This expert consultant reviewed the charts of 13 individuals who are receiving new-generation antipsychotic agents, some of whom are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s) diagnosed:

Initials	**Medication (s)**	**Diagnosis**
MM-1	Risperidone and quetiapine	Diabetes Mellitus and (history of) Acute Pancreatitis
CH	Clozapine and quetiapine	
MJT-1	Risperidone	
JFD	Quetiapine	Diabetes Mellitus and Hypercholesterolemia
JD-2	Quetiapine	Obesity
WHM	Olanzapine and risperidone.	Diabetes Mellitus
BW	Risperidone	Diabetes Mellitus
CG	Quetiapine and ziprasidone	Diabetes Mellitus, Hypercholesterolemia
RN	Risperidone Consta and fluphenazine decanoate	Diabetes Mellitus, Hypercholesterolemia and Mild Obesity
ERC	Quetiapine, haloperidol and risperidone	Diabetes Mellitus
CN	Risperidone M and fluphenazine.	Diabetes Mellitus, Hypercholesterolemia, and Morbid Obesity,
CW-1	Quetiapine.	Morbid Obesity
CB	Quetiapine	Diabetes Mellitus and Hypercholesterolemia

			The review of the charts of individuals receiving new generation antipsychotic medications showed that, in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, there were deficiencies that must be corrected in order to achieve substantial compliance. The following is an outline of the areas of deficiency: 1. Physician documentation of the risks and benefits of treatment and of attempts to use safer treatment alternatives (in almost all charts reviewed); 2. Frequency of required laboratory monitoring (triglycerides) in individuals who are suffering from Diabetes Mellitus, Hypercholesterolemia and/or Obesity and are receiving treatment with olanzapine and risperidone (WHM), quetiapine and ziprasidone (CG) or quetiapine (JD-2, CB and CW-1); and 3. Laboratory monitoring of prolactin levels in female individuals who are receiving risperidone (BW and MJT-1); and 4. Description of an individual's status as "stable" despite evidence of significant laboratory abnormalities (HgbA1C and Triglycerides), a diagnosis of Diabetes mellitus and ongoing treatment with risperidone and quetiapine (MM) **Compliance:** Partial **Current recommendations:** 1. Develop and implement monitoring tools with indicators and operational instructions to address parameters for the use of high risk medications (benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications). 2. Provide monitoring data regarding high risk medication uses, based on at least 20% sample (March to August 2008).

			3. Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).
MES	VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.
MES	VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	Same as above.
MES	VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	Same as above.
MES	VIII.A.2.a.v	evaluated for side effects; and	Same as above.
MES	VIII.A.2.a.vi	documented.	Same as above.
MES	VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	Please see sub-cells for findings.
MES	VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Findings:** The facility did not provide information, in its self-assessment report, regarding the implementation of requirements in VI.A.2.b.i and VI.A.2.b.ii. SEH does not currently have a set of individualized medication guidelines that meet this requirement. The facility has one guideline regarding the use of clozapine. This guideline does not include some important indications and screening requirements as well as information regarding interpretation of blood levels, drug-drug interactions and polypharmacy involving clozapine.

			Compliance: Noncompliance **Current recommendations:** 1. Develop and implement individualized psychotropic medication guidelines that address indications, contraindications and clinical and laboratory screening and monitoring requirements. 2. Revise the clozapine guideline to ensure alignment with current generally accepted standards. 3. Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.
MES	VIII.A.2.b.ii	develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;	**Findings:** Same as in VIII.A.1.h. **Compliance:** Partial **Current recommendations:** Same as in VIII.A.1.h.
MES	VIII.A.2.b.iii	establish a system for the pharmacist to communicate drug alerts to the medical staff; and	**Findings:** In its self-assessment report, SEH reported that the pharmacy currently has the capacity to communicate drug alerts to the medical staff and that the planned automated system (AVATAR) will permit this to be done electronically.

			SEH presented raw data regarding alerts that were reportedly communicated to the medical staff during this review period. At this time, the facility does not have a system to aggregate and categorize these alerts. **Compliance:** Partial **Current recommendations:** Develop a tracking log regarding drug alerts that were communicated to the medical staff during the review period.
MES	VIII.A. 2. b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Findings:** SEH did not provide specific information in its self-assessment report to address implementation of this requirement. The facility has a pharmacy procedure titled Alerting Orders, which includes "mechanisms for identifying adverse drug reactions (ADRs)" and a data collection tool, titled "Report of Suspected ADRs." Review of the procedure and the ten completed data collection tools showed the following deficiencies: 1. SEH does not have a policy and procedure that outlines all the components of an adequate system for reporting, aggregating and analyzing ADRs, as well as information regarding use of the system to improve the performance of practitioners and facility wide systems. 2. SEH does not provide adequate instruction to its clinical staff regarding the proper reporting and investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for: a. Identification and classification of reporting disciplines;

			b. Proper description of details of the reaction; c. Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d. Information about all medications that are suspected or could be suspected of causing the reaction; e. A probability rating if more than one drug is suspected of causing the ADR; f. Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc); g. Information regarding future screening; and h. Determination of need for intensive case analysis and other actions. 3. SEH does not have a formalized system of intensive case analysis based on established ADR-related thresholds. 4. SEH does integrate data regarding ADRs in the current system of psychiatric peer review. 5. SEH does not provide analysis of individual and group practitioner trends and patterns regarding ADRs. 6. SEH has not provided educational programs to address trends in the occurrence of ADRs. SEH does not have a procedure regarding Drug Utilization Evaluation (DUE). As mentioned in VIII.A.2.b.i, the facility has yet to develop individualized medication guidelines that can provide the basis for the process of DUE. Review of the facility's data regarding medication variances 9errors) and the current data collection tool showed the following deficiencies: 1. SEH does not have a policy and procedure that outlines all the components of an adequate system for reporting, aggregating and analyzing medication variances as well as information regarding use of the system to improve the performance of practitioners and

			facility wide systems. 2. The current system of reporting of variances is geared towards actual variances and provides limited information on potential variances. 3. The current system provides information on limited categories of variances, and ignores other possible categories that include documentation, ordering, procurement and storage of medications as well as medication security. 4. SEH does not give proper instruction to the clinical staff regarding the appropriate methods of reporting medication variances and of providing information that aid in the investigation and analysis of the variances. Specifically, the facility does not provide information or have written guidelines to staff regarding: a. Classification of reporting discipline; b. Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.; c. Description of the full chain of events involving the variance; d. Classification of potential and actual variances; e. All medications involved and their classification; f. The route of medication administration; g. Critical breakdown points; and h. Outline and analysis of contributing factors. 5. SEH does not have adequate system to aggregate or analyze MVR data. 6. SEH does not have a formalized system of intensive case analysis based on established MVR-related thresholds. 7. SEH does not integrate data regarding MVR in the current system of psychiatric peer review. 8. SEH does not provide analysis of individual and group practitioner trends and patterns regarding MVR. 9. SEH has not provided educational programs to address trends in the occurrence of MVR.

