying factors that contribute to violence in the hospital.
BJC	XII.E.1.g	actions taken.	**Findings:** The hospital is less effective in documenting the actions taken as a result of the findings from the trending and tracking of incident data. As reported in XIIE, the hospital has many recommendations for initiatives to reduce violence, but it is not clear yet which will be implemented and when. **Compliance:** Noncompliance **Current recommendations:** 1. Move beyond planning to implementation of actions taken in response to incident patterns and trends and include audits of the actions effectiveness.

BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Findings:** The hospital has continued to track individuals who were involved in three or more incidents in 30 days, individuals restrained or secluded for more than four hours and those with three episodes of restraint or seclusion in seven consecutive days or five episodes in 30 days. When an individual reaches one of these high risk triggers, the Medical Director is notified and he reviews the individual's treatment and, if necessary, meets with the treatment team. **Other findings:** See XIII.B. The IRPs of eight individuals were reviewed to identify whether their involvement in multiple incidents was identified and the recommendations made by the Medical Director noted and/or implemented. This review yielded positive findings. **Compliance:** Substantial-based on a limited sample. **Current recommendations:** 1. Continue current practice. 2. Ensure the High Risk Indicator Tracking and Review policy being drafted clearly states for treatment teams the hospital's expectations for referencing incidents in an individual's IRP and revising the IRP as necessary.
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	**Findings:** The hospital is in the process of developing a policy, High Risk Indicator Tracking and Review, governing the identification of individuals at risk and the expectations of how and who will be responsible for directing a treatment response to the high risk status.

		staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Other findings:** As stated, the hospital identifies monthly those individuals in care who have been involved in multiple incidents. The Medical Director reviews the individual's IRP and, as necessary, meets with the treatment team. The hospital's schedule for tracking other risk indicators covers the next nine months with implementation in three month intervals. **Compliance:** Partial **Current recommendations:** 1. Take steps to move the plan forward for identifying individuals who reach other risk indicators and for securing an appropriate clinical review and response.

	XIII. Quality Improvement		
BJC		By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	**Summary of Progress:** 1. The hospital has hired a new Performance Improvement Director, filling the position that had been vacant for part of the review period. 2. SEH is developing a policy, titled, High Risk Indicator Tracking and Review, which will define the Risk Management system and delineate procedures for tracking individuals at risk because of behavioral and medical conditions and for the review of the individual's treatment. 3. The hospital has created a schedule for introducing the tracking of additional risk indicators that spans the next nine months. 4. The hospital continues to track on a monthly basis those individuals in three or more incidents. The IRPs of these individuals are reviewed by the Medical Director who makes recommendations and comments. This process is recorded on a log. The hospital has recently (in October) added a column to this log that will document the response of the treatment team to the recommendations.
BJC			**Methodology:** <u>Interviewed</u>: 1. S. Bergmann, Director, Performance Improvement 2. J. Taylor, Director of Policy and Procedures 3. M. Hartley, RN, Nurse Executive <u>Reviewed</u>: 1. Analysis of Psychiatric Emergencies report 2. Risk Indicator Deployment Schedule 3. Treatment of Personality Disorders document 4. Monthly Risk Trigger Indicator reports 5. IRPs of eight individuals involved in multiple incidents: JW, DD, CL, MP, LM, DJ, JM, JA

			6. IRPs of seven individuals on high risk lists for aggression or victimization: KH, AJ, MH, TJ, MR, WW, SS
BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	**Findings:** The hospital hired a new Director of Performance Improvement in mid-August. The former Director left the position midway through the review period. The deployment schedule for the introduction of monitoring of risk indicators remains much the same as it was six months ago. Specifically, the indicators being tracked currently are aggression to self and others, allegations of A/N/E, deaths, restraint/seclusion, and suicide. The hospital plans to deploy 18 additional risk indicators in three month intervals over the next nine months. **Other findings:** The hospital has a draft of a High Risk Indicator Tracking and Review policy that it acknowledges is not yet complete and ready for approval. **Compliance:** Partial **Current recommendations:** 1. Complete work as planned on the High Risk Indicator Tracking and Review policy. 2. Implement the plan for monitoring high risk indicators as outlined on the deployment schedule when approvals have been obtained.
BJC	XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Findings:** The recommendations made by the Medical Director, following his review of the IRP of an individual who had reached the risk indicator for multiple incidents, were implemented in the IRPs of the eight individuals reviewed.

