BASELINE REPORT

St. Elizabeths Hospital
Washington, DC

February 11-15, 2008

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	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 Progress:** 1. SEH has conducted a self-assessment to serve as a baseline regarding status of implementation of the Agreement. The facility's report includes a candid assessment of current status and some corrective measures needed to move towards compliance with requirements of the Agreement. 2. SEH has a new administrative and medical leadership that appear to be committed to improving standards of care as envisioned in the Agreement. 3. SEH recently developed templates for process observation and clinical chart audits that include some indicators that align with requirements of this agreement. 4. The Department of Mental Health (DMH) has established a program, with a dedicated director, to provide coordination and monitoring of efforts to comply with specific provisions of this Agreement. 5. The hospital does not currently have a process for the conduct of treatment planning conferences that, if followed, ensures that integrated individualized treatment planning and service delivery can occur. 6. The hospital does not currently have policies and procedures to assure that documentation of individuals' response to treatment interventions in the mall are properly aligned with the short term goal in their Individual Recovery Plans. 7. The hospital currently uses its maximum-security forensic units for the placement of some civilly committed individuals who are considered "too dangerous" to maintain on civil units. This does not represent provision of care that is in line with individuals' functional abilities. Additionally, it does not provide impetus for growing staff capacity to provide appropriate treatment to all types of individuals.

			Methodology: Interviewed: 1. Janet Maher, DOJ Chief Compliance Officer 2. Beth Gouse, Ph.D., Acting Chief of Psychology and Special Assistant to the CEO 3. Dr. Clo Vidoni-Clark, Director of Civil Services 4. Joseph Henneberry, R.N, Director of Forensic Services 5. Robert C. Morin, Psy.D., Chief of Forensic Post Trial Section and Chair of the Forensic Review Board 6. Paul Montalbano, Ph.D., Chief of Forensic Pre-Trial Section Reviewed: 1. The charts of 63 individuals: AB, AC, AE, AJ, AR, BC, BT, CB, CH, CM, CS, CT, CW-1, CW-2, DG-1, DS, ERC, EW, FA, GD, GH, HH, HJ, HL, JA, JF, JG, JN, JR-1, JR-2, JR-3, JS, JW, KT, LR, MA, MB-1, MB-2, ME, MJ, MJT-1, MJT-2, MM-1, MP, MR, PC, PD, PF, PJ, PM, PPW, RB-1, RB-2, RB-3, RH, RS, SC, SK, TH, TJ, TM, TS and YS 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (as of October 31, 2007) 3. Department of Mental Health (DMH) SEH Policy #602-04, Interdisciplinary Recovery Plan (IRP) and Progress Note Requirements, revised September 18, 2006 4. DMH SEH Draft Policy #602-04, Treatment Planning, January 10, 2008 5. DMH SEH Draft Policy #602.1-08, Assessments, January 31, 2008 6. SEH template for Treatment Process Monitoring-Quarterly Self-Assessment 7. SEH template for Integrated Treatment Planning Process Monitoring Tool 8. SEH template for Integrated Treatment Planning Clinical Chart Audit form 9. DMH SEH Policy #601-02, Medical Records, October 22, 2002

			10. SEH template for Psychiatric Assessment and Initial Treatment Plan 11. DMH SEH Policy #101-04, Mandatory Guidelines for Restraints and Seclusion 12. DMH SEH Policy #111-03, Patient Admission/Discharge and Transfer Policy 13. DMH SEH Policy #201-05, Involuntary Medication Administration 14. SEH Database regarding individuals diagnosed with Cognitive Disorders 15. SEH Database regarding individuals diagnosed with Substance Use Disorders 16. SEH Database regarding individuals diagnosed with Seizure Disorders <u>Observed</u>: 1. Treatment planning meeting at RMB-1 for JW 2. Treatment planning meeting at RMB-4 for AE 3. Treatment planning meeting at RMB-5 for PC 4. Treatment planning meeting at RMB-5 for TP 5. Treatment planning meeting at RMB-6 for MC 6. Treatment planning meeting at RMB-6 for RH 7. Treatment planning meeting at JH-6 for KT <u>Toured</u>: 1. Psychosocial Rehabilitation Mall 2. Geriatric Center 3. Dual Diagnosis Mall 4. Behavior Management Mall

	A. Interdisciplinary Teams		
RB		By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	Please see sub-cells for findings and compliance.
RB and MES	V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Findings:** SEH has yet to implement this requirement of the Agreement. The monitor's findings in subsections V.A.2 through V.A.5 and in Sections V.B (Integrated Treatment Plans), V.C (Case Formulation), V.D (Individualized Factors) and V.E (Treatment Planning is Outcome-Drive) illustrate a pattern of deficiencies that impedes implementation of this requirement. In its self-assessment report, SEH recognized that the "hospital is making minimal progress in meeting the requirements around integrated treatment plans and (that) treatment teams are not yet functioning consistent with the Agreement." The facility indicated that it is in the process of finalizing a new format for an "Interdisciplinary Recovery Plan" in an effort to conform to the Agreement's requirements. The current format of the IRP includes some recent improvements in the outline of the plan (see findings in V.C.1 and V.D.1). However, the current process of treatment planning (see findings in V.A.2 through V.A.5) and content of the plans (see findings in V.B through V.E) indicate that the facility needs to institute major changes in its policies and procedures, training programs and self-monitoring processes in order to move towards compliance with this requirement (see recommendations in V.A.2 to V.A.5 and V.B through V.E). Team conferences gave no evidence that their primary goal was the provision of individualized, integrated treatment and discharge planning. Conferences were routinely non-integrated in their approach to the individual's treatment and discharge placement needs. Further

			information that fleshes out these findings will be found in cells below that concern the treatment planning process and the discharge planning process. **Compliance:** Noncompliance **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. Further specific recommendations will be found in cells below that address these issues in more detail.
RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Findings:** All observed teams were lead by either a treating psychiatrist or a clinical administrator, but not all clinical administrators were licensed clinical psychologists. **Compliance:** Partial **Current recommendation:** Hire adequate psychiatrists and licensed clinical psychologists to assure compliance with this aspect of the DOJ agreement.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Findings:** In two of the four treatment team meetings that this expert consultant attended, either the psychiatrist or the clinical administrator provided good leadership in the meetings themselves. In the team that had received pilot training in person-centered Treatment Planning, the psychiatrist was clearly attempting to follow an organized approach to effective clinical leadership that was reflective of early