			This expert consultant reviewed minutes of the Mortality Review committee (January 16, April 26, June 11, July 24, August 10 and December 13, 2007). This review focused on the process rather than content of the reviews. This expert consultant found deficiencies in the current process of mortality reviews as follows: 1. The current system does not provide timeframes and other parameters for different levels of interdisciplinary reviews to ensure that the reviews are utilized to identify factors that may have contributed to the mortality, institute measures to protect other individuals and identify opportunities for performance improvement. 2. The following aspects of an adequate interdisciplinary reviews were missing: a. An initial interdisciplinary review, including a special investigator's report to address issues of abuse/neglect; b. Process and content requirements for review of the medical and nursing death summaries; c. Process and content requirements for an internal peer review and an independent external medical review; d. A final interdisciplinary review of the conclusions during the initial review, results of the internal peer and external medical reviews and review of the final results of the post-mortem examination; and e. Mechanisms to ensure that recommendations for performance improvement have been properly developed and implemented to address both contributing and non-contributing factors, as indicated. **Compliance:** Noncompliance

			Current recommendations: 1. ADRs: a. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs: b. Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified above. c. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. d. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations. 2. DUEs: a. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines: b. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses c. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. d. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 3. MVR: a. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. b. Implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of

			variances. c. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. d. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. e. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. f. Ensure that MVR is a non-punitive process. 4. Mortality reviews: Develop and implement a policy and procedure for an inter-disciplinary mortality review system that includes the following: a. Definitions of expected and unexpected deaths; b. Delineation of first response activities, including the roles/responsibilities of different parties in the facility; c. An outline of the process, content requirements and roles/responsibilities in the first level of inter-disciplinary reviews of special investigators report and medical and death summaries; d. An outline of the process, content and roles/responsibilities in the final level of inter-disciplinary mortality reviews of an internal peer review, an independent external medical review and results of the post-mortem examination; and e. Tracking mechanisms to ensure that inter-disciplinary recommendations are developed and implemented for all contributing factors (or non-contributing factors that require performance improvement), as appropriate
MES	VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric	**Findings:** In its self-assessment report, SEH acknowledged that current

		staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.	psychiatry staffing levels fall short of the requirements of the Agreement in all the admission units and in some long-term units. Information provided by the Medical Director, during personal interview, indicated that the current configuration of psychiatry staff is as follows: SEH has a total of 20 units divided evenly between Civil and Forensic Services. There are two admissions (acute) units on the civil side and two pre-trial (acute) units on the forensic side with a third forensic unit housing female individuals that is both pretrial (acute) and post-trial (long-term). On the civil side, there is one psychiatrist per unit totaling 10 psychiatrists with an average case load of 22 individuals; seven of these psychiatrists are full-time and the remaining are part-time employees. On the forensic side, there is also one psychiatrist per unit, totaling 10 psychiatrists with an average case load of 21 individuals; seven of these psychiatrists are full-time. **Compliance:** Partial **Current recommendations:** 1. Identify and resolve barriers towards recruitment of needed levels of psychiatry staffing to ensure compliance in all admission and long-term units. 2. Provide summary data of case loads of current psychiatrists in all admission and long-term units. The case loads should be based on FTE status.
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Findings:** The facility's self-assessment report did not include information regarding requirements in VIII.A.4.a to VIII.A.4.c

			This expert consultant's findings were presented in V.A.2.e and VI.A.7 **Compliance:** Same as in V.A.2.e and VI.A.7. **Current recommendations:** Same as in V.A.2.e and VI.A.7.
MES	VIII.A.4.a	ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;	Same as above.
MES	VIII.A.4.b	ensure regular exchanges of data between the psychiatrist and the psychologist; and	Same as above.
MES	VIII.A.4.c	integrate psychiatric and behavioral treatments.	Same as above.
MES	VIII.A.5	By 24 months from the Effective Date hereof, SEH shall review and ensure the appropriateness of the medication treatment.	**Findings:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2 **Compliance:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2 **Current recommendations:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2
MES	VIII.A.6	By 24 months from the Effective Date hereof, SEH shall ensure that individuals are screened and evaluated for substance abuse.	**Findings:** The facility's self-assessment report indicated that hospital policy requires these screenings, but that the completed tool was found in only 50% of the charts. The facility did not present this policy for review. The facility's tool, tilted Mental Illness Drug and Alcohol

			Screening (MIDAS) includes appropriate indicators regarding the screening process. The current template for treatment process monitoring includes some indicators regarding the identification of substance abuse in the psychiatric assessment and the IRP. However, this tool does not include key indicators to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. See this expert consultant's findings in V.D.1 regarding the management of substance use disorders at SEH. **Compliance:** Partial **Current recommendations:** 1. Present the facility's policy and procedure regarding the screening of substance use disorders. 2. Develop and implement a substance use chart audit tool with indicators and operational tools to assess if substance abuse and the individual's vulnerabilities to relapse are adequately addressed in the case formulation, foci, objectives and interventions of the IRP. 3. Provide monitoring data based on at least 20% sample (March to August 2008). 4. Same as V.D.1.
MES	VIII.A.7	By 24 months from the Effective Date hereof, SEH shall institute an appropriate system for the monitoring of individuals at risk for Tardive Dyskinesia ("TD"). SEH shall ensure that the psychiatrists integrate the results of these ratings	**Findings:** The facility's self-assessment report does not include information regarding this requirement. SEH has a draft Policy and Procedure, Tardive Dyskinesia-Management

		in their assessments of the risks and benefits of drug treatments.	Guidelines for Psychiatrists. The procedure includes adequate guidelines, but needs to specify that certain antipsychotic medications carry lower risk than others and that attempts should be made, as clinically appropriate, to use the safest antipsychotic treatment available. This expert consultant reviewed the charts of five individuals who were identified on the facility's database regarding Tardive Dyskinesia (JJ PRB, GJF, SF and MM-2). The reviewed showed the following pattern of deficiencies: 1. The IRP did not identify TD as a diagnosis or include focus, objectives and interventions (PRB). 2. When TD was identified as a diagnosis, the IRP did not include corresponding focus, objectives and interventions (JJ, GJF, SF, and MM-2). 3. AIMs examination was not completed quarterly according to the schedule required by the facility's policy and procedure (PRB, GJF, SF, MM and JJ). **Compliance:** Noncompliance **Current recommendations:** 1. Finalize the policy and procedure regarding TD, including the information suggested by this expert consultant above. 2. Develop and implement a monitoring tool with indicators and operational instructions to assess compliance with this requirement. 3. Provide monitoring data based on a review of a 100% sample (March to August 2008).

