			general, the discharge criteria were stated in mostly vague and generic terms, not always attainable and not based on learning outcomes. As such, these criteria did not reflect what the individual must do specifically to be integrated into the community level of care. When individuals were admitted under legal codes, the discharge criteria are understandably aligned with the legal requirements for discharge. However, under these situations, the criteria were not individualized based on the mental health status of these individuals. In almost all cases reviewed, the documentation of progress towards discharge mirrored the deficiencies in the formulation of discharge criteria. Some of the IRPs did not include any documentation of discharge criteria and of progress towards discharge. The following are chart examples of inappropriate documentation of the discharge criteria and of progress towards discharge: <u>Discharge criteria</u>: 1. "Patient will be discharged when mentally stable" (HL);" 2. "Must have working knowledge of his medical health and able to recognize his medications, follow his diet and comply with these life style changes (unspecified)" (PPW); 3. Psychotic symptoms will be controlled and he will demonstrate ability to control his somatic delusions" (PPW);" 4. "No longer danger to self or others, meet regularly with CSW (social worker), continue group and individual therapy and community reentry activities" (ERC); 5. "Legal status resolved" (RB); and 6. No criteria were listed (RS). <u>Progress towards discharge</u>: 1. "Patient continues to be plagued by her illness and is therefore not stable for discharge" (YS); and 2. "Feels safe in the hospital and will not venture out" (FC).

			Compliance: Noncompliance **Current recommendations:** 1. Develop and provide a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. 2. Provide a summary outline of the above training including information about instructors and participants and training process and content (didactic and/or observational). 3. Provide aggregated data regarding results of competency-based training of all core members of the treatment team. 4. Revise current process observation and clinical chart audit tools to address requirements of this agreement regarding discharge planning. 5. Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample (March to August 2008).
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Findings:** The facility's draft Policy regarding Treatment Planning does not address this requirement. At this time, SEH does not have a mechanism to ensure that progress reviews are based on collected data. The following deficiencies were noted: 1. The treatment meetings attended by this expert consultant demonstrated inadequate reviews, based on clinical observations, of progress in the individual's symptoms, behavior and functional skills in response to interventions specified in the IRP.

			2. The treatment teams did not have access to progress notes written by facilitators of Mall interventions. As a result, the treatment teams did not have a mechanism for data-based reviews of the individuals' progress in active treatment provided at the Mall. **Compliance:** Noncompliance **Current recommendations:** 1. Same as in Section V.A.1 to V.A.1.5 2. Same as V.E.4 3. Develop and implement a mechanism for review by the treatment teams of progress notes developed by Mall facilitators that specify the individual's progress in Mall interventions.

	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 conducted a self-assessment to serve as a baseline regarding status of implementation of this 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. The psychological assessment process is not integrated into the overall treatment planning process for individuals in an effective manner. 3. The Social Work Initial Assessment does not currently attempt to resolve contradictions in social history. 4. A revised Rehabilitation Initial Assessment was presented during the visit. When implemented, it appears to meet the requirements of the DOJ agreement.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: Alberto Fernandez-Milo, M.D., Medical Director Reviewed: 1. The charts of 28 individuals (YS, FC, CT, FA, AR, HL, PT, RB, DG, FA, EM, AR, KR, PT, MM, JG,AJ, ME, SC, TS, JA, CW, MJ, EM, CS, CW, MP and HJ) 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (as of October 31, 2007) 3. Draft DMH SEH Policy #602.1-08, Assessments 4. DMH SEH Policy #601-02, Medical Records 5. List of all psychiatrists at SEH with their case loads and employment and board-certification status 6. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians 7. SEH Medical Staff Bylaws 8. SEH Diagnostic Manual 9. SEH template for Treatment Process Monitoring-Quarterly Self-Assessment 10. SEH template for Integrated Treatment Planning Process monitoring Tool 11. SEH template for Integrated Treatment Planning Clinical Chart Audit form 12. Active Case Medical Record Review Summary of Preliminary Findings 13. SEH template for Inpatient Chart Peer Review Form 14. DMH Mental Illness Drug and Alcohol Screening 15. SEH Database regarding individuals diagnosed with Cognitive Disorders 16. SEH Database regarding individuals diagnosed with Substance Use

			Disorders 17. SEH Database regarding individuals diagnosed with Seizure Disorders 18. SEH database regarding individuals with diagnoses listed as Rule/Out (R/O) or Not Otherwise Specified (NOS) <u>Observed</u>: 1. Treatment planning meeting at RMB-5 for 28-day review of TP 2. Treatment planning meeting at RMB-6 for 14-day review of MC. 3. Treatment planning meeting at JH-6 for 90-day review of KT.
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:** The facility's current draft Policy#602.1-08, Assessments includes an outline of the facility's expectations regarding the timeliness and some content requirements of a comprehensive admission assessment, including Psychiatric and Nursing Assessments, Psychological Assessment (including Psychological Risk Screening), Social Work Assessment and Rehabilitation Assessment. In addition, the policy includes requirements regarding Assessment Updates, Reassessments and Clinically-Indicated Assessments. Regarding Psychiatric Assessments and Reassessments, the current draft policy represents a good start, but more work is needed to restructure this policy to ensure operational alignment with specific requirements of the Agreement in the following areas: 1. Specific requirements regarding the content of the initial 24 hours psychiatric assessment, including the plan of care; 2. Specific requirements regarding the content of the complete psychiatric assessment (to be completed no later than the fourth calendar day after admission); 3. Specific requirements regarding the content of the psychiatric reassessments (the policy combines the requirements for

