REPORT 5

St. Elizabeths Hospital
Washington, DC

May 24-28, 2010

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	V:Integrated Treatment Planning		
MES and RB		By 36 months from the Effective Date hereof, SEH shall provide integrated individualized services and treatments (collectively "treatment") for the individuals it serves. SEH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are coordinated by an interdisciplinary team through treatment planning and embodied in a single, integrated plan.	**Summary of Status/Progress:** 1. SEH has made further revisions in its IRP Manual, including new examples of foci, objectives, interventions and discharge criteria. Although more work is needed to modify these examples and to improve the conceptual flow of the Manual, these revisions represented relative improvement compared to the last tour. 2. The facility has initiated an IRP mentoring system (pair coaches) and five units have received or were receiving training regarding the process of the IRP conference. 3. Observations of IRP conferences demonstrated that the Clinical Administrators have provided effective leadership in facilitating the interdisciplinary input into the IRP reviews during phase I of the reviews (prior to the individuals' arrival) as well as preparing a draft of the Case Formulation in the 6 P format. 4. The Performance Improvement Department has made some meaningful revisions in the IRB Observation monitoring tool. 5. SEH presented self-assessment data (IRB Observation, Comprehensive Psychiatric Assessment, Psychiatric Update and Inter-unit Transfer Assessments) during the period of August 2009 to February 2010. The data included reviews of patterns and trend. Although more work is needed to improve data aggregation and analysis, the self-assessment was comprehensive and candid. 6. The implementation of IRPs in AVATAR has improved the delineation of practitioners providing IRP interventions and the nature and frequency of these interventions. 7. SEH has improved the formulation of individuals' strengths, cultural preferences and life goals as part of the IRPs. 8. SEH has made significant improvement in the process of functional assessments of the individuals' cognitive level and assignment of groups at the Therapeutic Learning Center (TLC) commensurate with this level. The facility has increased the number of groups

			that offer cognitive remediation to individuals in need. 9. SEH has improved the oversight of medical services and appointed a new supervisor of the General medical Officer, who recently initiated a variety of policies/procedures and appropriate templates to improve the documentation of assessments of individuals. If properly implemented, these tools can improve the facility's practice in meeting the medical needs of individuals. 10. Forensic Services has maintained substantial compliance in the practice of FRB submissions and follow-up in the individual's medical record.
			Methodology: <u>Interviewed</u>: 1. Bernard Arons, MD, Medical Director 2. Beth Gouse, PhD, Chief of Staff 3. Clotilde Vidoni-Clark, PhD, Director of Treatment Services 4. Crystal Robinson, MT-BC 5. Danilo O. Garcia, MD, General Medical Officer 6. Edger Potter, MD, Supervisor General Medical Officer 7. Janet Maher 8. Josephine Reyes, MD, General Medical Officer 9. Lendicita Madden, MD, General Medical Officer 10. Nike Hamilton 11. Peter Thura, MD, General Medical Officer 12. Richard Gontang, PhD, Chief of Psychology 13. Robert Benedetti, PhD 14. Robert Morin, PsyD 15. Shelia Stone 16. Shomarka Keita, MD, General Medical Officer 17. Syed M. Zaidi, MD, General Medical Officer 18. Tyler Jones, MD, Medical Director, Intensive Services