			training experiences. In the remaining two teams, leadership was clearly lacking. In one case, the meeting was significantly disorganized and individual clinicians pursued their own agendas without any integration of the points being discussed. In the other team, all disciplines reported in an orderly but rote manner, and there was no interdisciplinary discussion or integration. In none of the teams did the designated clinical leader take responsibility for the full integration of assessment findings, treatment progress including integration with mall activities, and discharge readiness. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a training program in person-centered treatment planning that emphasizes the role of the team leader in providing organizational leadership in the conduct of treatment planning conferences. 2. Organize treatment planning conferences around a template that includes: a. Interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness; b. Current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses and how and when to make changes in treatment and risk factors for exacerbation; c. Discharge readiness and barriers to discharge; medication side-effects; and, d. If applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness. 3. Provide treatment teams with training in how treatment planning is

			different from both assessment and treatment. 4. Provide treatment teams with training in how to conduct the team meeting prior to when the individual joins the team, the meeting with the individual and the meeting after the individual leaves the team room.
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:** Individuals attended all of the observed treatment team meetings, and family members attended two of the four meetings. In all of the meetings individuals and/or family members spoke, but they were not active members of the treatment team. In most cases, the individual's contribution was to answer questions that were part of a mental status examination. In all cases, the information provided by the individual appeared to be of questionable usefulness to the treatment planning process due to the individual's level of psychosis or impaired functioning, but this did not alter the team members probing the individual for continued information. In one of the two cases where family members were present, significant information related to discharge planning was provided, but was not visibly integrated into the team's discussion, especially as related to appropriate discharge planning. **Compliance:** Noncompliance **Current recommendations:** 1. Provide treatment teams with training in effective ways to engage individuals and their families in the treatment planning conference. 2. See cell V.A.2.a, Recommendation 4.
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,	**Findings:** In two of the four teams, results of discipline-specific assessments that had taken place outside of the team meeting were presented,

		and, as necessary, revising treatments;	although in one of those cases, no evidence was found in the individual's chart regarding the documentation of those assessments. In the other two teams, assessment inappropriately took place in the team meeting. In no case was the assessment integrated in the team meeting in a manner that would guide the decision to continue or change current treatment interventions, and in all cases it appeared that current interventions were maintained. A review of the individuals' charts indicated, however, that the majority of treatment interventions discussed in the meeting were either/both not clearly delineated in the individual's written Interdisciplinary Recovery Plan (IRP) nor appropriately aligned with the short-term goal that the intervention was supposed to be assisting the individual in attaining. Thus, no real monitoring of treatment interventions by the interdisciplinary team took place. **Compliance:** Noncompliance **Current recommendations:** 1. See cell V.A.2.a, Recommendations 1 through 4. 2. Develop and implement a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short-term goals in mall treatment groups, so that teams can make intelligent decisions about next steps when treatment has been successful or further assessments/changes to treatment when treatment has been unsuccessful. . 3. Develop and implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: a. The name of the group/individual treatment; b. The name of the group/individual treatment provider; c. The name of the individual patient;

			d. The short-term goal for which the individual has been assigned to the modality; e. The number of attended sessions and offered sessions; f. The quality of the individual's participation; and g. The individual's progress toward achieving the stated short-term goal. 4. Develop and implement an auditing tool that monitors for all aspects of the progress note template. 5. Train all auditors to acceptable levels of reliability. 6. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Findings:** The observed treatment teams functioned in a multi-disciplinary rather than an interdisciplinary manner, in that no real integration of the reports from the various disciplines occurred and the impact of discipline-specific reports was not used in a manner that either validated the current treatment or indicated when changes in treatment would have been appropriate. **Compliance:** Noncompliance **Current recommendations:** 1. See cell V.A.2.a, Recommendations 1 through 4. 2. Develop and implement a Treatment Team Process Monitoring Audit tool that assesses teams for their compliance to newly trained processes in how to organize and execute a treatment planning conference. 3. Train auditors to acceptable levels of reliability on the above-described tool. 4. See cell V.A.2.a, Recommendation 9. 5. Aggregate, trend and provide data to hospital administration,

<table>
<tr><td></td><td></td><td></td><td>discipline chiefs and treatment teams as part of a process of ongoing performance improvement.</td></tr>
<tr><td>MES</td><td>V.A.2.e</td><td>verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and</td><td>Findings:
This expert consultant reviewed the charts of all individuals currently receiving behavioral plans (MP, CW, HJ, AB and CS). The following table identifies these reviews:

<table>
<tr><th>Initials</th><th>Date of behavior plan review</th><th>Identified target behavior(s)</th></tr>
<tr><td>HJ</td><td>9/7/07</td><td>Sexually inappropriate behavior</td></tr>
<tr><td>AB</td><td>8/10/07</td><td>Excessively demanding intrusive behavior, aggressive rumination, invading personal workspace of staff</td></tr>
<tr><td>CS</td><td>08/30/07</td><td>Does not regularly attend group at the treatment Mall and does not attend his WATP assignment as scheduled, sells various items on the grounds to other patients, intimidates staff and consumers</td></tr>
<tr><td>MP</td><td>9/10/07</td><td>Disrobing and yelling in the hospital community, damaging property, and not taking his medications</td></tr>
<tr><td>CW-1</td><td>11/2/07</td><td>Aggressive behavior towards peers and staff and inability to be consistently responsible to privilege</td></tr>
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This review showed a pattern of deficiencies in the integration of psychiatric and behavioral modalities. The deficiencies were noted in the following specific areas:</td></tr>
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			1. Psychiatrists' review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation. 2. An exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies. 3. Attempts to update the diagnosis and modify medication management based on a) and b) above. In addition, the review of the behavioral plans showed a pattern of process and content deficiencies in the development and execution of these plans as follows: Process deficiencies: 1. SEH does not have sufficient staffing of trained psychologists to provide needed services. 2. SEH does not provide behavioral treatment for many individuals who suffer from a variety of psychiatric symptoms and maladaptive behaviors that represent appropriate indications for this intervention. Many of these individuals are refractory to current pharmacological therapies. These behaviors include, but are not limited to, the following: a. Aggression that at times requires restrictive interventions; b. Self-care and intellectual deficits; and c. Refusal of medications and other treatment and rehabilitation interventions. 3. Behavioral interventions and plans are not specified in the objectives and interventions sections of the treatment plans. 4. There is failure to provide competency-based training to staff on plan implementation. 5. There is lack of monitoring of the appropriateness and consistency of implementation by the team or across situations, individuals or environments.