			assessments and reassessments); and 4. Specific requirements regarding risk assessment during the first 24 hours of admission (see VI.A.2) In addition, this policy includes specific requirements regarding the Interdisciplinary Case Formulation. This information should be part of the Policy and Procedure/Manual regarding the IRP (see V.C). The draft policy includes appropriate requirement to ensure that the psychiatric reassessments align with the psychiatric factors listed in this formulation. SEH's self-assessment report indicated that, at this time, the psychiatric assessments "are not meeting this requirement. The facility's self-assessment tool regarding Treatment Process Monitoring includes some indicators regarding psychiatric interventions in the IRP and psychiatric progress notes. However, the indicators are not sufficiently aligned with specific requirements of the Agreement regarding psychiatric assessments and reassessments. Chart reviews by this expert consultant indicated that, in general, the admission psychiatric assessments and the psychiatric reassessment do not meet the requirements of the Agreement as illustrated by findings in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7 **Compliance:** Noncompliance **Current recommendations:** 1. Revise and finalize the current policy and procedure regarding Assessments to address this expert consultant's findings above. 2. Develop and implement self-monitoring tools, including indicators and operational instructions, that address the timeliness and

			content requirements for the initial psychiatric assessment (24 hours), admission psychiatric assessment (by fourth day) and psychiatric reassessments. 3. Provide monitoring data regarding psychiatric assessments and reassessments based on at least 20% sample (March to August).
MES	VI.A.2	By 24 months from the Effective Date hereof, SEH shall develop an admission risk assessment procedure, with special precautions noted where relevant, that includes available information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopements, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital care is needed; and any mitigating factors and their relation to current risk;	**Findings:** The current format of the admission psychiatric assessment includes a section titled "Level Of Care" that provides information (yes or no) regarding the presence of risk (danger to self, danger to property, elopement risk and fall risk) as well as a severity scale (mild, moderate and severe) and a space a space for an explanation of the risk. SEH has a draft Policy and Procedure regarding Assessments that includes a requirement for "psychological risk screening" to be completed as part of the comprehensive psychological assessment by the fourth calendar day after admission. SEH has yet to develop a monitoring tool to assess compliance with this requirement. The facility did not provide specific information regarding this requirement in its self-assessment report. At this time, SEH does not have an adequate mechanism to ensure a risk assessment within the first 24 hours of admission that meets generally accepted standards of care. The current format of the "level of Care" section does not provide the specific information that serves as the basis for conclusions about presence or absence of risk and the degree of risk. Chart reviews by this expert consultant showed the following general deficiencies: 1. The "Level of Care" section did not include an explanation when the psychiatrist has concluded that the individual is not at risk.

			2. The "Level of Care" section did not provide specific information to address how recent the risk was, its relevance to dangerousness and any mitigating factors that influence the quantification of risk. 3. When the level of risk was quantified as mild, moderate or severe, there was no adequate explanation to justify the established level of risk. 4. In almost all the charts reviewed, the mental status examination did not include an explicit statement about the presence or absence of ideations, intent and/or plan in the various categories of risk, including suicidality and homicidality. 5. The current structured format of the mental status examination (mood and thought content) did not lend itself to providing specific information about dangerousness. **Compliance:** Noncompliance **Current recommendations:** 1. Same as IV.A.1 2. Develop and implement a mechanism for risk assessment within the first 24 hours of admission. At a minimum, the assessment must provide information regarding: a. The type of risk (e.g. suicide, homicide, physical aggression, sexual aggression, self-injury, fire setting, elopement, etc); b. Timeframes for risk factors; c. Description of severity of risk and its relevance to dangerousness; and d. A review of the circumstances surrounding the risk events, including mitigating factors. 3. Revise the current format of the admission psychiatric assessment to ensure that the mental status examination provides specific information regarding dangerousness. 4. Ensure that the monitoring tool regarding the initial psychiatric

			assessment includes indicators and operational instructions to address risk assessment. 5. Provide data regarding risk assessment as part of the initial psychiatric assessment monitoring data, based on at least 20% sample (March to August 2008).
MES	VI.A.3	By 12 months from the Effective Date hereof, SEH shall use the most current Diagnostics and Statistics Manual ("DSM") for reaching psychiatric diagnoses;	**Findings:** The facility reported that all psychiatrists have been provided copies of the current version of DSM to utilize as a diagnostic guide. The facility has a Diagnostic manual that is aligned with the most current DSM. However, in its self-assessment report, SEH recognized that peer review is needed to ensure compliance with this requirement. SEH has yet to develop a monitoring tool to assess compliance with this requirement. The facility did not provide specific information regarding this requirement in its self-assessment report. Chart reviews by this expert consultant (see VI.A.6) indicated that diagnostic accuracy is highly variable, that the facility has yet to ensure that clinically justifiable diagnoses are provided for each individual, and that all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next reassessment. Some of the charts of individuals diagnosed with cognitive impairments (see VI.A.6) did not include an adequate cognitive examination, as part of the mental status examination, a diagnostic formulation or a differential diagnoses that meets the needs of these individuals for diagnostic accuracy. **Compliance:** Partial **Current recommendations:** 1. Same as in VI.A.1 and VI.A.6.

			2. Ensure that the monitoring tools regarding psychiatric assessments and reassessments include indicators and operational instructions that address diagnostic accuracy, including that the diagnoses are consistent with the individuals' history and current presentation. 3. Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments (March to August 2008).
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 above. **Compliance:** Partial **Current recommendations:** Same as above.
MES	VI.A.5	By 12 months from the Effective Date hereof, SEH shall ensure that, within 24 hours of an individual's admission to SEH, the individual receives an initial psychiatric assessment, consistent with SEH's protocols;	**Findings:** Same as in VI.A.1, VI.A.2 and VI.A.3. In addition, chart reviews by this expert consultant revealed inadequate formulation of strengths of the individuals. In most charts, the strength formulation was basically a generic description of the individual's characteristics rather than a formulation of attributes that could be utilized in the IRP. Examples include: 1. "Can communicate, ambulatory" (HL); and 2. "Able to communicate needs" (PT). At a minimum, the initial psychiatric assessment must provide sufficient information regarding the reason for hospitalization, current and past history, risk assessment, current mental status and provisional diagnosis as well as a plan of care that includes special precautions to

			ensure safety of the individual and others and medications, with rationale. The complete admission assessment must also integrate additional information that became available following admission to the facility to permit a more complete review/assessment, including psychosocial history, substance abuse, psychiatric risk factors, strengths, diagnostic formulation, differential diagnosis, and management of identified additional risks. **Compliance:** Partial **Current recommendations:** Same as in VI.A.1 and VI.A.2.
	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, VI.A.3 and VI.A.6. **Compliance:** Partial **Current recommendations:** Same as in VI.A.1, VI.A.3 and VI.A.6.
MES	VI.A.6.b	all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments;	**Findings:** SEH did not provide information regarding this requirement in its self-assessment report. Documents provided by the Medical Director, during a personal interview, indicated that SEH currently has a facility-based residency training program in Psychiatry with a total of 28 residents (PGY I to