			Reviewed: 1. The charts of the following 55 individuals by Dr. El-Sabaawi: AC, AF, AS, AW, AWB, BA, BH, BP, CB, CG, CH, CL, DA, DB, DE, DJ, DLB, DM, DT, EG, EW, GKW, GS, JH, JJ, JR, JV, KP, LC, LL, LM, LR, LW, MH, MK, ML, MP, MT, ND, PH, PW, RAH, RCM, RH, RM, SF, SH, SS, TJ, TL, TN, TR, TVB, TW and VG 2. The charts of the following 23 individuals by Dr. Boggio: AW, BW, CD, CLH, DA, DJ, FF-1, FF-2, JB, JC, JD, JR, JW, KY, LD, LM, LS, MH, ML, MW, RM, SS and TS 3. Saint Elizabeths Hospital (SEH) Self-Assessment Report (April 9, 2010) 4. SEH IRP Manual, revised: a) Summary of IRP coaching pairs, March 18, 2010; b) Tips for coaches during Phase 1 (of the IRP conference), April 5, 2010; c) Tips for coaches during Phase 2 (of the IRP conference), April 5, 2010; d) Guidelines for compliance monitors of IRP Meetings, March 22, 2010; e) Operational Instructions for Clinical Formulation, revised November 30, 2009; f) Operational Instructions for Clinical Formulation Update, revised November 30, 2009; g) Clinical Formulation Update-Examples 1 and 2, November 30, 2009; h) IRP Meetings (Phase 2) with Individuals in Care, revised March 17, 2010; i) Tip Sheet for Special/Additional IRP Meetings, not dated; j) Operational Instructions for Initial IRP, revised march 15, 2010; k) Operational Instructions for IRP, revised December 1, 2009; l) Examples of Focus Statements and Objectives for Initial IRP, not dated;

			m) IRP, revised December 16, 2009; n) Tip Sheet for Completing Objectives, revised March 15, 2010. 5. SEH data regarding Clinical Administrator training that was provided during this review period (October 2009 to March 2010). 6. SEH IRP Meeting Observation Tool, revised September 13 and December 14, 2009 and February 1, 2010 7. SEH Operational Instructions, Review Tool For IRP, revised September 13 and December 14 and February 1, 2010 8. SEH Audit Sample Plan 9. SEH IRP Process Observation data summary (August 2009 to January 2010) 10. SEH External Posting description for a PBS Data Analyst. 11. SEH Policy #602.2-04: Interdisciplinary Recovery Planning for Inpatient Services, revised August 13, 2009 12. SEH Engagement Tip Sheet 13. SEH Operational Instructions For Clinical Formulation, revised November 30, 2009 14. SEH Operational Instructions For Clinical Formulation Update, revised November 30, 2009 15. SEH Policy #602.1-08: Assessments, revised March 30, 2010 16. SEH Policy #601-02: Medical Records, revised April 7, 2010 17. SEH summary data regarding Timely Completion of Initial Assessments by Discipline (August 2009 to February 2010) 18. SEH Psychiatric Reassessment Self Audit Results (August 2009 to February 2010) 19. SEH Comprehensive Psychiatric Assessment Audit summary data summary (August 2009 to February 2010) 20. SEH Psychiatric Update (Reassessment) summary data summary (August 2009 to February 2010) 21. SEH Audit Tool Clinical Formulation/Clinical Formulation Update, April 5, 2010. 22. SEH Audit Tool Clinical Formulation/Clinical Formulation Update, April 5, 2010.

			23. SEH Operational Instructions, Audit Tool, Clinical Formulation/Clinical Formulation Update, April 5, 2010. 24. SEH Medication Information Manual: A Guide To Understanding Your Mental Health Medication, August 2009 25. SEH Consumer Survey Template 26. SEH Medication Card Sample 27. SEH Risk Trigger Event System, revised March 19, 2010 28. SEH Policy #111.2-08: Patient Transfers, revised August 26, 2009 29. SEH Patient Transfer Audit Tool Revisions, March 16, 2010 30. SEH Patient Transfer Monitoring Tool, revised October 21, 2009 31. SEH Patient Transfer Monitoring summary data (August to December 2009) 32. SEH Policy #116.1-09, Medical Emergency Response, revised April 7, 2010 33. SEH Policy #209-10, General Medical Services, May 7, 2010 34. SEH Policy #208-10, Seizure Management, April 7, 2010 35. SEH Policy #111.2-08, Transfers of Individuals In Care, May 6, 2010 36. SEH documents regarding cognitive remediation interventions during this review period <u>Observed</u>: 1. Team meeting at unit 2B for IRP review of JB 2. Team meeting at unit 1E for IRP review of RH 3. Team meeting at unit 1E for IRP review of LD 4. Team meeting at unit 1E for IRP review of JC 5. Team meeting at Annex A for IRP review of TB 6. Team meeting at unit 1D for IRP review of LL 7. Team meeting at unit 1D for IRP review of JW 8. Team meeting at unit 2D for IRP review of MH 9. Team meeting at unit 1G for IRP review of DJ