	B. Psychological Care		
RB		By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological supports and services to individuals who require such services.	**Methodology:** Interviewed: Beth Gouse, Ph.D., Acting Chief of Psychology Reviewed: The charts of 19 individuals: AB, CG, CM, CS, CW, DC, ED, HJ, JG, JW, KM, LM, MB, MP, MW, OA, TS, WL and WM
RB	VIII.B.1	By 18 months from the Effective Date hereof, SEH shall provide psychological supports and services adequate to treat the functional and behavioral needs of an individual including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, SEH shall:	Please see sub-cells for findings and compliance.
RB	VIII.B.1.a	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	**Findings:** Those individuals who were referred and for whom Behavior Plans were developed were appropriately chosen. The primary referral reasons were for the purpose of aiding in decrease of aggressive or other maladaptive behaviors, and for lack of adherence to prescribed pharmacological and/or psychosocial treatment. No referrals were made due to the individual being prescribed multiple medications. Thus, while the five individuals with current plans were appropriately chosen, an institution the size of St. Elizabeths would be expected to have over 100 individuals on Positive Behavior Support Plans or Behavioral Guidelines. There is currently no mechanism for determining individuals in need of behavioral interventions. Dr. DeLacy informed this expert consultant that she was given reports reflecting the fact that three individuals had seclusion and restraint as

			part of a behavioral intervention (cf. Cell V.B.3 for further information). No information regarding these plans was provided to this expert consultant, nor were they included among the plans submitted as part of the DOJ team's initial document request. Thus, this expert consultant was not able to review these plans. **Compliance:** Noncompliance **Current recommendations:** 1. Develop and implement a mechanism to ensure that all individuals who may be in need of Positive Behavior Support Plans/Behavioral Guidelines receive appropriate screening for such services. This will likely necessitate that psychologists provide an initial assessment of all newly admitted individuals and that the Department develops and implements a timeline for the assessment of those individuals who were admitted in the past and are still at the hospital. 2. It does not seem possible that the hospital would be able to achieve the above and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists. 3. Develop and implement an auditing tool that is used for the review of medical records to assure that when all newly admitted individuals are required to receive a psychological screening to determine the need for Positive Behavior Support Plans/Behavioral Guidelines, compliance with this requirement can be tracked. 4. Develop and implement an auditing tool for the review of the records of those individuals already admitted to the hospital to determine if they would benefit from the use of Positive Behavior

			Support Plans/Behavioral Guidelines. Among the items that the tool must audit are: individuals with multiple acts of self-harm or aggression; individuals with multiple instances of seclusion and/or restraint; individuals who are not making appropriate progress toward discharge; and individuals who are subject to polypharmacy. 5. 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. 6. Establish by clear policy that the planned use of seclusion and/or restraint as part of a behavioral intervention is clearly prohibited.
RB	VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement;	**Findings:** This expert consultant's review of behavioral plans revealed the following: 1. Reviewed plans contained a description of the maladaptive behavior(s). 2. No formal functional analysis of the maladaptive behaviors was undertaken, but efforts were made to ascertain some precursors. Significantly, full functional analysis was hampered due to the fact that reports did not consistently indicate the individual's psychiatric diagnoses or medication regimen, and it appeared to be routinely observed that only behaviors due to personality factors (vs. Axis I disorders) were the appropriate object of behavior plans. This also made impossible a full integration of pharmacological and behavioral interventions for these individuals, the majority of whom had clearly active symptoms of psychotic disorders. 3. Reviewed plans contained descriptions of adaptive behaviors, but these were written in terms of an absence of the maladaptive behavior rather than in terms of developing *competing* adaptive behaviors. 4. Individuals were seldom asked about their preferred reinforcers, and often these were surmised based on staff input. More

			significantly, when individual preferences were noted, no effort was made to utilize these reinforcers in a constructive manner except in the case of one individual. 5. Vague point allocations were indicated in the behavior plans, and only one had information on how points could be used to purchase reinforcers. It was not clear that point allocation appropriately reflected the necessity for small daily reinforcement, except perhaps in one case. **Compliance:** Noncompliance **Current recommendations:** 1. Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. At a minimum, such plans include: a. A description of the maladaptive behavior b. A functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior c. Documentation of how reinforcers for the individual were chosen and what input the individual had in their development d. The system for earning reinforcement 2. The use of individualized token economies in the development of behavioral interventions is strongly discouraged, as the more individuals are placed on such plans the more unwieldy individualized token economies will be to implement. Rather, it is recommended that the hospital consider the adoption of a unit-based token economy in which all individuals are rewarded over the course of the day for generally accepted prosocial behaviors appropriate to specific time frames, e.g., attention to ADLS; meal attendance; mall attendance; and appropriate use of unstructured time. These

			systems are much easier to administer, and the hospital may find it advantageous to develop and pilot such a program on one unit or series of units as part of an overall plan of implementation. 3. Form one Positive Behavior Support Team. Led by a clinical psychologist skilled in behavior analysis and consisting of a registered nurse, 2 psychiatric technicians and 2 data analysts, this team will be the hospital's front line for the development of appropriate Positive Behavior Support Plans/Behavioral Guidelines. They will assist in the training of all clinical staff in the appropriate use of these technologies.
RB	VIII.B.1.c	ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;	**Findings:** Aversive contingencies (e.g., restriction from the treatment mall) were frequently found in behavior plans. Behavior plans failed to include positive reinforcement for adaptive behavior other than the use of tokens. For example, even when an individual indicated that one-on-one time with staff was a positive reinforcer, it was not made a part of the plan, except as something that the individual could "purchase" with earned tokens. No direction was provided to nursing and level of care staff on the use of routine types of positive reinforcement for appropriate behavior, e.g. "catching someone" engaged in neutral or positive behavior and providing immediate verbal reinforcement. On the other hand, extensive information was provided to nursing and level of care staff for how to engage in limit-setting and minimal attention. **Compliance:** Noncompliance **Current recommendations:** 1. See Recommendation 1 in cell VIII.B.1.b. 2. Develop and implement a training program for nursing and level of

			care staff on the various means of positive reinforcement that are available in the hospital's therapeutic milieu.
RB	VIII.B.1.d	ensure that psychologists adequately screen individuals for appropriateness of individualized behavior plans, particularly individuals who are subjected to frequent restrictive measures, individuals with a history of aggression and self-harm, treatment refractory individuals, and individuals on multiple medications;	**Findings:** See cell VIII.B.1.a. **Compliance:** See cell VIII.B.1.a. **Current recommendations:** See cell VIII.B.1.a.
RB	VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Findings:** No systematic requirement for the review of progress by individuals on behavior plans by either the psychologist who developed the plan or the treatment team currently exists. No notes were found by psychologists indicating the progress of individuals on behavior plans. Additionally, none of the individuals on behavior plans had comments about their progress on these plans indicated in their regular treatment plan reviews. Finally, there is currently no program for the training of nursing and level of care staff in the implementation of such interventions and no monitoring of the fidelity of their implementation across shifts. **Compliance:** Noncompliance **Current recommendations:** 1. Develop a policy that directs psychology staff about when and how to monitor and document an individual's therapeutic progress(or lack thereof) when they are making use of Positive Behavior Support Plans/Behavioral Guidelines. At a minimum this documentation must occur monthly and most directly document the