			PGY IV) as well as three forensic psychiatry fellows in a program affiliated with Georgetown University School of Medicine. SEH also provides, or has agreements to provide, a core psychiatry rotation to 17 third-year Medical Students from a number of local universities, including George Washington, Howard and the Uniformed Services University Schools of Medicine. In addition, there are three physicians who are part of a clinical externship program that provide US-based experience to foreign-trained physicians The facility's Policy #601-02, Medical Records, requires that all signatures by residents, students and externs are countersigned by the attending physicians. This expert consultant did not find examples of notes written by trainees that were not countersigned by the attending physicians. However, chart reviews showed that, in some cases, there was evidence of inadequate communications between the attending physicians and the trainees. For example, in the chart of FC, the resident's note indicated that the individual had refused the examination by the resident and asked to be interviewed by the attending physician. Although the note was cosigned by the attending, there was no evidence that the individual was subsequently examined by the attending. **Compliance:** Partial **Current recommendations:** 1. Provide the facility's procedure that ensures adequate supervision of trainees and appropriate communications between the trainees and attending physicians. 2. Provide self-assessment data regarding implementation of this requirement.
MES	VI.A.6.c	differential diagnoses, "rule-out" diagnoses,	**Findings:**

		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	The facility's self-assessment report did not include this requirement. This expert consultant reviewed the charts of 17 individuals who received diagnoses listed as NOS or R/O. The following table outlines the initials of the individuals and corresponding diagnosis: **Initials** / **Diagnosis** FA — Dementia NOS AJ — Dementia NOS ME — R/O Cognitive Disorder, NOS AR — Psychotic Disorder NOS SC — Psychotic disorder NOS and Depressive Disorder NOS TS — Mood Disorder, NOS (most recent IRP) JA — Dementia NOS CW — Cognitive Disorder, NOS HL — Mood Disorder, NOS, Cognitive Disorder, NOS and Impulse Control Disorder, NOS RB — Dementia NOS and Psychotic Disorder NOS MJ — Cognitive Disorder NOS and Mild Mental Retardation EM — R/O Cognitive Disorder AR — Cognitive Disorder, NOS CW — Cognitive Disorder, NOS The reviews showed a general pattern of inadequate justification and/or finalization of these diagnoses and/or incomplete assessment of differential diagnoses, when clinically indicated. **Compliance:** Partial

			Current recommendations: 1. Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4. 2. Provide CME training to psychiatry staff in the assessment of cognitive and other neuropsychiatric disorders. 3. Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation. 4. Develop and implement corrective actions to address the deficiencies in the finalization of diagnoses listed as R/O and/or NOS
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 **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:** As mentioned in VI.A.1, the current draft policy regarding Assessments does not include sufficient guidance regarding the process and content of psychiatric reassessments. SEH did not provide specific information regarding this requirement Charts reviewed by this expert consultant demonstrated lack of a consistent format for the documentation of the reassessments. In general, the following pattern of deficiencies in the content of the reassessments was noted: 1. The assessment of interval events did not adequately cover significant clinical developments. Most of the reassessments

			represented cross-sectional reviews and were geared towards current presentation and crisis events. 2. The diagnoses were not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses were not adequate when needed. 3. There is little or no documentation to indicate that the psychiatrist had used information regarding the individual's response to specific treatments as data to refine diagnosis. 4. The risks and benefits of current treatments were not reviewed in a systematic manner. 5. The assessment of risk factors was limited to some documentation of crises that lead to use of restrictive interventions. There was no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis. 6. There is limited or no documentation of actual and/or potential side effects of high risk medication uses, including benzodiazepines, anticholinergic medications, new generation antipsychotics and/or polypharmacy. This pattern was noted even when these medications are used in individuals who are particularly vulnerable to the risks. 7. There was no review of the specific indications for the use of stat medication, the circumstances for the administration of these medications, the individual's response to this use or modification of treatment based on this review. 8. When behavioral interventions are provided, there was no documentation to indicate an integration of pharmacological and behavioral modalities. 9. There is little or no discussion of the contextual basis and functional significance of the current symptoms. 10. There is no documentation of the goals of individual psychotherapy and of the individual's progress in treatment when the IRP indicates that the psychiatrist is providing this intervention.

			Compliance: Partial **Current recommendations:** 1. Same as in VI.A.1. 2. Develop and implement a standardized format for psychiatric reassessments that address and correct the deficiencies identified above.

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: 1. Beth Gouse, Ph.D., Acting Chief of Psychology Services 2. Sid Binks, Ph.D. Neuropsychologist Reviewed The charts of 22 individuals: BO, BW, DJ, HM, JB, JL, LB, LC, LJ, LS, ML, MM, MR, PD, PR, RF, RG, RH, RS, SA, WH and WP
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:** Currently, the hospital has no policy on required timelines for completing psychological assessments, or indeed a tracking mechanism that assures that all referred assessments are completed. The Psychology Department does not maintain a monitoring system on the referral and completion of any psychological assessments. A *Peer Review Form for Psychologists*, which is currently in draft form, does address some issues of the psychological assessment process. The hospital's neuropsychologist, who reports to the neurologist, does maintain a log of referrals, and indicated that only four individuals were on the waiting list at the time that the hospital completed its baseline self-assessment. A document submitted by the neuropsychologist at the time of the baseline assessment indicated the status of referrals between 09/01/07 and 01/25/08, but did not indicate referral date and completion date, so timeliness could not be determined. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a policy governing the appropriate timelines