			From the August Risk Indicator List: • JW at risk because of several falls. Recommendation: Reconsult with neurology, possibly titrate a specific medication. IRP 10/12: Individual was no longer on the specified medication. Falls noted in present status and causative diagnosis for the falls is identified. • DD involved in multiple incidents of medication refusal. Recommendation: D/c a specific medication. IRP 10/25: Medication had been discontinued. • CL at risk for multiple incidents of SIB and aggression: Medical Director provided immediate medical attention for the injury and treatment directed at the behavior. IRP of 9/15/10: Will receive 15-30 minutes of counseling on coping skills daily and individual psychotherapy once a week. Treatment groups to include art therapy, mental health teaching group, emotion regulation group and What's Up Doc group. From the July Risk Indicator list: • MP involved in multiple incidents. Recommendation: Get Clozaril level and minimize the use of two other medications. Review of the E-MAR found that blood work was completed in early September following August refusals and the two other medications were discontinued in September. • LM involved in multiple assault incidents. Recommendation: Reinstitute Behavior Guidelines. Response: PBS plan implemented. • DJ involved in multiple incidents. Recommendation: Ensure allergy list includes a specific named medication. E-MAR shows the medication listed as an allergy. • JM involved in incidents related to sexually inappropriate behaviors. Recommendation: Address the behaviors in IRP. IRP 9/2/10 describes the behaviors in Focus 1 and will work 1:1 with male staff for 30 minutes/week to increase understanding

			of appropriate sexual behaviors. • JA involved in four incidents of aggression in July. Recommendation: Address the behavior in IRP and watch side effect of medication closely. September 1 IRP addresses the behavior in Focus 1, indicates individual has a PBS plan and will be provided 1:1 counseling with nursing staff for one hour each week. **Other findings:** The hospital's listing of individuals in care who have been involved as aggressors in incidents of aggression to others includes 34 names. Psychology had not been requested to provide guidance in the form of a PBS plan, Behavior Guidelines or Initial Behavioral Interventions for 24 of these 34 individuals. Review of three individuals on the High Aggressor List found that the IRPs of each address aggression. Specifically: • IRP of 10/22/10 for KH addresses control of impulsive behavior to reduce danger to self/others. • 8/10/10 IRP of AJ addresses improving social skills and interacting in a respectful manner to reduce aggression. • The 5/18/10 IRP for MH lists various calming classes, including music, dance and spirituality as means to address unprovoked aggression. In contrast, the IRPs reviewed of four individuals on the list for victimization did not mention this risk factor. The individuals include: TJ (IRPs 5/25 and 9/21 reviewed), MR (IRPs 9/21 and 10/27 reviewed), WW (10/19 IRP reviewed) and SS (10/27 IRP reviewed). **Compliance:** Partial **Current recommendations:**

			1. Ensure that the High Risk Indicator Tracking and Review policy presently being developed addresses the role of psychology services in the treatment of individuals who reach risk triggers. 2. As planned, following the completion and approval of the High Risk Indicator Tracking and Review policy, build the technology infrastructure to support the data gathering and notification to treatment teams, and provide training to all levels of staff necessary for effective implementation.
BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Findings:** The report of the Analysis of Psychiatric Emergencies study found that five individuals in care were involved in nearly half of the psychiatric emergency incidents reviewed. The report recommended that the hospital develop a "formal case consultation process to assist treatment teams in developing focused treatment options for those individuals. Ideally, the consultation process would feature the provision of multidisciplinary advice from internal staff as well as ready access to external experts when needed." **Other findings:** As noted earlier, there are multiple recommendation that have been made for initiatives to reduce violence in the hospital. It is not presently clear which will be implemented and when. See also the cell below. **Compliance:** Partial **Current recommendations:** 1. Document the decisions from the hospital leadership's discussions of the variety of recommendations presented to the leadership to reduce the level of violence in the hospital.

			The hospital's CAP acknowledges the need to present the results and recommendations of studies to the Executive and to develop tracking procedures for recommendations.
BJC	XIII.B.2	the anticipated outcome of each step; and	The hospital continues to do significant work in recognizing the level of violence, studying its sources and characteristics, and making recommendations to reduce its frequency and improve the safety of individuals in care. While the number of risk indicators that the hospital is tracking is presently limited, the hospital plans to add the review of 18 more indicators over the next nine months. Presently, when an individual reaches a risk indicator, his/her treatment is reviewed by the Medical Director. When the full array of indicators is being tracked, the number of reviews that will be required will far exceed the capabilities of the Medical Director acting alone. Rather, as recommended in the hospital's study of psychiatric emergencies, the High Risk Indicator Tracking and Review policy presently being drafted should include a multidisciplinary consultation process. The drafting and approval of this policy and its implementation are essential for the hospital to meet this requirement of the Settlement Agreement.
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	See cell above.
BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Findings:** As cited in XII.E, on a systemic level, the hospital, through the work of its committees and studies (i.e., Violence Reduction/ Safety Committee, the Personality Disorders workgroup and the Psychiatric Emergency study) has acknowledged the problem of violence and identified many possible initiatives to address it. Following a period of implementation, the hospital will be in a position to evaluate the outcomes. On an individual level, the Medical Director is reviewing the IRP of individuals who have figured in multiple incidents or episodes of