			individual's progress toward achieving the behavioral goals for which the plan was created, including the decrease in targeted maladaptive behaviors and increase in adaptive behaviors. 2. Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans. 3. Develop and implement a Behavior Consultation Committee (BCC) for the regular review of individuals who are placed on Positive Behavior Support Plans. The BCC will also serve as a consultative committee to which treatment teams may come for clinical advice and consultation regarding individuals who are having difficulty progressing in treatment. The membership of the BCC is such to ensure that clinical and administrative decision makers are present so the necessary resources and support can be provided to help treatment teams implement suggested clinical strategies. At a minimum, membership would include the Executive Director (or delegate); the Medical Director (or delegate); the Chiefs of Psychology, Social Work, Nursing and Rehabilitation Therapy, and representatives of the Positive Behavior Support Team.
RB	VIII.B.1.f	ensure an adequate number of psychologists for each unit, where needed, with experience in behavior management, to provide adequate assessments and behavioral treatment programs.	**Findings:** 1. It was acknowledged that the Psychology Department staff have not received specialized training in the development of behavioral technologies. Documentation of training related to Behavioral Services (RB Tab #24) was either training related to verbal and physical interventions that may be useful in calming an individual in a crisis. No training in the development of behavior plans, functional behavior analysis, or likely targets for behavioral guidelines or positive behavior support plans was provided. 2. As indicated above, no system for assessing individuals who may be in need to behavioral technologies currently exists, and the current staffing pattern of psychologists does not appear likely to allow for

			timely and ongoing assessment of all newly admitted individuals to determine the appropriateness of providing them with Positive Behavior Support Plans/Behavioral Guidelines. 3. The current vacancies in the Department of Psychology and the lack of focused training in this area indicate that adequate psychological service resources for positive behavioral plans in accordance with standard practices is not present at this time. **Compliance:** Noncompliance **Current recommendations:** 1. Hire a consultant in behavioral treatment who is skilled in the development of Positive Behavior Support Plans/Behavioral Guidelines that meet currently accepted professional standards. 2. It does not seem possible that the hospital would be able to achieve this part of the agreement and maintain ongoing assessments of newly admitted individuals without increasing the number of staff psychologists to correspond with the DOJ ratios established for psychiatrists. It is recommended that the hospital consider using this staffing ratio for psychologists, and then develop a recruitment plan to increase the number of staff psychologists.
RB	VIII.B.2	By 18 months from the Effective Date hereof, SEH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs.	**Findings:** There is currently no clear system in place to determine how individuals are signed to groups, although the delineation of separate treatment malls for dually diagnosed individuals, geriatric individuals and those needing behavior management is a step in the right direction. Nevertheless, the review of individual charts showed very little coordination between assessment of the individual's functional needs and the assignment to appropriate groups, with the exception of some dually diagnosed and geriatric individuals.

			Compliance: Noncompliance **Current recommendations:** 1. Assure that the initial assessments of all disciplines include an assessment of the types of group interventions from which the individual would most clearly benefit based on diagnosis, symptoms status, functional level and discharge setting. 2. Determine, based on the hospital's current census, the type and number of the various groups that must be offered in each of the treatment malls. 3. Develop a process for assigning individual clinicians as group leaders for those therapeutic modalities for which they are adequately trained. 4. Develop group treatment offerings that are manual-based. Empirically validated and part of a curriculum development process. 5. Develop an auditing process to assure that clinicians are appropriately trained in all therapeutic modalities they are providing and that there is adequate fidelity to the curriculum and the manual for the group. 6. 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.. 7. Periodically, conduct a needs assessment based on current census to determine necessary changes to the mall curriculum.
RB	VIII.B.3	By 18 months from the Effective Date hereof, SEH shall provide adequate active psychosocial rehabilitation sufficient to permit discharge from SEH into the most integrated, appropriate setting available.	**Findings:** See cell VIII.B.2. Additionally, there was no evidence offered in the hospital's self assessment that indicated what discharge-related guidelines were used to develop the hospital's current group curriculum.

			Compliance: Noncompliance **Current recommendations:** 1. See the Recommendations from Cell VIII.B.2. 2. Additionally, demonstrate that the development of group treatment curriculum is based on the discharge needs of individuals.
	VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
RB	VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	**Findings:** See cell VIII.B.1.c. **Compliance:** Noncompliance **Current recommendations:** See cell VIII.B1.c.
RB	VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Findings:** The hospital currently has a dual diagnosis treatment mall, and a review of charts indicated that those individuals assigned to that mall were appropriate for the programming being offered. However, given the vast number of dually-diagnosed individuals, the hospital did not analyze as part of its self-assessment, the number of individuals with dual diagnosis and their treatment assignments. **Compliance:** Noncompliance **Current recommendations:** Develop and implement a process that assures that all individuals with

			substance abuse diagnoses are being referred to appropriate substance abuse groups and treatments.
RB	VIII.B. 4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Findings:** No information regarding community living plans for individuals with cognitive impairments was provided. **Compliance:** Noncompliance **Current recommendations:** Undertake a systematic analysis of the care needs and community placement supports and services required for all individuals with cognitive impairments, and where appropriate develop community living plans for these individuals that optimize community tenure.
RB	VIII.B. 4.d	programs are developed and implemented for individuals with forensic status recognizing the role of the courts in the type and length of the commitment and monitoring of treatment;	**Findings:** The hospital has appropriate and adequate programming for individuals who have been found to be incompetent to stand trial. This programming follows accepted community standards of care. **Compliance:** Substantial **Current recommendations:** Continue current policy and procedure.
RB	VIII.B. 4.e	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;	**Findings:** As indicated in many other places in this report, chart documentation and treatment planning conferences did not evidence that an individual's interventions were reviewed and revised as appropriate in a timely manner. Please see, in particular, Cells V.A.2.a and V.A.2.c. Additionally, as noted above, no system for reviewing and monitoring

			Positive Behavior Support Plans/Behavioral Guidelines currently exists. Please see Cell VIII.B.1.e for further specific information. **Compliance:** Noncompliance **Current recommendations:** See Recommendations in cells V.A.2.a; V.A.2.c; and VIII.B.1.e.
RB	VIII.B. 4.f	clinically relevant information remains readily accessible; and	**Findings:** While notes for many group therapies were found in reviewed charts, these notes did not typically address the progress toward the individual's short-term goals. **Compliance:** Noncompliance **Current recommendations:** Develop 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 necessary changes if treatment when treatment has been successful and there is a need to implement the next step in treatment or when treatment is unsuccessful and further assessment.
RB	VIII.B. 4.g	staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.	**Findings:** No documentation was provided indicating how or if staff members were trained in the implementation of the specific behavior plans currently in operation. **Compliance:** Noncompliance

			Current recommendations: 1. Develop a protocol for the training of nursing and level of care staff across shifts in the implementation of Positive Behavior Support Plans, document such training, and develop an audit tool for the assessment of fidelity in the implementation of these plans. 2. Train auditors to acceptable levels of reliability. 3. Provide operational definitions of all terms in a written format to aid in data reliability and validity.