			for the completion of referrals for all psychological assessments. Since the monitoring of all psychological assessments falls within the purview of the Psychology Department, the hospital should consider reorganization so that the neuropsychologist reports through the Chief of Psychology. 2. Develop and implement a tracking system to determine when all referrals for any type of psychological assessment are made and track these assessments to completion. This process will help the Psychology Department and the hospital better understand its need for psychological services, so that an adequate number of psychologists can be hired. 3. Develop standard templates for all psychological screening and assessment reports that mirror the requirements of the DOJ agreement. At a minimum, address: a. The individual's identifying information b. Precipitants to hospitalization c. The reason for the referral d. Relevant social, educational, employment and legal history e. History of head or brain injury f. Past mental health and substance abuse history g. Risk for harm factors where relevant h. The dates and results of previous psychological assessment i. The psychological tools and measures employed in the assessment process j. The results of all psychological tools and measures k. Conclusions that directly address the referral question and draw a connection between testing results and other current and accurate data l. Recommendations that flow logically from the conclusions or that provide clarification for the referral question m. Any recommendations for further assessment 4. Develop and implement a monitoring tool or tools (in conjunction with other clinical auditing tools) that address the psychological

			assessment process. At a minimum, monitor: a. All of the items indicated in the template outlined in Recommendation 3 above; b. Timeliness of the assessment process as per yet to be established policy guidelines c. The quality of each section of the evaluation d. The process by which the assessment results are communicated to the treatment team and documented in the individual's medical record. e. The process whereby the treatment team documents its response to each recommendation of the psychological assessment, including any rationale for not following a specific recommendation. 5. The auditing/monitoring data can be used as part of the peer review process for individual psychologists. Aggregate and trend as part of an ongoing performance improvement process that will help determine where needed intervention, training or supervision is best directed within the department. 6. Train auditors to acceptable levels of reliability. 7. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
	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:** Those psychological evaluations that were essentially risk assessments expressly stated the purpose for which they were performed. These were typically completed on forensic individuals to provide assistance in determining the next higher level of privilege. The majority of the neuropsychological assessments also had clearly stated reasons for which they were performed.

			Compliance: Substantial **Current recommendations:** 1. Continue current practice with Risk Assessments and Neuropsychological Assessments. 2. See cell VI.B.1, Recommendation 4. An important item to monitor is that all psychological assessments clearly state the referral question, and that the referral question is directly answered in the assessment's conclusion section. 3. Have psychologists work with treatment teams informally or provide teams formal training in assisting them in how to structure appropriate referral questions.
RB	VI.B.2.b	be based on current and accurate data;	**Findings:** In almost all instances, reviewed assessments/evaluations demonstrated evidence that their conclusions were based on accurate and current data. There were two notable exceptions. One was a sex offender risk assessment in which the evaluator reported that the individual "through no fault of his own" has received "only nominal sex offender treatment" over a 13-year period. However, the basis for both of these statements was not found in the report. First, there are significant statements in the report about the individual's personality variables that might reasonably be expected to interfere with treatment adherence and progress that are not addressed in the conclusions. Second, no actual review of whatever sex offender treatment the individual received was attempted, nor were the reasons explained for why that treatment was so meager. The second exception was in an evaluation in which the referral question included ascertaining the current level of psychosis. Conclusions merely stated that symptoms

			appeared to be in remission during much of the individual's course of hospitalization, but that he may be masking them. No current data was cited as a basis for this latter conclusion was offered. In the above indicated sex offender evaluation, the evaluator indicated the use of two instruments incorrectly identified as "actuarial" tools. While the results of these tools were not inappropriately included in an actuarial risk assessment statement, care must be taken in the proper identification of measures used in all psychological assessments, so that their conclusions will be correctly interpreted. **Compliance:** Partial **Current recommendations:** 1. Continue to use current and accurate data in arriving at their conclusions, as was evident in the great majority of reviewed assessments. 2. See cell VI.B.1, Recommendations 4, 6 and 7.
RB	VI.B.2.c	provide current assessment of risk for harm factors, if requested;	**Findings:** When an assessment of risk was requested, these questions were appropriately answered in the evaluation. **Compliance:** Substantial **Current recommendations:** 1. Maintain current level of practice. 2. See cell VI.B.1, Recommendations 4, 6 and 7.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Findings:** Determinations were present for all evaluations that were risk

			assessments. Determinations for several neuropsychological evaluations were vague and unclear with regard to the referral question, and in several cases, the basic referral question was not answered in clear and straightforward language – in one case, even when the referral question was restated at the beginning of the report's conclusion. Boilerplate language was frequently used in the Impressions and Recommendations sections of these evaluations. Even when substantial testing was completed, differential recommendations of sufficient depth were missing. **Compliance:** Noncompliance **Current recommendations:** 1. Develop clear guidelines for the Conclusions and Recommendations sections of all psychological assessments and screenings. 2. Provide directions on how the psychological assessment is to directly answer the referral question and make appropriate recommendations based on that answer. 3. Auditing tools for monitoring the psychological assessment process must include items relevant to determining ongoing compliance with this element of the DOJ agreement. See cell VI.B.1, Recommendation 4. 4. See cell VI.B.1, Recommendation 7.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Findings:** The empirical basis for most conclusions was indicated. Exceptions included the evaluation referenced in Cell VI.B.2.b, in which the empirical basis for concluding that the individual might be masking psychotic symptoms was not provided and a neuropsychological evaluation that provided conflicting empirical data for supporting a

			differential diagnosis of Dementia NOS in an individual recovering from a gunshot wound to the head. The individual had sustained prior head trauma, and the report's conclusions seemed to imply that the etiology of the cognitive difficulty was unclear, but that the person's functioning was likely to recover. While recovery from the gunshot wound might lead to higher levels of cognitive functioning, the interrelationship between this event and the cognitive sequelae of past head trauma were not well formulated. **Compliance:** Partial **Current recommendations:** 1. See cell VI.B.2.d, Recommendation 1. 2. Provide directions on how the empirical basis for all conclusions is to be addressed in the assessment report. 3. See cell VI.B.2.d, Recommendations 3 and 4.
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:** This process is not currently occurring. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a timeline for the completion of this item of the agreement. 2. Use whatever tool that is developed for the monitoring of current psychological assessments for timeliness, quality and completeness to make the determination as to whether individuals previously assessed need additional psychological assessment (see Cell VI.B.1).