			6. There is lack of follow up assessment of the effectiveness of behavioral interventions. 7. The behavioral interventions are not integrated with either psychopharmacological therapies or the overall treatment. Content deficiencies: Behaviors of concern are generally not well defined, and are not measurable and observable. 1. Some maladaptive behaviors are not incorporated in the plans. 2. There is failure to complete functional analysis of behavior in a manner that meets professional standards. 3. There is little or lack of use of direct observations of behavior. 4. Data from functional assessments is not utilized in the assessment of decreases/increases in maladaptive/pro-social behaviors and in the designing of antecedent and consequent treatments. 5. The identification of precursor behaviors is inadequate. 6. There is failure to obtain data regarding precursors from appropriate sources. 7. Reinforcement strategies are generally inadequate and there is no indication of a reinforcement assessment being done. 8. The interventions generally do not include identification of replacement skills or means of teaching these skills. When replacement behaviors are identified, they are not functionally equivalent to the function of the maladaptive behavior. 9. The interventions generally fail to include strategies to enhance the quality of life of individuals and to develop collateral social behaviors. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement corrective actions to ensure proper

			integration of psychiatric and behavioral treatment modalities. 2. Develop and implement corrective actions, including staffing levels and needed training, to ensure correction of the process and content deficiencies identified by this expert consultant above.
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:** Team meetings appeared to occur according to a designated schedule, in that all participants knew that a meeting was occurring on the day the conference was scheduled. However, a sample review of charts indicated that 60% of treatment planning conferences did not occur at the required 30- and 60-day intervals. This figure is less than the aggregate 78% of active case records reviewed and found to have "current" IRPs but closer to the aggregate 65% of closed case records that were reviewed and found to have "current" IRPs in the self-assessment data provided to DOJ by SEH. SEH staff was clear that the training of chart auditors had not reached acceptable levels of inter-rater reliability and no operational definition of "current" was provided in the training materials reviewed by this expert consultant. Nevertheless, it was clear that the hospital sees this as important data to continue monitoring and that further training of auditors was needed **Compliance:** Partial **Current recommendations:** 1. Continue the current process of monitoring both active and closed cases for the timeliness of IRP conferences. 2. Present data graphically as a process monitoring variable that can be trended. 3. Make results available to hospital administration, discipline chiefs and treatment teams as a part of an ongoing performance improvement process. 4. Train auditors to acceptable levels of reliability.

			6. See cell V.A.2.a, Recommendation 9.
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 initiated a pilot training program in person-centered treatment planning that has brought about obvious change in the one treatment team observed that has participated in this training. No timeline for the full roll out of this or other training was provided. **Compliance:** Noncompliance **Current recommendations:** See cell V.A.2.a, Recommendation 1.
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:** 1. Observed treatment teams had the full complement of appropriate staff. 2. The hospital did not provide data in its self-assessment about their progress in assuring a stable core of treatment team members. 3. Information about the ratio of psychiatrists to individual patients can be found in Cell VIII.A.3 (infra). **Compliance:** Partial **Current recommendations:** 1. Provide data on the hospital's current progress toward achieving stable core team membership. 2. Recommendations regarding the level of staffing for psychiatrists can be found in cell VIII.A.3.
RB	V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as	**Findings:** As indicated in cell V.A.2.f, 60% of reviewed charts showed evidence

		clinically determined by the team leader.	that IRPs were not occurring during the required 30 and 60 day intervals. **Compliance:** Partial **Current recommendations:** See recommendations in cell V.A.2.f.

	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:	Please see sub-cells for findings and compliance.
MES	V.B.1	where possible, individuals have input into their treatment plans;	**Findings:** SEH current Policy #602-04, Interdisciplinary Recovery Plan (IRP) and Progress Notes Requirements includes a requirement that the IRP is developed in collaboration with the individuals and with the individuals' consent. However, this policy does not specify operational requirements to ensure that the individuals provide meaningful input in the IRP. The revised Policy #602-04, Treatment Planning (draft) does not provide guidance regarding this process. SEH reported that, in general, the individuals attend their IRP meetings, but that the level of engagement varies and the individuals do not routinely sign their IRPs. The facility has a self-assessment tool that measured attendance based upon the signatures of the IRPs. The facility's data indicated that only 18% of individuals in civil services and 39% in forensic services signed their IRPs. SEH recognized that this monitoring mechanism is inadequate to reflect actual attendance. In October 2007, the forensic service reportedly began to track the actual attendance of individuals, but the civil service has reportedly just begun to report these data. SEH has yet to provide training focused on the process of engagement of individuals in their IRP plans. SEH has developed, but yet to implement, a process monitoring tool that addresses attendance by the individual and parameters for the engagement of individuals in the team meeting. The indicators are adequate, but the facility has yet to develop operational instructions

			for this tool. Observations by this expert consultant of several IRP meetings indicated that the individuals were in attendance in most meetings. In a few meetings, the individuals refused to attend, which appeared to be a function of severe illness. In general, the IRP team members approached the individuals with respect during the meetings and made an effort to engage them in the planning process. However, the interactions with the individuals were generally focused on conducting assessments rather than obtaining the individuals' input in the IRP plans. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectations regarding the process of engagement of individuals in their IRPs. 2. Develop and provide a training module focused on Engagement of Individuals. The purpose is to ensure that the individuals provide substantive input in the formulation and revisions of treatment objectives and interventions. 3. Provide summary outline of the above training including information about instructors, participants and training process and content (didactic and observational). 4. Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals. 5. Implement an IRP process observation monitoring tool with indicators and operational instructions to assess if individuals give substantive input into IRP objectives and interventions, including Mall groups and other therapies.

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<tr><td></td><td></td><td></td><td>6. Present process observation data, to address this requirement based on at least 20% sample (March to August 2008).</td></tr>
<tr><td>MES</td><td>V.B.2</td><td>treatment planning provides timely attention to the needs of each individual, in particular:</td><td>Please see sub-cells for findings and compliance.</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:
SEH reported that the initial assessments were completed within the required timeframes, but that the quality varied significantly. However, this report was not data-based.

The facility developed a draft Policy and Procedure #601-08, Assessments, but the document has yet to finalize the required timeframe regarding the completion of an admission comprehensive assessment that includes the disciplines of psychiatry, nursing, psychology, social work, nutrition and rehabilitation. The current Policy and Procedure #601-02, Medical Records specifies the following timeframes for each type of assessment:

<table>
<tr><td>Nursing</td><td>8 hours</td></tr>
<tr><td>Psychiatric</td><td>24 hours</td></tr>
<tr><td>Medical</td><td>24 hours</td></tr>
<tr><td>Psychological</td><td rowspan="7">By fourth admission day</td></tr>
<tr><td>Social Work</td></tr>
<tr><td>Rehabilitation</td></tr>
<tr><td>Nutrition</td></tr>
<tr><td>Podiatry</td></tr>
<tr><td>Dental</td></tr>
</table>

These time frames are appropriate to meet the needs of individuals.