			Other: Special Meeting with Clinical Administrators at SEH
	A. Interdisciplinary Teams		
		By 36 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:	Please see sub-cells for findings and compliance.
RB and MES	V.A.1	Have as its primary objective the provision of individualized, integrated treatment and be designed to discharge or outplace the individual from SEH into the most appropriate, most integrated setting without additional disability;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2009:** • Same as in V.A.2 to V.A.5. • Same as in V.B, V.C, V.D and V.E. **Findings:** Same as in V.A.2 to V.A.5, V.B, V.C, V.D and V.E. During this review period, SEH has continued and improved its actions to address this requirement. The following is a summary: 1. Using internal mentors (coaches), the facility provided some IRP training of Clinical Administrators in their roles as the initial authors of the IRP document. 2. The IRP team staff was provided with example IRP documents. 3. Five units have received or are receiving IRP in-vivo mentoring (RMB 3, 4, 5 and 6 and JHP 10. Mentoring included IRP observations, record review and feedback to team members and assistance in revising the IRP. The facility provided an adequate description of the current mentoring (coaching) process, including

			the following documents: a) Summary of IRP coaching pairs; b) Tips for coaches during the two phases of the IRP conference and c) Guidelines for compliance monitoring of IRP Meetings 4. The IRM Manual was updated with new examples of clinical formulations/updates, foci, objectives, interventions and discharge criteria. Although more work is needed to modify these examples and to improve the conceptual flow of the Manual, these revisions represented relative improvement compared to the last tour. 5. The facility recently initiated a contract for external consultant assistance to improve the process and content of IRP. 6. The Performance Improvement Department implemented several revisions in the facility's monitoring tool for observation of the IRP meeting. The most recent revision (February 1, 2010) contained improved process for the review of the individual's present status and participation by different disciplines in treatment/rehabilitation interventions. SEH presented self-assessment process outcome data based on the revised IRP observation tools (August 2009 to January 2010). The sample consisted of "at least two IRP conferences on 10 of 15 units." The facility's data demonstrated adequate improvement in the following processes: 1. Review of the individuals' strengths; 2. Including the individuals' cultural preferences; 3. Obtaining individuals' input regarding discharge planning and 4. Review of the individuals' life goals. However, these data showed that further improvement is needed in the following areas:

			1. Review of the individuals' progress in treatment/rehabilitation; 2. Development of objectives that are measurable and attainable and 3. Development and revision of interventions with input from the individuals. Chart reviews and team observations by this expert consultant (see V.A.2 to V.A.5 and V.B, V.C, V.D and V.E) found evidence of several process improvements during this review period (see summary of progress above). Overall, however, the facility has yet to make progress in ensuring effective participation by the individuals in the IRP conferences and ensuring proper linkages between the assessments, case formulations, foci, objectives and interventions in the content of the IRPs. This task is critical to the proper implementation of the IRP model. **Compliance:** Partial, improved compared to the last review. **Current recommendations:** 1. *Same as in V.A.2 to V.A.5.* 2. *Same as in V.B, V.C, V.D and V.E.*
RB	V.A.2	be led by a treating psychiatrist or licensed clinical psychologist who, at a minimum, shall:	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Fill all team psychology vacancies. **Findings:** All teams are led by psychiatrists and psychologists are not considered core team members as per the Agreement. **Recommendation 2, September 2009:**