	C. Pharmacy Services		
MES		By 36 months from the Effective Date hereof, SEH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols that require:	**Methodology:** Interviewed: 1. Alberto Fernandez-Milo, M.D., Medical Director 2. Terry Harrison, Pharm.D., Chief Pharmacist 3. Ermis Zerislassie, Pharm.D., Assistant Chief Pharmacist Reviewed: SEH raw data regarding recommendations made by the pharmacists based on drug regimen review (July 1 to December 31, 2007)
MES	VIII.C.1	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug-to-drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	**Findings:** In its self-assessment report, the facility stated that it has policies involving review of medication (orders by the pharmacy). However, in a personal interview with the Pharmacy Director and the Assistant Director, it was learned that the facility did not have a formalized procedure to ensure the following: 1. Appropriate parameters for the scope of review by the pharmacist; 2. The circumstances for withholding the dispensing of the medication based on the pharmacist's concerns; 3. Requirements for documentation by the physician of justification for continuing the medication despite the pharmacists' concerns; 4. A tracking mechanism and required follow up for situations when the physician has continued the order without documented justification of the rationale for the disagreement. SHE has yet to develop a self-monitoring tool to address the requirements in VIII.C.1 and VIII.C.2. The facility also presented raw data regarding recommendations made by the pharmacist based on reviews of drug regimens. The

			recommendations were focused on concerns related to drug-drug interactions. **Compliance:** Partial **Current recommendations:** 1. Develop a procedure to ensure pharmacist's review of new medication orders, including changes in current orders and communication of these concerns to the medical staff. The concerns should address, but not be limited to, drug-drug and drug-food interactions, allergies, contraindications, side effects and need for additional laboratory monitoring and dose adjustments. 2. Develop tracking and follow-up mechanisms to address situations when the physician has not addressed the pharmacist's concerns. 3. Develop and implement self-monitoring mechanisms to assess compliance with the requirements in VIII.C.1 and VIII.C.2.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Findings:** Same as above. **Compliance:** Same as above. **Current recommendations:** Same as above.

	D. Nursing and Unit-Based Services		
LDL		SEH shall within 24 months provide nursing services that shall result in SEH's residents receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, SEH shall:	Methodology: Interviewed: 1. Dr. Albert Fernandez-Milo, Director of Medical Affairs 2. Dr. Janet Mirdamadi, Infection Control Coordinator 3. Dr. Joseph Henneberry, Director of Forensic Services 4. Dr. Clo Vidoni-Clark, Director of Civil Services 5. DiAnne Jones, Assistant DON, Forensic Services 6. Deborah Krahling, Assistant DON – Civil Services 7. Laverne Plater , Nurse Consultant, Civil Services Reviewed: 1. Medical records of 11 individuals: BW, NB, DG, KJ, MM, CB, RM, JP, GD, ML and JB 2. Infection Control Program Manual, policies, and graphs 3. Staffing Standards (GNA 100.4) 4. Admission Procedures (NSP 300.0) 5. Levels of Observation (PSS 401.1, Revised 4/15/03) 6. Levels of Observation/Suicide Prevention (PSS – 400.1, Revised 5/04) 7. Documentation of the Nursing Process, (NSP 300.1) 8. Psychiatric Standards of Nursing Care 9. Medical Consultation Services (QIR 200.4) 10. Monitoring of Vital Signs, Height and Weight (NCP 600.24) 11. Patient Transfer to and Return from Outside Facility (NSP 300.8) 12. Emergency Medical Equipment (QIR 200.1) 13. Code Procedures (QIR 200.0) 14. Medication Administration (MED 500) 15. Noting and Transcribing Orders (MED 500.1) 16. Guidelines for Medication Use in the Treatment Mall (MED 500.2A) 17. Requirements for Personnel Administering Medications (MED 500.8)

			18. Reporting Medication Errors (202-05) 19. Adverse Drug Reactions (203-05) 20. Medication Error and ADR data; Peer Review System for Nursing (QIR-202) 21. Nursing Documentation Review Findings March – July 07; Nursing Competency Assessment (SDR 300.2) 22. Nursing Staff Orientation outlines and competency measures 23. Mandatory Guidelines for Restraints and Seclusion (101-04) current and draft policies 24. Involuntary Medication Administration (210-05) 25. Advance Directives (126-06) 26. Education and Staff Development Restraint Application PowerPoint slides 27. CPI program content 28. Therapeutic Communication and De-escalation power point slides 29. Varied additional documents provided prior to the visit and provided in two notebooks during the visit Observed: 1. Change of Shift Report – RMB 6; JHP Ward 12 2. Treatment planning meeting RMB 5 (JB); JHP Ward 9 (JF and PL) 3. Meal observations – JHP Wards 2, 9, 12; Civil Geriatric Mall Toured: 1. RMB 5 2. RMB 6 3. JHP 9 4. JHP 12
LDL	VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related	**Findings:** There are numerous competency assessments for nursing staff. While some are heavily oriented toward procedures, others have some treatment content embedded e.g. documentation. Neither course

		symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;	outlines nor competency measures were noted for mental health diagnoses/related symptoms. While no course outlines were reviewed, the medication competency, and documentation competency contain some measures relative to psychotropic medications and side effects, as well as documenting and reporting individuals' status. However, these are not comprehensive and it is difficult to further evaluate status without reviewing course outlines. The Nursing Competency Assessment policy is not sufficiently detailed/explicit to assure that staff do not perform duties unless competent to do so. For example, there is no description of actions to temporarily limit duties if annual competency is not achieved for a particular function. Additionally, there is not a clear description of how a charge nurse would know that contract nursing staff and/or staff who are temporarily assigned to the unit (different from their regularly assigned unit) are competent to perform certain assignments. There are no aggregate reports of competency achievement, therefore it is not possible to evaluate whether or not the expectations for competency are met. It is difficult to discern the thinking that informs the differentiation between topics and competency assessments that are conducted by the Nurse Educator in the St E's Education and Staff Development Office, and those that are conducted within the Nursing Department. There are areas of duplication. In the New Nursing Staff Orientation, (conducted in the Education and Staff Development area), the staff member him/herself initials that s/he can competently implement the procedure. In addition, some content provided in this centralized orientation (e.g. CPI training, Restraint Application) conflicts with a person centered and recovery based treatment approach. The content also does not sufficiently address skill application within the context of St E's philosophy. In contrast, the "Therapeutic Communication and De-escalation" training conducted in the Nursing Department has

			considerable emphasis on skill application. This program includes a practical approach to therapeutic and non-therapeutic communication that could serve as a foundation for additional training on person centered services and recovery. CPI content focuses primarily on "management" of aggression and violence. It does not sufficiently emphasize the concept that all behavior has meaning. It also does not sufficiently emphasize the need to understand the circumstances that give rise to behavioral emergencies, especially those that are iatrogenic. There is minimal content that would promote understanding of triggers to aggression, and alternatives to restrictive measures, such as Day Room Restrictions, seclusion and restraint. Further, CPI's emphasis on "acting out" tends to feed the perception that aggressive behavior is willful, rather than representing an underlying phenomena and/or need that must be understood in order to be effectively addressed in the least restrictive manner. **Compliance:** Partial **Current recommendations:** 1. Clearly differentiate the purpose and content of nursing staff orientation that occurs in the Education and Staff Development Office and that which occurs within the Nursing Department. 2. Train all nursing staff on mental health diagnoses, related symptoms, emphasizing the concept that all behavior has meaning. 3. Develop/revise nursing competency policies and procedures to assure: clear time lines and accountability for determining individual staff orientation and annual competencies; that nursing staff members are only assigned/perform duties after achieving/maintaining competency.