SEH has yet to develop monitoring tools that address the timeliness and content requirements for each disciplinary assessment (psychiatry,</td></tr>
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			psychology, nursing, social work, rehabilitation, nutrition. The current tool, Treatment Process Monitoring-Quarterly Self-Assessment includes requirements regarding the documentation of disciplinary interventions in the IRP that were intermixed with other requirements regarding documentation on the disciplinary progress notes. Chart reviews by this expert consultant indicated that the admission psychiatric assessments were generally completed within 24 hours of admission. However, there was a pattern of deficiencies in the admission psychiatric assessments (see Section VI.A.5) that must be corrected to achieve substantial compliance with this requirement. In addition, the current format requires that the psychiatrist completes the Initial Treatment Plan, including Active problems, Long-Term Goals, Short-Term Goals and Interventions, without input from any other discipline. This initial plan guides the care of individuals pending completion of the IRP by the fifth hospital day and must be completed by a coordinated inter-disciplinary input, including, at a minimum, psychiatry, nursing and medicine. **Compliance:** Partial **Current recommendations:** 1. Finalize the draft Policy and Procedure #602-08, Assessments to specify timeliness and content requirements for all initial/admission disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment). 2. Develop self-assessment monitoring tools to assess timeliness and content requirements for all disciplinary assessments (see corresponding sections of this agreement regarding each disciplinary assessment). 3. Present monitoring data regarding the timeliness and quality of each disciplinary assessment based on at least 20% sample (see

			corresponding sections of this agreement regarding each disciplinary assessment). 4. Ensure that the initial treatment plans are completed with an inter-disciplinary input, including, at a minimum, psychiatry, nursing and medicine.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Findings:** SEH Policy, #602-04, Treatment Planning (draft) includes a timeframe of 24 hours for completion of the initial plan and five to seven days of admission for completion of the comprehensive IRP. The timeframe for the comprehensive IRP is not aligned with this requirement. SEH reported that the initial IRPs were completed within the required timeframes, but that the quality varied significantly. The facility reported that 79% of the IRPs in the forensic service and 76% in the civil service were current. However, the facility did not explain the auditing mechanism, including the indicators, methodology and, timeframes for data collection This expert consultant's review of charts indicated that, in general, the IRPs were completed within the required timeframes. The deficiencies regarding the content of these plans are outlined for each corresponding section of the agreement. **Compliance:** Partial **Current recommendations:** 1. Develop and implement an IRP Policy/Procedure/Manual that includes the facility's expectation that the comprehensive IRPs are completed within five days of admission. 2. Develop a clinical auditing tool with indicators and operational instructions to monitor the timeliness of the initial and

			comprehensive IRPs. 3. Present chart auditing data (March to August 2008) based on at least 20% sample regarding the timeliness of the comprehensive IRPs.
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Findings:** SEH did not provide specific information regarding implementation of this requirement. The draft Policy #602-04, Treatment Planning includes a requirement that the IRPs are reviewed "every 30 days during the first 60 days of hospitalization and every 60 days thereafter, or more frequently if clinically indicated." This frequency is consistent with requirements of the Agreement. SEH has developed, but yet to implement, a process monitoring tool that includes indicators related to scheduling and occurrence of the treatment team meetings (5th calendar day after admission, 5th calendar day after transfer, 30 days after admission for the first 60 days and every 60 days thereafter). The content of the updates/revisions of the treatment plans is addressed in subsections V.E.1, V.E.2 and V.E.3. Chart reviews by this expert consultant and observations of treatment team meetings indicated that the facility has yet to implement the requirement regarding monthly reviews of the IRPs. **Compliance:** Partial **Current recommendations:** 1. Ensure that the self-assessment process observation tool includes an indicator and operational instruction that addresses the identification by the team of someone to be responsible for

			scheduling and coordination of necessary progress reviews 2. Monitor this requirement using the process observation tool based on at least 20% sample (March to August 2008).
MES	V.B.3	individuals are informed of the purposes and major side effects of medication;	**Findings:** In its self-assessment report, SEH recognized that it has yet to develop a mechanism to assess whether individuals are informed of the side effects of medications. The facility has plans to assess this item through chart reviews or individual satisfaction survey. At this time, SEH requires that informed consent be obtained for medications, but the facility did not present its specific policy requirements regarding process and content of informed consent. **Compliance:** Partial **Current recommendations:** 1. Ensure that the clinical chart audit tool contains an indicator and operational instruction regarding this requirement of the Agreement. 2. Present clinical chart audit data based on at least 20% sample (March to August 2008) regarding compliance with this requirement. 3. Provide the facility's procedure regarding the process and content of informed consent.
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:** This requirement is monitored in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5) **Compliance:** Noncompliance

			Current recommendations: 1. Same as in V.D.1, V.D.2 and V.D.3 2. Same as in V.D.4 and V.D.5
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Findings:** SEH Policy #101-04, Mandatory Guidelines for Restraints and Seclusion includes a mechanism of a review by the Medical Director of individuals who have been placed in seclusion and/or restraints continuously for more than 12 hours or have experienced two or more episodes of seclusion and/or restraints on any duration within 12 hours. The policy does not include operational parameters for the process, content and documentation of this review. The current Policy #201-05, Involuntary Medication Administration includes a mechanism for a review by the Medication Review Officer, but this review is focused on issues of capacity rather than risk factors. The facility was unable to provide documentation of the reviews conducted by the Medical Director regarding seclusion/restraint triggers during this reporting period. SEH has yet to develop and implement a comprehensive system of risk management triggers and thresholds and levels of intervention and review commensurate with the level of risk. The review of the Medical Director of high risk situations should be integrated within that system. As such, this item is monitored in section XII.E.2. **Compliance:** Noncompliance. Same as in XII.E.2 **Current recommendations:**

			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:** The hospital has recently established a process whereby all NGRI acquittees must have a clinical report of progress presented to the Forensic Review Board (FRB) on at least an annual basis. Reviewed FRB clinical reports all had appropriate clinical information that was sufficient for the FRB to answer the privilege level question that the report was addressing; however, these reports did not focus enough on identifying risk factors, their management and progress toward their elimination. Reviewed court letters fairly and accurately summarized the findings of the clinical reports to the FRB, but would also have been made crisper if the risk factor issues discussed in the previous paragraph were a standing part of the clinical reports to the FRB. Clinical recommendations of the FRB regarding changes in diagnoses were routinely not followed up on by the treatment teams. Additionally, there was no documentation to indicate that these recommendations were even reviewed by the treatment teams. This causes concern that treatment recommendations in the newly mandated annual reviews will achieve the same fate. **Compliance:** Partial **Current recommendations:** 1. Develop a template for all FRB clinical reports that is more clearly focused on the assessment of risk factors. Identify a section early in the report that describes the risk factors that were responsible for the individual's forensic hospitalization, and any risk factors

			that have developed while the individual has been hospitalized and impact movement to a less restrictive level of care. Treatment while hospitalized can then address progress in managing/ameliorating those risk factors and what interventions have been successful/unsuccessful in that regard. Finally, the individual's current status on each risk factor can then be addressed, as well as treatment strategies for ameliorating current risk. 2. Develop a system for assuring case review/consultation occurs for individuals who fail to make timely progress toward lesser restrictive levels of care, that the recommendations of such consultations and the treatment team's responses to these recommendations are documented in the individual's medical record and that higher levels of review occur if individuals continue not to make progress. 3. Develop a monitoring system to collect, aggregates and analyzes the data necessary to assure that Recommendations 2 and 3 are implemented and reviewed. Make the data from this process available to hospital administration, discipline chiefs and treatment teams in accord with a process of performance improvement.
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:** The review of non-pharmacological treatment interventions is addressed in subsections V.E.3, V.E.4 and V.E.5 and in section VIII (Specific Treatment Services). Please refer to those sections for compliance findings and recommendations.
MES	V.B.8	an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and	**Findings:** SEH's Policy #601-02, Medical Records includes a requirement that all clinicians identified in the most current IRP complete a transfer note prior to the transfer of individuals. The draft policy #602.1-08, Assessments does not include provisions regarding the timeliness and content of the inter-unit transfer assessments.