			Hire PBS psychologist. **Findings:** A PBS psychologist with no other duties has been hired. **Other findings:** Clinical administrators who facilitated two of the three observed IRP conferences demonstrated adequate to exceptional ability in managing the conference, assuring interdisciplinary participation and patient involvement. Facilitators were hampered by the current format and content of the written IRP. **Compliance:** Substantial. **Current recommendation:** Maintain practice of team leadership by psychiatrists and co-facilitation by clinical administrators.
RB	V.A.2.a	assume primary responsibility for the individual's treatment;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. **Findings:** This has still not been accomplished, although the hospital has just recently hired a new consultant to assist in this area. Meaningful discharge criteria were not found in one reviewed record, although discharge issues were appropriately addressed at each observed IRP conference and were regularly found in SWIAs, suggesting a

			breakdown in moving from assessment to treatment planning. **Recommendation 2, September 2009:** Enhance training efforts to assure that IRP conferences can be completed in the time indicated on the checklists. **Findings:** All three of the observed IRP conferences were able to be completed in about 45 minutes. **Other findings:** The team leader and the facilitator approached the IRP conferences collaboratively and assumed responsibility for the individual's overall treatment. **Compliance:** Substantial. **Current recommendation:** Continue work with consultant.
RB	V.A.2.b	require that the patient and, with the patient's permission, family or supportive community members are active members of the treatment team;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Develop and provide a roll out plan for the completion of training modules related to the IRP process. **Findings:** There was evidence at each of the observed IRP conference that family members were invited where appropriate. However, the hospital's own data on this requirement showed inadequate progress in this area.

			Compliance: Partial. **Current recommendation:** Determine what obstacles exist that prevent IRP teams from inviting families to conferences and develop a corrective action plan to overcome identified obstacles.
RB	V.A.2.c	require that each member of the team participates in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Begin monthly audit of 20% of records and present trended data by month. **Findings:** This recommendation has been deleted from this cell as it is addressed elsewhere. **Other findings:** Data provided by the hospital shows inconsistent results in this area. While core team attendance at IRP conferences is above 80% for all disciplines, adequate monitoring and revising of discipline-specific interventions is occurring at significantly lower rates. **Compliance:** Partial. **Current recommendations:** 1. Audit IRP conferences as per instructions found in Cell V.B.9 2. Work with consultant to revise IRP training to include process for discipline-specific review of objectives/interventions and how to make timely changes.

RB	V.A.2.d	require that the treatment team functions in an interdisciplinary fashion;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Revise or provide evidence of training related to the development of individualized discharge criteria. **Findings:** By agreement with the hospital, this recommendation is being removed as not applicable to this cell. **Recommendation 2, September 2009:** Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. **Findings:** By agreement with the hospital, this recommendation is being removed as not applicable to this cell. **Recommendation 3, September 2009:** Enhance training efforts to assure that IRP conferences can be completed in the time indicated on the checklists. **Findings:** By agreement with the hospital, this recommendation is being removed as not applicable to this cell. **Other findings:** All observed IRP conferences were conducted in a truly interdisciplinary manner, with appropriate input from all disciplines. There was some tendency for individual clinicians to repeat what others had said, rather than to always offer new input, but overall this

			process is working well. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
MES and RB	V.A.2.e	verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Implement the draft behavioral interventions policy and templates.* **Findings:** Policies and templates regarding behavioral interventions have been implemented. **Recommendations 2 and 6, September 2009:** • *Resume and ensure consistent training of direct care providers on the principles and practice of PBS.* • Re-start work with consultant. **Findings:** This review found a persistent deficiency in that too many individuals who were appropriate candidates for behavioral interventions did not receive this modality. Since the last review, only one PBS plan and two sets of behavioral guidelines were completed by the facility. This limited number of interventions was inadequate to meet the needs of the individuals. Plans were underway for hiring of an external PBS consultant to assist the facility in meeting this requirement. The contract for the consultant was renewed and the consultant is scheduled to begin