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:** A draft policy, entitled *Assessments*, dealing with all mental health assessments, and indicating that this requirement will be met was presented as part of the hospital's baseline self-assessment. However, the policy has not yet been finalized and was not implemented by the time of the DOJ visit in February 2007. **Compliance:** Noncompliance **Current recommendations:** 1. Finalize and implement the draft policy. 2. Give careful consideration to requiring that all new admissions receive at a minimum a cognitive screening in addition to the required risk assessment. Both chart reviews and discussion with psychology staff suggest that a high percentage of those individuals admitted to St. Elizabeths Hospital have some measure of cognitive impairment that will be an important determinant in providing adequate treatment and rehabilitation, as well as a prominent issue in discharge planning.
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:** No formal procedure for the communication and documentation of that communication is outlined in current hospital or Psychology Department policy. Evaluation reports are generally placed in the individual's medical record, but there appears to be no formal process for indicating that they have been "received" by the treatment team. In one of the reviewed cases a recommendation for group therapy was not incorporated into the individual's treatment plan until two months following the completion of the evaluation. A recommendation for individual therapy was made in the evaluation as well, but then another referral about this same issue was generated about six months later

			and had not been addressed in the subsequent month. In 60% of the neuropsychological assessments that were reviewed, no evidence was found that recommendations regarding diagnostic clarification were addressed by the referring treatment teams, even when that had been the purpose of the referral, In one case, the neuropsychological assessment report was not even filed in the individual's chart despite having been completed months before. **Compliance:** Noncompliance **Current recommendations:** 1. Develop policies and procedures that address the process by which psychological assessment results are directly communicated to the treatment team and such communication is noted in the individual's medical record. 2. Develop policies and procedures that address the proper documentation of the treatment team's response to all recommendations from psychological assessments, including whatever rationale might exist for not following those recommendations. 3. Monitor through chart auditing tools for fidelity to these processes.

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: 1. Crystal Robinson, MT-BC Chief of Rehabilitation Therapy, Forensics 2. Michelle Coleman, OTR/L, Acting Chief of Rehabilitation Services, Civil Reviewed: The charts of five individuals: CG, KJ, JJ, LL and MF
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:** The Rehabilitation Therapy (RT) Assessment provided as part of the hospital's self-assessment package is inadequate in meeting the requirements of the DOJ agreement. However, to the hospital's credit, the two RT chiefs have developed and are piloting a revised version, which will meet the DOJ requirements. It was the understanding of this consultant that each newly admitted individual will be assessed by an RT, and that the new form will be implemented across admission units. However, draft policy still calls for an RT assessment only when requested by the head of the treatment team. **Compliance:** Noncompliance **Current recommendations:** 1. Implement the newly revised Initial RT Assessment across all admission units. The newly designed assessment provides important material for the functional assessment of individuals that is critical to determining their level of care while in the hospital and upon discharge. 2. Develop and implement an auditing tool that monitors the medical record for the presence, timeliness and quality of the Initial RT

			Assessment. 3. Auditors must be trained to reliability. 4. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
	VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	Please see sub-cells for findings and compliance.
RB	VI.C.2.a	be accurate as to the individual's functional abilities;	**Findings:** The newly developed Initial RT Assessment meets this requirement in its design, but has not yet been implemented. **Compliance:** Noncompliance **Current recommendations:** Same as above.
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Findings:** The newly developed Initial RT Assessment meets this requirement in its design, but has not yet been implemented. **Compliance:** Noncompliance **Current recommendations:** Same as above.
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Findings:** The newly developed Initial RT Assessment meets this requirement in its design, but has not yet been implemented.

			Compliance: Noncompliance **Current recommendations:** Same as above.
RB	VI.C.2.d	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	**Findings:** The newly developed Initial RT Assessment meets this requirement in its design, but has not yet been implemented. **Compliance:** Noncompliance **Current recommendations:** Same as above.
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:** No information about the hospital's plan for meeting this requirement was provided in the self-assessment materials. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a plan to address this issue. 2. Utilize some version of the audit tool referenced in cells VI.C.2.a through VI.C.2.d for use in this review process. 3. Develop and implement a plan for the provision of treatment mall services to all forensic individuals.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Daisey Wilhoit, LICSW, Chief of Social Work Services, Civil 2. Rafaela Richardson, LICSW, Chief of Social Work Services, Forensic Reviewed: The charts of five individuals: CG, KJ, JJ, LL and MF
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 current Social Work Initial Assessment (SWIA) does not provide for 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. In the reviewed charts, there was no evidence that the SWIA provided information that was incorporated into the individual's initial IRP, even when specific discharge information was indicated in the assessment. Discharge related information in the individual's IRP consisted primarily of boiler plate language, frequently stating that the social worker would "coordinate placement activities with the case manager," a statement of almost universal relevance that indicated no attention to specific discharge related-needs based on an individual's relevant social factors. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the SWIA to include a narrative section following the section on Social History that indicates what attempts were made to reconcile conflicting information and the outcome of those

			attempts, as well as further plans to reconcile information if appropriate. 2. Develop written guidelines for the SWIA that clearly articulate how individual social workers are to document their sources for conflicting data in the Social History section of the assessment. Simply providing check boxes for all sources of information does nothing to resolve conflicting information, and may in fact, increase confusion, for when multiple sources are checked, it could imply that conflicts were resolved. 3. Develop and implement an auditing tool to monitor the presence, timeliness and quality of this and all sections of the SWIA. 4. Train auditors to acceptable levels of reliability. 5. Provide operational definitions of all terms in a written format to aid in data reliability and validity.