			restraint and seclusion. Over the next nine months, the hospital plans to begin tracking additional risk indicators. When and how the review of these individuals will occur will be identified in the High Risk Indicator Tracking and Review policy that is presently being developed. **Compliance:** Partial **Current recommendations:** 1. Continue to work toward the implementation of measures to reduce the level of violence in the hospital. 2. Continue work on the Risk Indicator tracking and review system to bring it into full implementation. The hospital's CAP requires the development of policies and procedures identifying the process that will occur when high risk indicators are identified and for monitoring the response. As indicated, initial work on the policy has begun.
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	Because the High Risk Indicator Tracking and Review policy is still being developed, tracking of the full list of risk indicators is still at least nine months in the future, and a formal system for treatment reviews has yet to be identified, full compliance with this section of the Settlement Agreement will be delayed until implementation has been completed.
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	The hospital is not yet able to meet this Settlement Agreement requirement. See other findings and recommendations. The hospital's CAP identifies a logical progression of steps to construct a component of the risk management system using high risk indicators when it addresses the development of policies and procedures for High Risk Indicators, tracking mechanisms to measure compliance with the policy and procedures, tracking and trending of high risk data and

<table>
<tr><td></td><td></td><td></td><td>presentation of this data to the Risk Management Committee, Performance Improvement Committee and Medical staff.</td></tr>
<tr><td>BJC</td><td>XIII.C.3</td><td>modifying corrective action plans, as necessary.</td><td>The hospital is not yet able to meet this Settlement Agreement requirement. See other findings and recommendations.

See cell above for the hospital's CAP.</td></tr>
<tr><td>BJC</td><td>XIII.D</td><td>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.</td><td>Findings:
As noted in XII.E, the hospital has identified many sources and characteristics of violence and initiatives to stem the trend have been made by various committees and as a result of studies. It has yet to be determined which recommendations will result in action plans in the near future.

Other findings:
With the hospital endeavoring to create a violence-free treatment environment, the findings from the SEH 2010 Consumer Survey (8/03/10) provide a valuable perspective. The highest negative responses show 1/3 of respondents did not feel free to complain and 41% did not feel they could object to medication or treatment. In contrast, 65% believed the hospital atmosphere helped them recover. This is consistent with the finding that nearly 75% of the respondents found contact with the clinical staff helpful to them.

<table>
<tr><td>Issue</td><td>% disagree & strongly disagree</td><td>% neutral</td><td>% agree & strongly agree</td></tr>
<tr><td>Hospital atmosphere helped me get better</td><td>22</td><td>13</td><td>65</td></tr>
<tr><td>I had enough privacy</td><td>14</td><td>16</td><td>61</td></tr>
<tr><td>Felt safe</td><td>29</td><td>15</td><td>58</td></tr>
<tr><td>Was clean & comfortable</td><td>13</td><td>12</td><td>75</td></tr>
</table>
</td></tr>
</table>

			Friends &family were able to visit	15	13	72
			Contact with my doctor was helpful	16	11	73
			Contact with nurses/therapists was helpful	13	11	75
			Staff were sensitive to my cultural background	23	19	58
			Staff were sensitive to religious/spiritual beliefs and practices	18	14	68
			I was treated with dignity and respect.	28	18	54
			I felt free to complain	33	14	53
			Felt free to refuse medication or treatment	41	14	45
			My complaints were addressed	23	18	59

Compliance:
Partial

Current recommendations:
1. Continue making progress toward implementation of the various Performance Improvement recommendations and plans described in earlier cells.

As cited in the cells above, the hospital's CAP addresses the use of studies, incident and other data, and high risk indictors to advance the hospital's objective of reducing violence and improving the quality of life of individuals in care.

	XIV: Environmental Conditions		
BJC		By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	**Summary of Progress:** 1. The new state-of-the-art hospital was designed with safety as a prime consideration, particularly in the elimination of smoking porches and the design of secure courtyards, and in the construction and equipping of bathrooms and bedrooms. 2. The hospital continues to conduct a quarterly survey of all residential units and treatment areas that reviews over 100 elements in 15 areas. Across all 15 areas, 88% of the units received ratings of 95% or better in the 4th quarter survey. Any area that is found unacceptable must provide a corrective action plan.
BJC			**Methodology:** Interviewed: 1. A. Venson, Director of Facilities and Safety 2. Several staff on units and treatment areas toured 3. S. Bergmann, Director of Performance Improvement Reviewed: 1. Environmental Self-assessment Survey Report-Fourth Quarter 2010 Toured: 1. Annex A and Annex B, Units 1A (Allison), 1C (O'Malley) 1F (Shields), 2D (Franz), Transitional TLC and Intensive TLC
BJC	XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Findings:** The new hospital's design incorporates elements that minimize suicide hazards. Specifically, the single bathrooms have both a privacy curtain hung from ceiling tracks and doors. This permits