			providing services to the hospital in June 2010. **Recommendations 4 and 5, September 2009:** • *Ensure documentation of the psychiatrist's review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation.* • *Ensure documentation in the psychiatric progress notes of an exchange of data between the psychiatrist and the psychologist for individuals receiving PBS interventions. This exchange must be utilized to distinguish learned behaviors from those that are targeted for pharmacological therapies and to update diagnosis and treatment, as clinically appropriate.* **Findings:** SEH presented self-assessment data based on the Psychiatric Update (Reassessment) tool (August 2009 to February 2010). The indicator regarding this requirement showed compliance rates that ranged from 79% (November 2009) to 100% (August and September 2009). It was not possible to assess the overall compliance based on these data because the facility did not present weighted averages of compliance rates. However, reviews by this expert consultant of psychiatric reassessments found no significant improvement since the last report. In general, the psychiatric documentation did not adequately or consistently provide evidence of the following: 1. Review by the psychiatrists of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation. 2. An exchange of data between the psychiatrist and the psychologist for individuals in order to distinguish learned behaviors from those that are targeted for pharmacological therapies and to update diagnosis and treatment, as clinically appropriate.

			Recommendation 7, September 2009: Fill vacant treatment team psychologist positions. **Findings:** The facility reported recent gains in hiring of psychologists, including three additional psychologists (who began work on March 29, 2010), a new PBS team leader and two new PBS specialists. Recruitment was underway for a data analyst and a nursing position (assigned to the PBS team). **Recommendations 3 and 8, September 2009:** • *Ensure attendance and participation by psychologists in IRP reviews*. • Develop a corrective action plan for low attendance rate of psychologists at IRP conferences if this practice continues and is not simply a result of vacancies. **Findings:** SEH recognized that attendance by psychologists at IRP conferences has been less than adequate but that attendance level has risen to 75% in January 2010. However, since psychologists are not core members of the IRP teams per the Agreement, this recommendation is being removed. **Other findings:** The hospital has not yet filled the RN or the data analyst positions for the PBS team, and was unable to indicate when those positions would be filled. The lack of a complete PBS team will continue to hamper the hospital in the development of integrated behavioral and psychiatric interventions. Under the direction of the Chief of Psychology and the PBS

			psychologists, a practice of developing Initial IRP Behavioral Interventions (IIRPBI) has been recently implemented with the hope that this will increase the capacity at the team level for integrating behavioral and psychiatric interventions. This is a positive development, but the current IIRPBIs are uneven in quality and their formatting is not sufficiently standardized, especially as regards documentation requirements, both for individual clinicians and for success or failure of the IIRPBI. **Compliance:** Partial. **Current recommendations:** 1. *Ensure documentation of the psychiatrists' review of the behavioral modalities prior to their implementation to ensure compatibility with psychiatric formulation.* 2. *Ensure documentation in the psychiatric progress notes of an exchange of data between the psychiatrist and the psychologist for individuals receiving PBS interventions. This exchange must be utilized to distinguish learned behaviors from those that are targeted for pharmacological therapies and to update diagnosis and treatment, as clinically appropriate.* 3. *Ensure adequate and consistent training of direct care providers on the principles and practice of PBS.* 4. Complete the formation of the PBS team. 5. Standardize the format for IIRPBIs. 6. Provide specific instructions in policy for how the success or failure of an IIRPBI is to be documented in the medical record. 7. Develop a process for monitoring IIRPBIs.
RB	V.A.2.f	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated	**Current findings on previous recommendations:** **Recommendation 1, September 2009:**