SEH did not provide self-assessment data regarding this requirement.

This expert consultant reviewed the charts of six individuals who required inter-unit transfers during this reporting period in the civil (JG, BC and RS) and forensic (HH, JS and AC). The following table outlines the date of transfer for each individual:

JG	1/30/08
BC	1/17/08
RS	1/17/08
HH	12/10/07
JS	12/4/07
AC	12/24/07

The review showed that most psychiatric transfer assessments included brief history and course of hospitalization and current diagnosis and medications. However, the following pattern of deficiencies was noted:

1. No psychiatric transfer assessment was completed (HH).
2. None of the assessments addressed the anticipated benefits of the transfer.
3. The assessments did not include a review of the risk factors.
4. The assessments did not include the status of barriers to discharge.
5. In general, the assessments did not provide the information required to ensure continuity of care.

Compliance:
Partial

Current recommendations:

			1. Ensure that Policy #602.1-08, Assessments includes requirements regarding the timeliness of Inter Unit Psychiatric Assessments and their content. The content must address the following: a. Identifying data; b. Anticipated benefits of transfer; c. Brief history; d. Brief course, including medical; e. Review of risk factors; f. Current diagnosis; g. Barriers to discharge; and h. Plan of care. 2. Develop and implement a self-assessment inter-unit transfer tool to ensure timeliness and proper content of these assessments. 3. Present monitoring data regarding psychiatric inter unit transfer assessments based on at least 20% sample (March to August).
MES	V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart.	**Findings:** SEH has yet to develop peer review/monitoring processes that specify the following: 1. Indicators regarding psychiatric participation in the IRPs. 2. Indicators regarding timeliness and content requirements of all initial/admission disciplinary assessments; 3. Indicators regarding timeliness and content requirements of psychiatric reassessments (progress notes); 4. Indicators regarding timeliness and content requirements of psychiatric transfer notes; 5. Indicators regarding timeliness and content requirements regarding discharge summaries. 6. Individualized guidelines regarding the use of medications on the facility's formulary. 7. Drug Utilization Evaluation system based on established indicators. 8. Systems for review of high-risk medications (benzodiazepines,

			anticholinergics, new generation antipsychotic agents and Stat medications). 9. Systems for review of tardive dyskinesia clinical monitoring and management. The facility has yet to establish individual practitioner and system-wide Patterns and trends regarding the above items and corrective actions, as needed. **Compliance:** Noncompliance **Current recommendations:** See corresponding sections of the Agreement that address items 1 through 8 outlined by this expert consultant above.

	C. Case Formulation		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:	Please see sub-cells for findings and compliance.
MES	V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Findings:** The facility's current format of an "Integrated Recovery Plan (IRP)" includes an "Integrated Summary of Discipline Assessments." However, the facility has yet to implement an inter-disciplinary Case Formulation as required in this agreement. In its self-assessment report, SEH recognized that the "integrated case formulations are not yet occurring," but that efforts are underway towards automation of the its medical records and identification of needed training to facilitate implementation of the Case Formulation. The draft Policy #602-04, Treatment Planning includes information about the Case Formulation, which is a good start. However, the policy needs be expanded to include guidance to staff in the following areas: 1. Operational issues that should be considered in the process of synthesis of the assessment data; 2. Specifics regarding the process and content of each of the 6-Ps (Pertinent History, Predisposing, Precipitating and Perpetuating Factors, Previous Treatment and Present Status); 3. Identification of strengths and life goals of the individuals; and 4. Delineation of the individual's needs that constitute appropriate targets for treatment (to address illness), rehabilitation (to

			address functional impairment) and enrichment (to address quality of life). SEH developed, but has to yet implement, a template for a clinical chart audit tool. This instrument includes appropriate indicators to ensure that the Case Formulation: 1. Reflects an analysis of the information gathered by each discipline; 2. Includes a review of the each of the 6-Ps; 3. Considers the biochemical and psychological factors for each of the 6-Ps; 4. Considers age, gender, culture, treatment adherence and medication issues; and 5. Enables to the team to reach determinations about the individuals' treatment needs. However, this instrument is insufficient to ensure appropriate monitoring (and mentoring) for the following reasons: 1. There are no instructions to ensure that these indicators are operationally implemented; 2. Additional indicators are needed to ensure that the formulation includes information that supports the diagnosis/diagnostic formulation/differential diagnosis of the psychiatric assessments and reassessments. 3. The indicators should delineate psychoeducational and psychosocial factors for each of the 6-Ps. SEH has yet to initiate training of the treatment teams regarding the principles and practice of Interdisciplinary Case Formulation. The training must ensure that the formulation serves as appropriate bridge between the disciplinary assessments and the foci (long-term goals), objectives (short-term goals) and interventions of the IRP.

			Chart reviews by this expert consultant confirmed that the facility has yet to implement the Inter-disciplinary Case formulation. The reviews focused on the "Integrated Summary of Discipline Assessments" and showed the following pattern of deficiencies: 1. The summary was inconsistently completed by the teams. 2. The information in the summary was essentially a rehash of the information in the assessments. 3. The information in the summary did not include an adequate inter-disciplinary review of factors across the domains of psychiatric, behavioral, functional and quality of life. These domains are essential to the principles of IRP. As such, the current summary did not provide the basis for proper delineation of the individual's needs, and for initiation of appropriate treatment, rehabilitation and enrichment interventions to successfully address these needs and to facilitate transition of the individuals to less restrictive levels of care. **Compliance:** Noncompliance **Current recommendations:** 1. Ensure that the Policy and Procedure/Manual regarding IRP contains sufficient guidance to staff regarding the principles and practice of the Inter-disciplinary Case formulation. 2. Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation meets the principles of individualized recovery-focused planning. 3. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational).