			staff to enter and keep the door open if an individual is on 1:1 observation while still maintaining the individual's privacy. All plumbing is enclosed and mirrors are metal, rather than glass. Bedrooms are outfitted with wardrobes that have sliding doors, rather than hinged doors. This eliminates the possibility of an individual wedging a knotted sheet in the door hinge and using it hang himself. On all of the units where the request was made, a staff member was able to show where a cut down instrument was kept. On 1F, the cut-down instrument was readily accessible in the emergency cart. In contrast, on 1A the instrument was in the emergency cart but still in the original plastic molded packaging and would require a tool (scissors or similar tool) to free it. In short, it was not accessible in an emergency. **Compliance:** Substantial-This rating does not apply to Annex A and Annex B where the environment is not free of suicide hazards. **Current recommendations:** 1. Audit all hospital units and treatment areas to ensure that cut down instruments are accessible in an emergency.
BJC	XIV.B	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Findings:** Persons entering the new hospital must pass through a metal detector and may have their belongings searched. Incident data finds that the hospital has been more successful in finding contraband since the move to the new hospital, i.e., 34 contraband incidents were identified in the period Sept. 09-February 10 as compared to 56 contraband incidents in the following six months ending in August 2010. A portion of the contraband detected was cigarettes and lighters and matches. During the quarterly self-assessment, reviewers look for

			evidence of smoking. No evidence of smoking was found on any of the residential units or treatment areas during the 4th quarter self-assessment. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	**Findings:** The new hospital has secure outdoor courtyards rather than the smoking porches. These are in direct view of one of the common areas and the nurses' station. Smoking is no longer permitted at the hospital and smoking materials are considered contraband. Review of the staffing data for the one-week period September 1-7 provided by the hospital reveals that there were 32 day shifts in the 11 new hospital units that were staffed with one RN; the remaining day shifts were staffed with two or three RNs. In Annex A and Annex B, where many individuals leave the hospital to attend day programs in the community, the day shift was typically staffed with one RN. Please find more specific staffing information in the nursing section of this report. **Other findings:** In Annex B, there were problems in accounting for the whereabouts of individuals. Specifically, security checks sheets are filled in at 9:00 AM through to 2:30 PM for individuals in community day programs and those at the TLCs. [In other units (new hospital) the security sheets go with the unit staff to the TLC and are completed there during mall hours.] On Annex B, the EARN sheets were inaccurately filled out. Staff had

			initialed boxes indicating they had met with an individual during time slots when the individual was not on the unit. During the tour of the Intensive TLC at lunch time it was evident that staff members were present and were moving around the dining area observing individuals eating lunch. At the same time, individuals were moving about getting in line for food and bussing their trays. In one instance observed, an individual finished his lunch, bussed his tray, and got in line and received a second tray. The supervisors have a listing of individuals who are on special diets and who are at risk of choking, but no staff are specifically assigned to observe these individuals. **Compliance:** Partial **Current recommendations:** 1. Investigate the practices for accounting for individuals and set expectations for a standardized method that is accurate and accountable. 2. Consider the advisability of initiating accountable zone supervision during lunchtime at the Intensive TLC.
BJC	XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.	**Findings:** In the new hospital and in the RMB building where Annex A and Annex B are located all elevators were fully operational at the time of our tour. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.

BJC	XIV.E	By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.	**Findings:** The fire and evacuation plan for the new hospital was approved prior to the May occupancy and does not require review for a year. **Compliance:** Substantial **Current recommendations:** 1. Continue current practice.
BJC	XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	**Findings:** The 4th Quarter Environmental Self-assessment reviewed surveyed 15 categories and 111 specific standards. The Safety category includes seven standards: staff wear ID badges, fire exit locks are operable, corridors are unobstructed, no extension cords in use, electric panels and fire response equipment are unobstructed, area has no trip hazards and a fire evacuation map is posted on the unit. All of the hospital's residential units and both TLC areas received perfect scores on the Safety standards. **Other findings:** During the tour, Annex A was quite warm. Staff acknowledged that temperature control is this building can be problematic as the heaters and coolers often must run at the same time. Annex A was also problematic as plaster was coming off the ceiling in one of the bathrooms, vents were dirty and rusted, and in one bedroom toured the paint was peeling off the walls. The hospital plans to renovate the first floor of the building that houses Annex A and Annex B and move the individuals into the renovated units. Plans for the renovation have been

			developed, but work has not yet begun. **Compliance:** Partial-This rating does not apply to the new hospital where the physical environment was clean and pleasing. Conditions in Annex A and Annex B, however, did not meet an acceptable standard. **Current recommendations:** 1. Implement, as resources become available, the plans to renovate the area where individuals living in Annex A and Annex B will be housed.