		treatment plans, and the scheduling and coordination of necessary progress reviews occur.	Assure that the Rehabilitation Therapy and Psychology Departments are fully staffed. **Findings:** By agreement with the hospital, this recommendation is being removed as not applicable to this cell. **Recommendation 2, September 2009:** Revise IRP checklists to assure that teams routinely review the Mall Progress Note findings with the individual. **Findings:** By agreement with the hospital, this recommendation is being removed as not applicable to this cell. **Other findings:** The clinical administrator on each unit has been designated to fulfill this role. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	V.A.3	provide training on the development and implementation of interdisciplinary treatment plans, including the skills needed in the development of clinical formulations, needs, goals, interventions, discharge criteria, and all other requirements of section V.B., infra;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Revise IRP training program to ensure that it contains conceptual clarity on the move from the development of individual-specific discharge criteria to appropriate foci of hospitalization, measurable and behavioral objectives and appropriate interventions.

			Findings: The IRP format continues to be problematic, as there is lack of conceptual clarity in the flow from discharge criteria through foci, objectives and interventions. Examples provided in the IRP manual are incorrect. For example, under the Psychiatric Focus, an example is given that has to do with not assaulting others, and the focus statement example is given in terms of what the individual should not do rather than what specifically the individual could learn to do as a result of treatment. In this same focus area, the example for an objective is quite wordy and talks about the individual learning to engage with the staff and learn de-escalation techniques. This example would benefit from greater focus on specific behavioral and measureable strategies that the individual can learn. Therefore, if this is going to be the proper focus for this problem, then a better example for a focus statement would be: Mr. J has a history of assaulting others in the community and needs to develop skills to express his anger more appropriately. A corresponding example for an objective would be: Mr. J will be able to identify three things that he tends to do when he is angry that have gotten him into trouble in the past. Reviewed IRPs did not contain measureable discharge criteria. Focus statements are overly broad and objectives frequently repeat focus statements. Only one reviewed IRP was found to contain acceptable measureable objectives, and this was only true in one focus area. The hospital suspended its previous training program and plans to implement new training with a newly hired consultant. Additionally, some teams have received coaching/mentoring in the process of conducting IRP conferences, and positive results from that process were evident. **Compliance:** Partial.

			Current recommendations: 1. Continue work with new consultant. 2. Develop and implement a training plan for all IRP teams.
RB	V.A.4	consist of a stable core of members, including the resident, the treatment team leader, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the patient's family, guardian, advocates, clinical psychologist, pharmacist, and other clinical staff; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Fill current vacancies in the Psychology and Rehabilitation Services Departments. **Findings:** Since neither Psychologists nor Rehabilitation Therapists are part of the core team as per the Agreement, this recommendation is being removed. **Recommendation 2, September 2009:** Develop staffing plans to assure that PNAs and FPTs are able to attend IRP conferences on a regular basis. **Findings:** FPTs and PNAs have now been re-designated as Recovery Assistants (RA). In the observed teams, it was clear that this change was not merely a superficial one, as RAs not only participated appropriately in all cases, but in most teams had very specific information that was of clinical importance to the team in their consideration of the individual's progress in treatment. Data presented by the hospital indicated that Social Workers were present at over 80% of IRP conferences, and they were present at all observed IRP conferences. Other clinical staff and community representatives were also present as needed. **Compliance:**

			Partial. **Current recommendation:** Determine obstacles to Social Work attendance of at least 90% of IRP conferences and implement corrective action plan to achieve this benchmark.
RB	V.A.5	meet every 30 days, during the first 60 days; thereafter every 60 days; and more frequently as clinically determined by the team leader.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Present auditing data as trended data. **Findings:** Currently, the hospital's data shows a positive trend toward meeting a 90% threshold for this requirement for the 30 and 60 days IRPs, but the data do not indicate that this threshold has been consistently met. **Recommendation 2, September 2009:** Implement requirement for 30 day teams as per the Agreement. **Findings:** 30 day teams have been implemented in policy although not always in practice. **Recommendation 3, September 2009:** Develop supervisory processes to increase the rate of compliance with 30-day and 60-day teams. **Findings:** There is an audit tool but no supervisory process was implemented, and may not be needed if current data trends continue.