			4. Report compliance and noncompliance in the aggregate to evaluate effectiveness of processes to assure competency. 5. Augment CPI with content that is consistent with St. E's policies/philosophy and the desired culture change. Consider incorporating content that supports trauma informed services.
LDL	VIII.D.2	Ensure that nursing staff monitor, document, and report accurately and routinely individual's symptoms, actively participate in the treatment team process and provide feedback on individual's responses, or lack thereof, to medication and behavioral interventions;	**Findings**: Nursing documentation is rarely directed toward the IRP or the problem list, therefore it is difficult to determine if individuals' status is consistently monitored. The physical layout of the nursing work area on some civil units is such that nursing staff have general visibility of the day room. However, they were rarely seen working with individuals. Rather, individuals making comments/requests initiated interactions. These interactions consistently occurred over the counter that separates the workspace from the day room. In JHP, some nursing staff were seen in hallways or observing individuals on Day Room Restriction. However, the interaction was generally brief question/answer or social interaction. In the dining areas, staff were observed interacting with one another or observing patients without interaction. Nursing documentation tends to use language that does not reflect observations unique to the individual. Documentation is primarily compliance-related e.g. calm, cooperative, following directions, no complaints/no problems, or conversely argumentative, difficulty following rules, hostile. Further, there were numerous examples of redundant documentation e.g. the very same information was documented by PTs, and RNs/LPNs within two hours of each other on the same shift. IRP nursing interventions were primarily related to medication compliance; observations relative to this were generally present in the record. Findings from the Nursing Admission Assessment were not integrated into the IRP. The Nursing Care Plan is separate from the IRP and utilizes discipline specific diagnoses

			(Nursing Diagnoses). It fails to include strengths, or person centered goals. Progress notes do not relate to goals. Nursing staff did not participate in treatment planning meetings except for occasional anecdotal remarks. However, it should be noted that the observed treatment planning meetings were conducted more like individual interviews, therefore did not afford a clear opportunity for nursing staff to participate. **Compliance:** Noncompliance **Current recommendations:** 1. Discontinue the use of Nursing Diagnoses and utilize IRP with problem numbers to formulate plans and document interventions and progress toward goals. 2. Develop standardized areas of assessment/goal focus for all disciplines to utilize. Pending this common framework, nursing assessments and contributions to the IRP must immediately address the following minimum priority areas: psychiatric/mental health concerns, medical/health and wellness concerns, dangerousness to self or others. 3. Explore physical/environmental changes that would afford nursing staff a private area to work, and also allow them to provide active treatment/be fully "with" individuals when not doing paperwork.
LDL	VIII.D.3	Ensure that nursing staff monitor, document, and report routine vital signs and other medically necessary measurements (i.e., hydration, blood pressure, bowel sounds and movements, pulse, temperature, etc.), including particular attention to individuals returning from hospital and/or emergency room visits;	**Findings:** In most instances, vital signs were well documented, although other areas such as intake and output were less consistently present. Documentation was minimal when individuals were transferred to an emergency room for evaluation; when returning, information was minimal to non-existent. For example, there was no MD or RN progress note after an ER visit for evaluation of NMS; no notes following ER visit for cellulitis/possible osteomyelitis/gangrene. There was

			inconsistent evidence that recommendations were reported to the physician or followed up on. Change of shift report did not include important information relative to physical status. **Compliance:** Partial **Current recommendations:** 1. Develop a real-time monitor of documentation related to physical status so that improvements are immediate. 2. Develop a template for change of shift report that contains prompts so that important information is reported that relates to the IRP as well as physical/medical status. 3. Develop/revise policies to specify expectations relative to RN to MD interface as it relates to medical and behavioral emergencies, transfers to and from other treatment settings, and changes in physical condition. The expectations should include timeframes for reporting to the MD and timeframes for the MD response based on the severity of the issue/individual's need.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Findings:** For the most part, medications administered were documented, including response to PRN meds, though the latter was rarely behavioral or individualized and did not consistently include the individual's subjective report. There was no documentation of first dose response, and no requirement that this be monitored and evaluated. Policies currently require that medication errors be documented on two forms (Unusual Incident Report and Medication Error Report, sometimes referenced as Medication Variance). Medication error/variance reporting reflects a relatively low number in relation to the numbers of medications administered, raising questions about the

			accuracy of reporting. Medication Error reports reflect that 30% of the medication errors are due to "*workflow disruption*". There is no evidence that actions have been taken to resolve the issue. Further, another 36% of medication errors are attributed to *"knowledge deficit"* or *"performance deficit"*. Most of the actions documented in the error log involve instructing involved staff to re-read policy or "counseling" the staff. Further, 50% of the errors were *"prescribing errors"*. There is no evidence of systemic/process evaluation/ actions taken to resolve these trends. The volume suggests that this is a significant improvement opportunity and that process changes could support individual staff to more accurately perform functions associated with medications. **Compliance:** Partial **Current recommendations:** 1. Develop/revise policies that describe medication variances, a subcategory of which would be medication errors. 2. Designate one form for medication variance reporting. 3. Review/revise processes used to analyze, identify trends, take actions for improvement, and monitor the effectiveness of actions taken to reduce medication variances. 4. Require that nursing staff monitor individuals' response to the first dose of a medication and that they document the response on the MAR.
LDL	VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the	**Findings:** There is a competency-based medication administration training program. However, no aggregate data were available to evaluate the numbers of staff who satisfactorily completed orientation and annual

		completion of the Medication Administration Records;	competencies. The content of the competency evaluation tool is generally appropriate. A rotating schedule for competency assessment has been established on the Civil Services although there is conflicting information about frequency. **Compliance:** Partial **Current recommendations:** 1. Develop aggregate reports on the percent of staff who satisfactorily complete orientation and annual competencies prior to administering medications. 2. Develop a clear procedure regarding actions taken to limit practice when competence is not achieved. 3. Develop competency measures for medication teaching and for staff interactions that would support an understanding of individuals' potential side effects and/or barriers to adherence. Models associated with stages of change would be useful to accomplish the latter.
LDL	VIII.D.6	Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors;	**Findings:** The Medication Error Report (May – December 07) reflects that documentation errors were reported. See associated findings in VIII.D.4 **Compliance:** Partial **Current recommendations:** See VIII.D.4
LDL	VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side	**Findings:** There is not consistent evidence of medication teaching in the records,