	VII. Discharge Planning and Community Integration		
RB		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. Due to a lack of adequate assessment and documentation upon admission and throughout the treatment planning process, the hospital is not able to adequately determine if individuals are being appropriately discharged to settings commensurate with their needs. 2. Additionally, the hospital currently lacks a mechanism for follow up with discharged individuals and/or their community case managers to determine if the discharge was successful and necessary community-based services and supports were implemented and utilized.
RB			**Methodology:** <u>Interviewed</u>: 1. Daisey Wilhoit, LICSW, Chief of Social Work Services, Civil 2. Rafaela Richardson, LICSW, Chief of Social Work Services, Forensic <u>Reviewed</u>: The charts of five individuals: CG, KJ, JJ, LL and MF <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-6 for RH
RB	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each	**Findings:** In none of the reviewed charts was evidence found that meaningful discharge planning had begun upon admission.

		individual bearing on discharge, including:	Psychiatric Assessments routinely indicated that housing was a problem on Axis IV, but this issue was not integrated into the case formulation of the initial IRP. The SWIA routinely used boilerplate language to discuss discharge planning, and typically used phrases such as "will coordinate placement activities with the case manager" as the social worker's plan. **Compliance:** Noncompliance **Current recommendations:** 1. Provide guidelines for how appropriately individualize the Discharge Plan of the SWIA to accurately reflect the relevant discharge needs of all newly admitted individuals. At a minimum indicate the likely discharge placement and the necessary community based supports and services that will be necessary to optimize community tenure. 2. Provide guidelines on how to integrate the above information from SWIA into the case formulation and long term goals of the individual's initial IRP. Utilize later treatment planning conferences to incorporate goals and objectives consistent with the development of a written Wellness and Recovery Action Plan that at a minimum addresses: the individual's strengths and acquired skills, warning signs for relapse regarding any and all aspects of the individual's diagnoses or risk factors; strategies to put in place when warning signs are encountered; supports and services which the individual will be provided upon discharge.
RB	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Findings:** The SWIA routinely listed individual strengths, but too much emphasis was placed on a check-off form, rather than a real analysis of individual strengths, and the indicated strengths were not meaningfully

			integrated into the individual's initial treatment plan. Where the present assessment form provides an opportunity for an "integrative analysis" of those issues that have been highlighted in an assessment of these factors, and that might answer the issues raised in this section of the agreement, that section of the assessment was typically a summary rather than an integrative analysis. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the SWIA to include an analysis of individual strengths that are relevant to the individual's chosen discharge setting. 2. Develop this section of the Assessment so that it is a narrative block rather than a check-off form. 3. Develop and implement an auditing tool that monitors for the presence, timeliness and quality of this and all sections of the SWIA. 4. Train auditors to acceptable levels of reliability. 5. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
RB	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Findings:** The current SWIA does not address this issue at all, and therefore, does not address the issue as it bears on discharge. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the SWIA to address specifically the individual's symptoms of mental illness or psychiatric distress as it directly impacts on anticipated placement.

			2. See cell VII.A.1, Recommendations 3 through 5.
RB	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Findings:** The SWIA does not address this issue in a meaningful manner, and this was indicated in the hospital's self assessment. Particularly noteworthy is the lack of documentation regarding past placement attempts, successes and failures and the reasons for either. Where the present assessment form provides an opportunity for an "integrative analysis" of those issues that have been raised in the course of the assessment, and that might answer the issues raised in this section of the agreement, that section of the assessment was typically a summary rather than an integrative analysis. **Compliance:** Noncompliance **Current recommendations:** 1. Revise the SWIA must to address those 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. Provide integrative analysis of this issue in the SWIA. 2. See cell VII.A.1, Recommendations 3 through 5.
RB	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Findings:** The SWIA catalogues individual skills using a check-off form, but in no way relates appropriately individualized skills to the anticipated discharge setting. **Compliance:** Noncompliance

			Current recommendations: 1. Revise the SWIA to provide a mechanism whereby individual social workers can discuss the skills necessary for the anticipated discharge placement. 2. See cell VII.A.1, Recommendations 3 through 5.
RB	VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	**Findings:** While individuals were present at all observed treatment planning meetings, their meaningful input into discharge planning was notably absent. In two cases only was discharge planning specifically discussed with the individual. In one case, the role of the individual's need for and use of a prosthesis in the discharge setting was unknown to the team in advance of the treatment planning conference, despite the fact that the prosthesis was an important element of the individual's self-assessment and discharge placement. In the other case, the individual, who had been assessed by all members of the team to be "high functioning" was allowed to entertain a discharge-related goal for which there was no evidence that she would be suited. **Compliance:** Noncompliance **Current recommendations:** 1. Provide hospital staff with training in how to effectively engage individuals in their own treatment and discharge planning. 2. Provide hospital staff with training in how to run effective and organized treatment planning conferences. See Cell V.A.2.a for further information.
RB	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Findings:** The hospital provided no information in its self-assessment on its progress toward this goal. Reviewed treatment plans routinely did not address anticipated discharge placements and the skills needed for

			individuals to be able to optimize placement in the anticipated discharge setting. **Compliance:** Noncompliance **Current recommendations:** 1. Develop policies and procedures that assure that all treatment plan documents include the anticipated place of discharge or level of necessary care, integral community-based services and supports, and current barriers to discharge to that setting, measurable interventions related to these barriers, the person responsible for delivering the intervention, and the timeframe for completion of the intervention. 2. Provide training in developing this portion of the treatment plan in conjunction with in the hospital-wide treatment plan training recommended in cell V.A.2.a. Provide additional and more focused and specific training in this process to all social workers.
RB	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Findings:** Same as above. **Compliance:** Noncompliance **Current recommendations:** Same as above.
RB	VII.C.2	the persons responsible for accomplishing the interventions; and	**Findings:** Same as above. **Compliance:**