			Compliance: Partial. **Current recommendations:** 1. Continue auditing as per the instructions in Cell V.B.9. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	B. Integrated Treatment Plans		
		By 36 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the development of treatment plans to provide that:	
MES	V.B.1	where possible, individuals have input into their treatment plans;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2009:** • *Provide specific information to indicate that each IRP team has a dedicated mentor and that mentors provide consistent feedback to the teams and to the facility management regarding the IRP process. Ensure the self-report specifies the number of mentors, their disciplines and the process of mentoring the teams.* • *Ensure that team mentors address the process deficiencies (1 to 9) outlined in other findings [in this cell in the previous report].* **Findings:** The facility's data regarding IRP team training/mentoring was presented in V.A.1. The information indicated some improvement in the process of IRP team training but further improvement is needed to ensure compliance with this requirement (see V.A.1). **Recommendation 3, September 2009:** *Ensure that the revised IRP Process Observation Monitoring Form includes operational instruction to assess if the team has made clinically appropriate revision in the case formulation, objectives and/or interventions in response to the individual's expressed cultural preference/needs.* **Findings:**

			As mentioned earlier, SEH has made several modifications in its IRP observation auditing tool to address this recommendation. If properly implemented, the revised tool can meet the facility's self-assessment needs regarding this requirement. **Recommendation 4, September 2009:** *Ensure that the IRP training Module regarding the engagement of individuals includes lesson plan and post-tests.* **Findings:** The facility did not provide specific information regarding this recommendation. However, the operational instructions that accompanied the modified IRP monitoring observation tool contained an adequate outline of the facility's expectations regarding the engagement of individuals. In addition, as discussed in the previous report, the facility's IRP Manual contained a tip Sheet on "How To Engage" the individuals. This document was based on adequate principles. **Recommendations 5 and 6, September 2009:** • *Ensure that the self-report contains a summary outline of the engagement training provided during the review period. Specify the participating disciplines in the training and the training process (didactic, observation, feedback to teams) and content.* • *Provide aggregated data about results of competency-based training of core members of the treatment teams regarding the engagement of individuals.* **Findings:** The facility provided overview of the training that was provided to its Clinical Administrators regarding the development of the case formulation, foci, objectives and interventions, the PBS

			model and the use of AVATAR in IRP. However, the facility did not present specific information to address these recommendations. **Recommendations 7 and 8, September 2009:** • *Monitor the individual's attendance and participation in the IRP conferences using process observation data based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH presented self-assessment data based on the IRP Observation Auditing regarding the attendance by individuals in their IRP conferences. The data showed compliance rates that ranged from 91% to 100% during the review period (August 2009 to January 2010). In addition, the facility presented IRP Observation Auditing data (August 2009 to January 2010) regarding several processes that were relevant to this requirement. The following is an outline of the indicators and corresponding compliance rates (weighted averages were not provided): 1. Identification of strengths with the individual (67% to 93%); 2. Obtaining input from individuals into objectives and interventions (75% to 100%) and 3. Review of progress with the individuals (53% to 82%)

			Other findings: The expert consultants attended nine IRP meeting conferences to assess the IRP conference process. There was general evidence that the Clinical Administrators provided effective leadership in facilitating the following aspects of the IRP conferences: 1. Timeliness of the meetings; 2. Attendance and participation by core members specified in the Agreement; 3. Participation by direct care staff in the review; 4. Attendance by the individuals; 5. Review of disciplinary assessments; 6. Review of some risk factors; 7. Discussion of key questions to be addressed during the individual's presence; 8. Quality of the interactions between the IRP teams and the individuals; 9. Review of the foci, objectives and interventions by the IRP teams and 10. Review of individuals' strengths, cultural preferences and life goals in some meetings). However, persistent process deficiencies were noted in the following areas: 1. Consistent attendance of all core members (in a few meetings, the psychiatrist or social worker did not attend and no coverage was provided); 2. Adequate update of the present status section of the case formulation: symptoms, functional status, all applicable risk factors, interventions and response, use of restrictive interventions, rating scales, medical conditions that impact