		effects they may be experiencing and document responses;	nor is there evidence that individuals are queried about side effects. There are some unit based medication education groups in JHP, and some on the treatment mall in civil services. However, it is not clear if side effects are discussed. Medication competencies do not include measures to evaluate competency to work with individuals relative to their response to medications, side effects, and barriers to adherence. **Compliance:** Noncompliance **Current recommendations:** 1. Revise Medication Administration policy to include expectations for medication education, queries regarding side effects and response to medications, and ways to understand and explore barriers to adherence 2. See VIII.D.5, Recommendation 3.
LDL	VIII.D.8	Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess individuals' status and to modify, as appropriate, the treatment plan;	**Findings:** See VIII.D.2. **Compliance:** Noncompliance **Current recommendations:** See VIII.D.2.
	VIII.D.9	Ensure that each individual's treatment plan identifies:	Please see sub-cells for findings and compliance.
LDL	VIII.D.9.a	the diagnoses, treatments, and interventions that nursing and other staff are to implement;	**Findings:** IRPs rarely include nursing interventions, and when they do the goals/objectives/interventions are typically related to medication compliance. The RN Nursing Assessment on admission should provide

			the foundation for identifying the focus of nursing interventions that will be integrated within the IRP and that will support the individual's recovery. However, the assessments are frequently incomplete. Despite observations or information that should trigger a more in-depth assessment, at times these were absent (e.g. suicidal risk assessment, falls risk assessment). The assessment sometimes contained information that conflicted with other admission data, and there was not evidence of these being reconciled in the record. Implications for immediate health and safety needs were not consistently explored or addressed. There is no comprehensive assessment for dysphagia. The Initial Nursing Care Plan utilizes St. E's Nursing Standards of Care (Nursing Diagnoses). This discipline-specific language is cumbersome, not understood by others on the interdisciplinary team, and can limit an individualized, recovery focus. Of particular concern is the consistent lack of attention to medical problems that present on admission or that emerge during the course of hospitalization. In some instances, medical problems on admission were not addressed and the individual subsequently required ER evaluations and/or was hospitalized for conditions that related to problems that were noted to be presented on admission but not addressed. In some instances, either the MD or the RN noted physical problems, but they did not consistently address those problems in the initial plan and/or these were not carried through to the IRP. Nursing staff were knowledgeable about, and emphasized, the individual's legal status, but were not knowledgeable about treatment goals and individualized interventions. There appears to be little to no understanding of psychiatric illnesses. For example, aggressive behavior was described as "willful" in circumstances involving an individual experiencing frank symptoms of schizophrenia; documentation in a record that described someone who was so

			depressed that she was not eating or drinking also included entries describing her as "quiet, cooperative, in room" without evidence of interventions. The fact that many nursing staff seem to lack an understanding of diagnoses contributes to the observed tendency to make social and/or culture bound judgments about behavior. There were physician orders for "assault precautions", "elopement precautions" and/or "violence precautions". The orders were transcribed, however , nursing staff did not know what this order meant and there was no policy to describe expected interventions. **Compliance:** Noncompliance **Current recommendations:** 1. Discontinue Nursing Diagnoses 2. Develop one Initial Treatment Planning document that both the MD and RN use to direct initial treatment and nursing care. 3. Eliminate/do not transcribe orders for which there are no policies or protocols. 4. Establish and implement a training program to teach nursing staff about diagnoses, the underlying issues associated with behaviors, and generally accepted nursing interventions. 5. Develop triggers for and a comprehensive dysphagia assessment.
LDL	VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Findings:** Nursing documentation in the record rarely addresses treatment goals/objectives/interventions and is sometimes not accurate when describing important issues e.g. referred to MRSA infected abscess as an "injury". Nursing flow sheets, used for every shift during for first three days of hospitalization, have prompts similar to a standard mental status evaluation but do not have prompts to document behavioral observations and/or health concerns. BIRP notes are not

			well integrated with the IRP and often do not reference the problem list. Change of shift reports do not include information about interventions, progress toward goals, and are lacking important medical information that needs follow up e.g. blood glucose levels. **Compliance:** Noncompliance **Current recommendations:** 1. Revise nursing flow sheets to prompt observations/documentation that will contribute to an understanding of the individual, especially as it relates to psychiatric mental health issues, medical/health and wellness issues, and issues of potential dangerousness to self or others. 2. Develop template for change of shift report. Consider ways to use the data on this template as a basis for progress notes in order to minimize duplicative documentation. 3. Review/evaluate/revise nursing documentation requirements to eliminate duplication in record entries, and to determine the degree to which the current "BIRP" model facilitates documenting to IRP.
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Findings:** Monitoring of specific individuals seems to be primarily directed by physician's orders. The IRP contains insufficient specificity to direct monitoring. During mealtime, staff rarely knew which individuals were at risk for choking and/or why they were at risk and therefore monitored closely. In one instance, a staff member designated to observe an individual 1:1 while eating was involved in another activity and not watching the individual as he ate/drank. Some eating areas did not have posters depicting how to do the Heimlich maneuver.

			Compliance: Partial **Current recommendations:** 1. Fully integrate goals and interventions that involve nursing staff into IRP. 2. Develop clear expectations for monitoring individuals at risk for choking during meal times. 3. Assure that there are posters depicting the Heimlich maneuver in all eating areas.
	VIII.D.10	Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, SEH shall:	Please see sub-cells for findings and compliance.
LDL	VIII.D.10.a	actively collect data with regard to infections and communicable diseases;	**Findings:** The Infection Control Program Descriptions and Policies are not organized in a useable format and do not specify the actions staff must take related to infections and communicable diseases. Information in the written materials is repetitive, at times unrelated to the St. E's service population, and critical procedures are lacking e.g. a means to identify and take action on cluster outbreaks. Accountability and methods for reporting are not clear, thus there is little evidence that data are routinely collected. Graphs depicting some data, e.g. MRSA, HIV, Hepatitis B, are labeled "trends" and "incidents" but operational definitions are lacking. There are no data for TB screening and no monitoring system established. This, coupled with the fact that medication errors reflect trends in PPD omissions, is a finding of concern for this population. Data from an *Environmental Self Assessment Survey* (ES) revealed areas of specific concern as it relates to preventing and controlling infections: General Unit Cleanliness (25% of standards met); Food