			4. Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation. 5. Develop and implement a clinical audit tool that contains complete indicators and operational instructions. 6. Present chart audit data to address compliance with this requirement based on at least 20% sample (March to August 2008).
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Findings:** Same as above. **Compliance:** Noncompliance **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:** Same as above. **Compliance:** Noncompliance **Current recommendations:** Same as above.
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Findings:** Same as above. **Compliance:** Noncompliance

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

	D. Individualized Factors		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	Please see sub-cells for findings and compliance.
MES	V.D.1	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;	**Findings:** The facility's current format of IRP contains sections that are intended to delineate the reason for hospitalization, diagnosis, the individual's strengths/assets, active problems to be treated and long-term goals (foci) with corresponding short-term goals (objectives) and interventions. However, the implementation of this format demonstrates serious deficiencies that violate the basic principles of interdisciplinary recovery planning (see expert consultant's findings below). In its self-assessment report, the facility recognized that it does not currently meet the requirements in V.D.1 through V.D.6. In this report, the facility acknowledged that most treatment plans are currently "not individualized" and that the goals and objectives are "generic and not linked to specific individual outcomes." The revised Policy #602-04, Treatment Planning (draft) includes some definitions of foci (long-term goals), objectives (short-term goals) and interventions, which are aligned with provisions of the Agreement. The procedure contains the language of these provisions in V.D.1 to V.D.6. However, the procedure does not provide specific information to guide staff in the implementation of foci, objectives and interventions. For example, the procedure does not include the following: 1. Information regarding the main categories of foci of hospitalization;

			2. Operational requirements in the development of each focus of hospitalization; 3. Information regarding the Stages of Change model, including requirements to ensure proper matching of objectives and interventions to the individual's stage of readiness for rehabilitation; 4. Operational requirements in the development of objectives; 5. Operational requirements in the development of interventions; 6. Information regarding the delivery of interventions in the psychosocial rehabilitation activities on the Mall and linkage of Mall interventions to the IRP; 7. Information regarding strength formulation and requirements for linking objectives and interventions to the individual's level of functioning and strengths; 8. Information regarding approaches to individuals who are non-adherent to their IRPs; and 9. Examples of proper linkage of foci (goals), objectives and interventions. The facility's current template for observation monitoring does not adequately address the requirement of the Agreement in reference to the development of goals, objectives and interventions that build on the individual's strengths and that address all of the identified needs of the individuals. The current template for clinical chart auditing includes adequate indicators regarding the development of foci), objectives and interventions. However, the tool does not include indicators regarding the following key concepts: 1. Objectives and interventions that address treatment, rehabilitation and enrichment; and 2. Objectives and interventions that align with the individual's stage of change.

			The current templates have yet to include operational instructions to accompany the indicators. Review of charts showed that, in general, the formulation of foci (long-term goals) did not comply with requirements of the Agreement. Examples of foci that were vague, generic and/or not attainable are as follows: 1. "Delusions and hallucinations will stabilize" (YS); 2. "Patient will accurately perceive self, others and situations as they occur without distortion, and exhibits normal mood pattern during current hospital stay for the next 12 months" (RS); and 3. "Increase goal-directed behavior" (HL) This expert consultant reviewed the charts of individuals diagnosed with seizure disorders (CM, JR-1, MJT, SK, JR-2, MJ, RM, MR and CT), substance use disorders (RB-1, PJ, MB-1, MB-2, MA, GD-1 and CH) and cognitive disorders (JF, RB-3, JN, TM, GH and MR). The purpose of the review was to assess that foci, objectives, and interventions address the individuals' identified needs. These reviews demonstrated noncom-pliance with requirements of the Agreement in V.D.1 to V.D.6. The following are examples of general deficiencies: 1. Individuals diagnosed with seizure disorders: a. The IRP did not include seizure disorder as a diagnosis (SK). b. The IRP did not include any focus, objective or intervention related to the diagnosis of seizure disorder (MJ). c. The IRPs included foci that are unattainable for the individuals, not aligned with the individuals' needs and stated in generic terms: i. "Patient will be free of seizure or her seizure presently will be diminished" (CM); ii. "Maintain control of seizure disorder with medication"

			(JR-1); iii. "Patient will improve somatic status without experiencing seizure activity or further increases in serum cholesterol levels" (MJT); iv. "Remain seizure free with medication" (SK); and v. "Patient will be free of seizures" (JR-2). d. The IRPs included objectives that are mostly generic and not always aligned with the individual's needs or stated in measurable and behavioral terms: i. "Patient will take prescribed seizure medicine" (CM); ii. "Adhere to all treatment recommendations regarding his seizure medications" (JR-1); iii. "Remain compliant with medication (SK); iv. "Accept dilantin and phenobarbital as prescribed" (MR). e. The interventions were generic and not linked to the individual's needs: i. "Dr. will prescribe dilantin, Dr. will order dilantin level." (CM); ii. "Medicate as needed, maintain seizure precautions" (JR-1); iii. "Medical evaluation to ascertain somatic/physical response to treatment to improve physical well being" (MJT); and iv. "Dr. will monitor his seizure, ongoing" (JR-2). f. The IRPs did not include focus, objectives and/or interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize its impact on the individual's behavior and cognitive status. Examples include all individuals listed above. These individuals were receiving phenytoin and/or phenobarbital. Some of these individuals also suffer from documented cognitive impairments, which increase the risk of this treatment, including Mild mental Retardation and Cognitive Disorder, NOS (MJ), Dementia Due to head Trauma (MR) and (history of) Dementia (CT). g. The interventions did not include seizure tracking record for an

			individual who reportedly suffered seizure activity during the interval (SK). 2. Individuals diagnosed with substance use disorders: a. No focus, objectives or interventions were listed for an individual (GD). b. No objectives or interventions were listed for an individual (RB-1). c. The objective and intervention were not aligned with the individual's documented denial of having a problem with substance use (CH); d. There was no documentation that the objectives and interventions were aligned with the individual's stage of change and the stage of change was not identified in all charts reviewed. e. The objective was generic and not measurable (e.g. "continue to abstain from substance and avoid questionable situations and persons" in the chart of CH). 3. Individuals diagnosed with cognitive impairments: a. The IRPs did not include focus (goal), objectives or interventions to address the diagnosis of Moderate Mental Retardation (JF), Dementia Due to head Injury (GH), and dementia Due to head Trauma (MR). b. The focus of hospitalization did not delineate targets for treatment/rehabilitation/enrichment in a measurable and/or behavioral terms for an individual diagnosed with Dementia Due to general Condition (Hypoxia) With Behavioral Disturbance (JN). c. The IRP included objectives that are generic and not measurable (e.g. "cooperate with interview to assess psychiatric symptoms" in the chart of JN) and not based on learning outcomes (e.g. "attend five groups per week" in the chart of RB-