			Noncompliance **Current recommendations:** Same as above.
RB	VII.C.3	the time frames for completion of the interventions.	**Findings:** Same as above. **Compliance:** Noncompliance **Current recommendations:** Same as above.
RB	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.	**Findings:** The hospital has some activities that involve trips into the community and the utilization of community resources. It has also begun a more detailed program to accomplish this goal with the Skills Development Mall. However, the hospital's self assessment indicated that St. Elizabeths needs specific skill development programs that directly address the skills that individuals will need in the community, and this expert consultant concurs with that assessment. **Compliance:** Noncompliance **Current recommendations:** 1. Provide an assessment of the discharge placements to which the hospital refers individuals to determine the specific skills that will be necessary for successful community living in those placements. 2. Provide an adequate number of mall groups that teach these skills with manual based curriculum. 3. Develop and implement an auditing tool that monitors progress in

			the establishment and success of these skills-based interventions. 4. Train auditors to acceptable levels of reliability. 5. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
RB	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the individual for the services, and the discharge of the individual.	**Findings:** *Transfer/Discharge/Death Summaries* were reviewed. These items were completely missing in one summary, adequately presented in another (except for documentation that the information had been conveyed to the post-hospital provider) and inadequately presented in the remaining three reviewed summaries. Inadequacies included generic post-hospital treatment recommendations that did not address an appropriate set of supports and services and specification of only the pharmacological aspects of the post-hospital discharge treatment without adequate specification of the psychosocial treatments. **Compliance:** Noncompliance **Current recommendations:** 1. Develop separate forms for Transfer, Discharge and Death summaries. 2. Clarify policies and procedures to assure that the Discharge Summary is to include documentation that the information about the discharge treatment needs of the individual has been communicated to the outpatient providers. 3. Develop and implement an auditing tool to monitor each section of the Discharge Summary for compliance with the DOJ agreement. 4. Auditors must be trained to reliability. 5. Provide operational definitions of all terms in a written format to aid in data reliability and validity.
RB	VII.F	By 12 months from the Effective Date hereof,	**Findings:**

		SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	According to the hospital's self-assessment, this process has not yet begun, but a pilot tool was reportedly developed. The only audit tool found in the self-assessment materials was a *chart* audit tool more appropriately used for Cell VII.E. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement policies and procedures that specify which staff members are responsible for this aspect of community placement follow up, the timeliness by which data is to be collected and aggregated and an auditing tool that monitors compliance. 2. Train auditors to acceptable levels of reliability, and provide operational definitions of all terms in a written format to aid in data reliability and validity. 3. Present data to hospital administration and Social Work chiefs for appropriate follow-up action. 4. Submit a plan for how many additional staff are needed to implement the above recommendations and a timeline for hiring them.
RB	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Findings:** Same as above. **Compliance:** Noncompliance **Current recommendations:** Same as above.
RB	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Findings:** Same as above.

			Compliance: Noncompliance **Current recommendations:** Same as above.

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Progress:** 1. SEH conducted a self-assessment to serve as a baseline regarding status of implementation of this 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. Psychological Assessment reports do not currently follow a clearly delineated template and monitoring of compliance with the template must be initiated and continued. Current behavioral plans are inadequate and consultation is required to improve their quality to minimum acceptable standards. 3. Treatment interventions provided in the malls are routinely not aligned with the short-term goals in the individual's Interdisciplinary Recovery Plan. An adequate template for documenting responses to treatment modalities delivered in the malls does not currently exist.

	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. Alberto Fernandez-Milo, M.D., Medical Director 2. Syed Zaidi, M.D., General Medical officer and Member of the Pharmacy and Therapeutics (P&T) Committee 3. John Stellar, M.D., Chair of the P & T Committee 4. Terry Harrison, Pharm. D., Chief Pharmacist 5. Ermis Zerislassie, Pharm.D. Assistant Chief Pharmacist Reviewed: 1. Charts of 39 individuals (MM-1, MM-2, MJT-1, CH, JFD, JD-1, JD-2, CW-1, WHM, BW, CG, ERC, CN, CB, RS, CM, TS, PT, EW, RB-4, PW, EM, YS, FC, HL, KR, PJ, AB, CN, RM, SC, KS, GH, DA, CS, JJ, GJF and SF) 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (as of October 31, 2007) 3. SEH database regarding individuals receiving benzodiazepines 4. SEH database regarding individuals receiving anticholinergic treatments 5. SEH database regarding individuals receiving treatment with new generation antipsychotic medications 6. DMH File #1.23, Pharmacy Services/Standard Operating Procedures, Alerting Orders, May 16, 2002 7. SEH, Office of the Associate director for Medical Affairs, Guidelines for the Prescription of Multiple Psychotropic Medications, August 8, 2007 8. DMH File #2.5, Pharmacy Services Standard Operating Procedures, Subject: Monitoring Clozapine Patients 9. DMH File #2.7, Pharmacy Services Standard Operating Procedures, Subject: Use of Patient's Own Medications 10. CMHS Policy and procedure 350000.410.1G: Ordering, Recording

			and Administering Medications and Treatments 11. Ten completed Reports of Suspected Adverse Drug Reactions (October 18 to December 17, 2007) 12. Ten completed Medication Error reports (October 9 to December 29, 2007) 13. SEH Reported Medication Errors during 2007 (May to December 2007) 14. SEH raw data regarding drug alerts July 1 to December 31, 2007 15. DMS SEH Draft Policy and procedure (#XXX-08), Tardive Dyskinesia Management-Guidelines for Psychiatrists 16. Minutes of the P&T Committee (March to December 2007) 17. Minutes of the Mortality Review committee (January 16, April 26, June 11, July 24, August 10, and December 13, 2007) 18. SEH Mental Illness Drug and Alcohol Screening (MIDAS) Form
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 and VI.A.6.c regarding psychiatric assessments; same as in VI.A.7 regarding psychiatric reassessments. **Compliance:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c regarding psychiatric assessments. Same as in VI.A.7 regarding psychiatric reassessments.