			Handling and Refrigerator Monitoring (54% of standards met); Nursing Station (69% of standards met); Infectious Waste and Sharps Disposal (65% of standards met). Within other categories, absence of hand sanitizer, hand washing posters, and/or hand soap was noted. Unit observations were consistent with these findings. The Medical Director indicated that he is aware of the need to give attention to the Infection Control Program and Policies. **Compliance:** Partial **Current recommendations:** 1. The Medical Director should pursue his current plan to review the Infection Control Program. Consolidate the current Infection Control Program and Policies to provide clear direction for staff and accountability for reporting. As much as possible, develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload. 2. Immediately develop a clear TB screening program based on CDC guidelines, including those related to risk level. 3. Identify categories of data to be collected with initial focus on those data that relate to risks for this population. 4. Develop monitoring instruments and define intervals for the ICC on site monitoring of specific areas in the hospital. 5. Develop policies and procedures to identify cluster outbreaks. 6. Develop policies and procedures for food borne illness, flu, and norovirus. 7. Promote unit staff ownership for the unit environment. The Nursing Unit Manager should provide oversight for unit staff to complete the ES on a weekly basis, assuring inter-rater reliability, and a user- friendly way to document actions taken on deficiencies. 8. A mechanism should be established for regular senior level review

			of ES findings to assure resolution since in most instances multiple departments will need to be involved.
LDL	VIII.D. 10.b	assess these data for trends;	**Findings:** With the exception of the ES, based on reports provided there was no evidence that data were assessed for trends. **Compliance:** Noncompliance **Current recommendations:** 1. Identify priorities for data collection and analysis 2. The Infection Control Coordinator should provide preliminary written analysis. 3. Infection Control Committee should review data/data analysis no less than quarterly. 4. Aggregate data from the ES should be reviewed and analyzed by the Infection Control Coordinator on a monthly basis and reported to the Medical Director and the Assistant Directors of Nursing.
LDL	VIII.D. 10.c	initiate inquiries regarding problematic trends;	**Findings:** It was reported that based on the number of MRSA infections, all staff and patients were tested for colonization. It was reported that genetic testing determined that no staff contracted MRSA from patients and vice versa. However, because of the way data are displayed, it is not clear why this particular inquiry was pursued. There is no evidence that there was further inquiry into the problematic trends identified in the ES. **Compliance:** Partial

			Current recommendations: 1. The Infection Control Committee should determine areas for further "drill down" based on trends in data. 2. The Medical Director and Assistant Directors of Nursing should review the ES findings on a monthly basis.
LDL	VIII.D. 10.d	identify necessary corrective action;	**Findings:** There was no evidence of corrective actions recommended or taken to resolve identified issues. For example, see VIII D.10a. There are substantial findings in the ES that require attention, but there was no documentation that reflected actions were taken to resolve these issues. **Compliance:** Noncompliance **Current recommendations:** 1. Document corrective actions in an attachment to aggregate data/reports, specifying names and due dates. 2. The Medical Director and Assistant Directors of Nursing should initiate actions on ES findings and document the action taken.
LDL	VIII.D. 10.e	monitor to ensure that appropriate remedies are achieved;	**Findings:** There was no evidence that corrective actions were taken or monitored for effectiveness. **Compliance:** Noncompliance **Current recommendations:** 1. Develop a policy/procedure/process to monitor effectiveness of actions taken to resolve findings relative to infection and communicable diseases.

			2. Develop an instrument to monitor that the process was followed.

LDL	VIII.D.10.f	integrate this information into SEH's quality assurance review; and	**Findings:** See VIII.D.10.a through VIII.D.10.d. **Compliance:** Noncompliance **Current recommendations:** See VIII.D.10.a through VIII.D.10.d.
LDL	VIII.D.10.g	ensure that nursing staff implement the infection control program.	**Findings:** The findings from the ES, and observations made while touring units, reflect that nursing staff inconsistently follow important procedures designed to minimize infection and transmission of communicable diseases. For example, while there was verbal awareness that un-refrigerated snacks posed risk for food-borne illness, snacks with cream topping were observed on a counter for up to two hours. There was no documentation in an individual's record that contact precautions were consistently implemented as ordered. All nursing staff were observed wearing gloves in the dining rooms. They indicated that they were told to do so by the Infection Control Coordinator, but they do not know why this is required. Mealtime presents an important opportunity for nursing staff to engage with individuals in a way that builds skills and promotes socialization. In the absence of a specific reason for wearing gloves, their use distracts from the normalizing environment that is therapeutic and that promotes recovery. **Compliance:** Partial **Current recommendations:** 1. Develop policies/procedures that clearly define precautions, the

			steps to implement each type, and to document implementation of precautions. Consider developing a flow sheet to streamline this documentation. 2. Develop and implement a monitoring instrument/process to assess adherence to policies/procedures for precautions. 3. Evaluate the routine need for gloves in the dining room as it is not individualized and does not contribute to a recovery informed environment.
LDL	VIII.D.11	Ensure sufficient nursing staff to provide nursing care and services.	**Findings:** Both civil and forensic ADONs are making efforts to manage nursing staffing in the face of significant numbers of vacancies, variances between staffing levels and individuals' requirements for nursing care, identified barriers to recruitment, and some lack of clarity about their own roles. The ADONs are to be commended for monitoring the target NCHPPD, and for systematically gathering some data to better understand staffing, including reliance on agency and overtime. Reportedly, staff attendance and performance issues contribute to the challenges they face. On February 15, 2008, 42 nursing positions on the Forensic Services were reported to be vacant. More importantly, when compared to target NCHPPD (ranging from 4.0 – 5.5), there is a difference of 85 nursing positions. In order to deal with an insufficient number of RNs, on Wards 2,3,6, the staffing plan allows for an LPN to substitute for an RN on all three shifts. However, using the hospital's three-level system to describe individuals' medical status, on two of these three units between 20 – 25% of the individuals have unstable medical conditions. This represents a level of need that requires that an RN be in charge of the unit 24/7. It may also require additional RNs on duty. The absence of an RN poses significant health and safety risk to the individuals served.

			On the Civil Services, there are at least 30 vacancies, and there may be up to 38 (pending clarification). Further, when compared with the target NCHPPD (ranging from 3.0 – 5.5), there is a difference of 72 positions. On both Civil and Forensic services, nearly all the Nursing Unit Manager positions were vacant and/or filled by persons in acting capacity. These positions are integral to providing unit level nursing leadership to change the culture on the nursing unit and within the department as a whole. In addition to the absence of unit level nursing leadership, a review of schedules worked and ward assignment sheets reflects an overall insufficient number of RNs. The Staffing Standards policy (GNA – 100.4) is deficient and outdated (10/04). It does not describe the scope of nursing services, the levels and functions of personnel delivering nursing services, the model for nursing service delivery, the mechanism for determining staffing numbers and skill mix, staffing plan(s), scheduling processes, and intervals of staffing plan evaluation. As a part of this plan, the authority and responsibility for senior nursing positions needs to be delineated. Currently, the functional differentiation among the Service Directors, Director(s) of Nursing, and Assistant Directors of Nursing is not clear. This may contribute to the observation that many nursing policies are unsigned, communicating an absence of leadership for nursing care. **Compliance:** Noncompliance **Current recommendations:** 1. Develop a comprehensive SEH Plan for Nursing Services that includes the components described in findings (above). 2. Prioritize filling Nursing Unit Manager positions, the Forensic Nurse Consultant position, and an assistant position to the ADONs