			3." d. The stated objectives and interventions did not account for the level of functioning of an individual with a diagnosis of Alcohol-Induced Persisting dementia (TM). e. The IRPs included interventions that did not specify what the staff will do to assist the individual in achieving appropriate and specific objectives ("one-to-one counseling will assist patient with following directions and ward routines and provide redirection as necessary" in the chart of JN). f. In general, the facility did not provide cognitive remediation interventions based on needs assessment. In addition to the above examples, the IRPs generally did not include information regarding the present symptomatic and functional status of the individuals, vulnerabilities that require tailored interventions and barriers towards achievement of individualized discharge criteria. The current lack of an Inter-disciplinary Case Formation appeared to be the main reason for this deficiency. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the draft Policy #602-04, Treatment Planning to include the information addressed in this expert consultant's findings above. 2. Provide training modules dedicated to Foci /Objectives/Interventions and Stages of Change to ensure that the Foci, Objectives and Interventions meet the principles of individualized recovery-focused planning. 3. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). 4. 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. 5. Revise the process observation and clinical chart audit tools to include indicators and operational instructions to address this requirement. 6. Monitor the requirements in V.D.1 through V.D.6 using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008). 7. Ensure that individuals diagnosed with cognitive impairments receive appropriate cognitive remediation interventions.
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:** Same as above. In addition, chart reviews by this expert consultant indicated that, in general, SEH provided foci that are geared towards symptom reduction and legal status, but did not address the individual's needs in most domains that relate to functional impairment and quality of life. As mentioned above, the facility does not have a procedure to ensure that foci are reviewed in a systematic manner and that the individual's needs are identified, as appropriate, in the following areas: 1. Psychiatric and behavioral; 2. Social skills; 3. Dangerousness and Impulsivity; 4. Cultural Factors, Hope and Spirituality; 5. Substance Abuse; 6. Medical, Health and Wellness; 7. Legal; 8. School and Education; 9. Occupational skills; 10. Quality of Life, Leisure and Recreation; and

			11. Community Integration. **Compliance:** Noncompliance **Current recommendations:** Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Findings:** Same as in V.D.1. In addition, other chart reviews by this expert consultant revealed a general pattern of deficiency regarding this requirement. Other examples of inappropriate objectives include the following: 1. "Will accept realistic goals modifications offered by staff inside the framework (of) her own goals stated above in 30 days" (YS); 2. "Resist urge to indulge in fantasies, obsessions, false beliefs and/or impulse behavior" (RS); 3. "Learn about symptoms of mental illness and how they impact a person's life" (SC); 4. "Will be able to approach her peers in a calm manner and will accept redirection from staff when she is irritable" (FC); 5. "Continue to cooperate with diet and medications" (FC); and 6. "Continue to monitor levels, discuss levels and diet with nurse and GMO (general medical officer)" (ERC)" **Compliance:** Noncompliance **Current recommendations:** Same as above.

MES and RB (PSR/ Mall)	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Findings:** Same as in V.D.1. Other chart reviews by this expert consultant revealed a general pattern of deficiency regarding this requirement. Chart examples of inappropriate interventions also include the following: 1. "Psychiatrist will follow up on patient's ability to achieve as much as practically possible to help patient achieve some of the patient's goals and will continue to adjust the medications" (YS); 2. "Discuss the importance of being able to participate in treatment through mood stabilization" (FC); 3. "Staff counseling individually and as scheduled in order to promote patient's progress towards what is realistic inpatient's goals" (YS); 4. "Psych. Evaluation to ascertain mental status and response top treatment" (RS); 5. "Community meeting to allow for expression of concerns, improve milieu and increase social skills" (SC); 6. "Monitor the patient's medication compliance and effectiveness, as needed" (HL); 7. "Psychiatrist will monitor progress towards treatment plan goals, will provide supportive therapy and prescribe medications to improve mood" (JA); 8. "Nurse will administer medications to improve mood and possible symptoms of psychosis" (RB-1);' 9. "Close observation and behavior control, reminding patient of need for appropriate behavior;" 10. "Assistance to identify socially appropriate behaviors through education and role modeling;" and None of the reviewed charts found consistent alignment between the individuals' short-term goals, the treatment interventions indicated and delivered and notes regarding progress in treatment. Deficiencies

			were found in all of the following areas: the purpose of the group treatment intervention had no discernible relationship to the concomitant short-term goal; the individual was in groups that were not assigned to him/her or documented in the treatment plan; and progress notes, when they existed, did not identify progress toward the short-term goal. **Compliance:** Noncompliance **Current recommendations:** 1. Same as above. 2. Design and implement a training program for clinical staff (treatment teams and mall providers) in how to properly align mall treatment modalities with the individual's short-term goal as documented in the treatment plan. Ensure that all short-term goals have an accompanying mall treatment intervention, and mall providers are aware of the short-term goal for which the individual has been assigned to that particular mall group so that progress can be appropriately documented and the treatment team can address necessary changes in treatment programs. 3. Implement a template for Mall Progress notes for all mall treatment activities, whether group or individual therapy, that indicates: the name of the group/individual treatment, the name of the group/individual treatment provider, the name of the individual patient, the short-term goal for which the individual has been assigned to the modality; the number of attended sessions/number of offered sessions; the quality of the individual's participation; and the individual's progress toward achieving the stated short-term goal. 4. Develop, as part of the chart auditing system, a tool to monitor compliance with these recommendations. Make data available both at the individual level, so that progress toward discharge can be

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<td>appropriately tracked, and at the aggregate level so that performance improvement can be maintained.
5. Train auditors to acceptable levels of reliability.
6. Provide operational definitions of all terms in a written format to aid in data reliability and validity.</td>
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<tr>
<td>MES</td>
<td>V.D.5</td>
<td>design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and</td>
<td>Findings:
This expert consultant reviewed the charts of six individuals to determine the number of active treatment hours per week that were documented in the IRP reviews. The following table outlines the initials of the individuals and the number of intervention hours documented:

<table>
<tr><th>Initials</th><th>Number of hours</th></tr>
<tr><td>MJT #200203</td><td>16</td></tr>
<tr><td>JR #251886</td><td>3</td></tr>
<tr><td>SK #132872</td><td>3.3</td></tr>
<tr><td>MJ #115016</td><td>12</td></tr>
<tr><td>MR #112144</td><td>11</td></tr>
<tr><td>MM #119791</td><td>1.8</td></tr>
</table>

The review showed the following:

1. No individual was scheduled for the required active treatment hours.
2. Some of the IRPs did not specify the number of hours for some interventions.
3. The IRPs did not include specific information regarding the attendance and participation of individuals in scheduled activities.
4. The IRPs did not include information to ensure appropriate linkage between active treatment hours provided at the Mall and the objectives specified in the IRPs.