			Current recommendations: 1. Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. 2. Same as in VI.A.7.
MES	VIII.A.1.b	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	**Findings:** Same as in VI.A.7. **Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.c	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	**Findings:** Same as in VI.A.7. **Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.d	documentation of analyses of risks and benefits of chosen treatment interventions;	**Findings:** Same as in VI.A.7. **Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.e	assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls)	**Findings:** Same as in VI.A.7.

		including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Findings:** Same as in VI.A.7. **Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Findings:** Same as in VI.A.7. **Compliance:** Partial **Current recommendations:** Same as in VI.A.7.
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:** Same as in VI.A.7. At this time, SEH does not permit the use of medications on a PRN basis for behavioral indications. All such medications are administered on an emergency basis as "Stat." This expert consultant reviewed the charts of 10 individuals who

received "Stat" medications during this reporting period. The following table outlines initials of the individuals and date and type of medication administration.

Initials	Date	Medication(s)
JD-1	2/6/08	Lorazepam IM
JD-1	12/4/07	Haloperidol IM and lorazepam IM
JD-1	12/4/07	Haloperidol PO and lorazepam PO
RM	1/9/08	Ziprasidone IM
SC	12/4/07	Ziprasidone IM and lorazepam IM
HL	11/10/07	Ziprasidone IM and lorazepam IM
KS	10/28/07	Chlorpromazine IM
AB	12/31/07	Lorazepam IM and diphenhydramine IM
AB	1/2/08	Lorazepam IM and diphenhydramine IM
GH	1/14/08	Lorazepam PO
DA	12/26/07	Olanzapine IM and lorazepam IM
DA	12/26/07	Haloperidol IM and diphenhydramine IM
DA	12/26/07	Ziprasidone IM and lorazepam IM
CS	9/24/07	Fluphenazine HCL IM and lorazepam IM
CW-1	21/10-12/12	Ziprasidone IM and lorazepam IM

This review showed the following:

1. Only five charts (KS and AB re 12/31/07 administration, DA and JD and CS, CW) included documentation of a psychiatric assessment within 24 hours of the administration of the medication;
2. Only two charts (JD and CS) included an assessment that addressed the circumstances of the use.

			3. None of the charts reviewed included evidence of a psychiatric review (in the progress notes or IRPs) of the individual's response to treatment and the diagnostic and regular treatment implications of this use. 4. In the chart of CW-1, the stat medication order was written as PRN "for agitation." This is in violation of the facility's procedures that prohibit the administration of psychotropic medications on a PRN basis **Compliance:** Partial **Current recommendations:** 1. Same as in VI.A.7. 2. Develop and implement policy and procedure to codify the facility's expectations regarding the use of Stat medications. 3. Develop and implement a monitoring tool, with indicators and operational instructions, to assess compliance with this requirement. The tool should address documentation requirements by both medical and nursing staff. 4. Provide monitoring data based on 20% sample (March to August 2008).
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.

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<tr>
<td>MES</td>
<td>VIII.A.
2.
a.i</td>
<td>clinically justified;</td>
<td>Findings:
In its self-assessment report, SEH acknowledged lack of progress in the implementation of the requirements in VIII.A.2.a.i to VIII.A.2. a.vi. The facility indicated that plans are underway to develop an automated information system (AVATAR), beginning this spring, which is anticipated to facilitate compliance.

This expert consultant reviewed the charts of individuals receiving a variety of high-risk medications. These reviews are applicable to the requirements in VIII.A.2.a.i to VIII.A.2. a.vi.

Chart reviews revealed that too many individuals are receiving long-term regular treatment with benzodiazepines without documented justification or appropriate monitoring for the risks associated with this treatment. The following table outlines examples of this practice. (The diagnoses are listed only if they signify conditions that increase the risk of continued use.)

<table>
<tr><th>Initials</th><th>Medication</th><th>Diagnosis</th></tr>
<tr><td>EM</td><td>Lorazepam</td><td>R/O cognitive Disorder, NOS</td></tr>
<tr><td>YS</td><td>Lorazepam</td><td></td></tr>
<tr><td>RS</td><td>Lorazepam</td><td></td></tr>
<tr><td>FC</td><td>Clonazepam</td><td></td></tr>
<tr><td>HL</td><td>Chlodiazepoxide</td><td>Mild Mental Retardation</td></tr>
<tr><td>KR</td><td>Lorazepam</td><td>Mental Retardation</td></tr>
<tr><td>PJ</td><td>Lorazepam</td><td>Polysubstance Abuse</td></tr>
<tr><td>AB</td><td>Clonazepam</td><td>R/O Borderline Intellectual Functioning, Learning Disability (by history) and PCP Abuse</td></tr>
<tr><td>PT</td><td>Clonazepam</td><td>Polysubstance Dependence and R/O Borderline Intellectual Functioning</td></tr>
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JD-1	Lorazepam	Mild Mental Retardation
PW	Clonazepam	Borderline Intellectual Functioning
CN	Clonazepam	Alcohol Abuse.

The following table outlines this expert consultant's findings of examples of long-term use of anticholinergic medications without appropriate justification and/or monitoring for the risks of treatment. *(The diagnoses are listed only if they indicate conditions that increase the risk of continued use.)*

Initials	**Medication**	**Diagnosis**
RS	Benztropine	
CW-1	Benztropine	Cognitive Disorder NOS
CH	Benztropine	
MM	Diphenhydramine and chlorpromazine	
CM	Benztropine	
TS	Benztropine and diphenhydramine	
AB	Benztropine, diphenhydramine and chlorpromazine	R/O Borderline Intellectual Functioning and Learning disability (by history)
PT	Benztropine and diphenhydramine	r/o Borderline Intellectual Functioning
EW	Benztropine and chlorpromazine	
RB-4	Benztropine	Mild mental Retardation
PW	Diphenhydramine	Mild mental Retardation
JD-1	Diphenhydramine and chlorpromazine	Moderate mental Retardation