SEH has yet to develop and implement a system that tracks the number</td>
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			of active treatment per week. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a system to track active treatment hours scheduled per week. 2. Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours. 3. Provide data regarding the number of active treatment hours per week for all individuals at the facility (March to August 2008). 4. Identify barriers to individual's attendance at scheduled activities. 5. Develop and implement a Mall alignment monitoring tool, with indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. 6. Provide monitoring data regarding Mall alignment based on at least 20% sample (March to August 2008).
MES	V.D.6	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	**Findings:** Same as in V.D.1 through V.D.5 **Compliance:** Noncompliance **Current recommendations:** Same as in V.D.1 through V.D.5

<table>
<tr><td></td><td colspan="3">E. Treatment Planning Is Outcome-Driven</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 self-assessment report acknowledged lack of progress and provided no information regarding the implementation of the requirements in V.E.1 to V.E.5. The report recognized that the "treatment plans are not outcome-focused or revised as a patient's condition changes."

The draft Policy #602-04, Treatment Planning does not include specific requirements regarding the processes of reviewing and revising the IRPs as stated in this section of the Agreement.

The facility's current template for process observation monitoring does not include indicators to assess the review and revision of foci.

This expert consultant reviewed the charts of six individuals. The review focused on the revision of the objectives in response to changing needs of the individuals.

The following table outlines the initials of the individual and the dates of reviews of the IRPs:

<table><tr><th>Initials</th><th>IRP reviews</th></tr><tr><td>BT</td><td>6/29/07, 8/1/07 & 9/4/07</td></tr><tr><td>CW-1</td><td>9/6/07 & 12/11/07</td></tr><tr><td>HJ</td><td>6/20/07, 9/20/07 & 12/20/07</td></tr><tr><td>CB</td><td>7/5/07, 10/9/07 & 1/3/08</td></tr></table></td></tr>
</table>

			<table><tr><td>DS</td><td>7/23/07, 10/23/07 & 1/23/08</td></tr><tr><td>PM</td><td>6/18/07, 8/13/07 & 9/13/07</td></tr></table> The review showed that the treatment teams made an effort to revise the objectives (short-term goals) of the individuals in some situations. However, the following pattern of deficiencies was evident: 1. The objectives were not revised as indicated (BT, CW and PM). 2. The revised objective was not stated in measurable, objective and/or behavioral terms (CB). 3. When the objectives were revised, the corresponding interventions did not specify how staff will assist the individual in achieving the new objective (HJ). 4. The revised objectives did not include needed nursing and psychiatric interventions (DS and PM). 5. In general, the objectives were not revised to match the individuals' stage of readiness for rehabilitation. **Compliance:** Partial **Current recommendations:** 1. Revise the draft Policy #602-04, Treatment Planning to specify the requirements regarding reviewing and revising the Foci, Objectives and Interventions.. 2. Ensure that the training modules regarding Foci/Objectives/ Interventions and Stages of Change provide guidance regarding the processes of reviewing and revising the IRPs. 3. Revise the process observation and clinical chart audit tools to include indicators and operational instructions that address the processes of reviewing and revising the Foci, Objectives and Interventions. 4. Monitor the requirements in V.E.1 through V.E.5 using both process

			observation and clinical chart audit tools based on at least 20% sample (March to August 2008).
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:** The draft Policy #602-04, Treatment Planning specifies a schedule for reviews of the IRPs that is not aligned with this requirement. The facility's self-assessment report acknowledged that the IRPs "remain on a 90 day cycle for revision, and, in some cases, even that time frame is not met." Chart reviews by this expert consultant corroborated the facility's findings regarding implementation of this requirement and indicated that the facility has yet to implement monthly reviews of the IRPs. **Compliance:** Noncompliance **Current recommendations:** 1. Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement. 2. Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008).
MES	V.E.3	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;	**Findings:** The draft Policy regarding Treatment Planning does not clearly specify this requirement. Policy #101-04, Mandatory Guidelines for Restraints and Seclusion includes requirements for the treatment team to update the IRP within 24 hours whenever an individual has experienced two or more episodes of seclusion or restraints in 24 hours, an episode of seclusion and/or restraints on two or more consecutive days or the use of seclusion and/or restraints in excess of 24 hours. These are appropriate parameters for updates of the IRPs.

As mentioned earlier, the current templates for process observation and clinical chart auditing tools are not aligned with this requirement.

This expert consultant reviewed the charts of six individuals who have experienced the use of seclusion and/or restraints during this reporting period. The following outlines the initials of the individuals, the dates of the restrictive intervention(s) and dates of subsequent review of the IRPs:

Initials	**Date of seclusion and/or restraints**	**Date of subsequent review of the IRP**
HJ	1/28/08 (seclusion) and 1/28/08 (4-point restraints)	1/30/08
CW-1	12/10/07(chemical restraints)	12/11/07
PF	11/1/07 and 10/27/07 (4-point restraints) and 10/4/07 (4-point and chemical restraints)	12/3/07
LR	12/20/07 (seclusion)	1/4/08
CS	10/5/07 (4-point and chemical restraints)	12/10/07
MP	12/18/07 (seclusion)	No IRP review in the chart

This review showed a pattern of deficiencies as follows:

1. The IRP was not updated after two episodes of seclusion/restraint within a 24 hour period as required by the facility's policy (HJ).
2. There was no mention of the use of seclusion and/or restraints during the corresponding interval period (PF, LR and CS).
3. There was no documentation of the circumstances that led to the use of S/R during the interval period (all except HJ).

			4. In general, there was no documentation of modifications of treatment as a result of the use of seclusion and/or restraints. 5. The IRP review included a description of the patient as being threatening or assaultive without specifics (HJ). 6. The foci and/or objectives addressing the use of seclusion and/or restraints were vague and unattainable/unrealistic (e.g. "will not exhibit any aggressive or assaultive behavior towards staff and patient" (HJ), "no episodes of assault, continued application of limits (incomplete sentence)" and "cooperate with RMB-7 rules and her work schedule" (CW-1). **Compliance:** Noncompliance **Current recommendations:** 1. Ensure that the facility's Policy and Procedure regarding Treatment Planning codifies this requirement. 2. Ensure that the training module regarding Foci /Objectives/Interventions provide guidance to correct the deficiencies outlined by this expert consultant above. 3. Monitor implementation of this requirement using clinical chart auditing based on at least 20% sample (March to August 2008).
MES	V.E.4	provide that the review process includes an assessment of progress related to discharge; and	**Findings:** The facility's draft Policy regarding Treatment Planning does not provide specific requirements regarding the formulation of discharge criteria and the documentation of the present status of the individuals in terms of progress towards discharge. The current format of IRPs includes a section titled "Discharge/Outplacement Plan." This section includes a review of the discharge criteria and the individuals' progress towards discharge. However, the IRPs reviewed by this expert consultant showed that, in