			psychiatric/functional status, discharge criteria, progress towards discharge); 3. Consistent review of the diagnosis with the individuals; 4. Revision of foci, objectives and interventions with input from the individual; 5. Data-based review of the individual's participation in PSR Mall activities; 6. Linkages within the IRP (foci, objectives and interventions) and between Mall activities and objectives in the IRP; 7. Utilization of the individuals' strengths and life goals in the IRP; and 8. Review of progress towards individualized discharge criteria and discussion of barriers to discharge with input from the individual. **Compliance:** Partial. **Current recommendations:** 1. *Provide specific information to indicate that each IRP team has a dedicated mentor and that mentors provide consistent feedback to the teams and to the facility management regarding the IRP process. Ensure that the self-report specifies the number of mentors, their disciplines and the process of mentoring the teams.* 2. *Ensure that team mentors address the process deficiencies outlined in other findings above.* 3. *Ensure that the self-report contains a summary outline of the engagement training provided during the review period. Specify the participating disciplines in the training and the training process (didactic, observation, feedback to teams) and content.* 4. *Provide aggregated data about results of competency-based*

			training of core members of the treatment teams regarding the engagement of individuals. 5. *Monitor the individual's attendance and participation in the IRP conferences using process observation data based on at least 20% sample during the review period.* 6. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 7. *Reorganize the IRP manual to ensure conceptual flow of the document and to include more accurate examples of foci, objectives, interventions and individualized discharge criteria.*
	V.B.2	treatment planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
MES	V.B.2.a	initial assessments are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2009:** Same as VI.A.1 to VI.A.5. **Findings:** Same as in VI.A.1. In addition, SEH presented self-assessment data regarding timely completion of initial assessments by disciplines (August 2009 to February 2010). The data showed that, in general, the disciplines of Psychiatry, Social Work, Nursing and Rehabilitation completed their initial assessments within the required time frame as specified in the facility's

			policy regarding Assessments. The data regarding Nursing assessments were limited to January and February 2010. The data showed that the facility needs to make further progress to ensure timely completion of the initial assessments by Psychology. SEH has recently incorporated all their disciplinary assessments in the facility's AVATAR system. **Other findings:** This expert reviewed the charts of 10 individuals (RM, SS, AWB, AC, TN, MT, GKW, AW, LM and JR) who were admitted during this review period. The review found that the initial assessments were completed within the required time frame in all cases. **Compliance:** Substantial. **Current recommendations:** 1. *Monitor the timeliness of the initial disciplinary assessments during this review period.* 2. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 3. Same as in VI.A.1 to VI.A.5.
MES	V.B.2.b	initial treatment plans are completed within five days of admission; and	**Current findings on previous recommendations:**

			Recommendations 1-3, September 2009: • *Monitor the timeliness of the initial and comprehensive IRP based on at least 20% sample during this review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* • *Present a summary of the aggregated monitoring data in the progress report of both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences.* **Findings:** The facility reported that the initial IRPs (to be completed within 24 hours) and comprehensive IRPs (to be completed by the seventh calendar day of admission) were incorporated in AVATAR beginning in March 2010. The facility expects to present data for the next review period and has very limited data based on recent observations of the comprehensive IRP. **Other findings:** This expert consultant reviewed the charts of 10 individuals (RM, SS, AWB, AC, TN, MT, GKW, AW, LM and JR) who were admitted during this review period. The review found that the initial IRPs were completed as required in all cases except one (JR). **Compliance**: Substantial.

			Current recommendations: 1. *Monitor the timeliness of the initial and comprehensive IRP based on at least 20% sample during this review period.* 2. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average mean. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 3. *Present a summary of the aggregated monitoring data in the progress report of both attendance and participation by the disciplines of psychiatry, psychology and nursing in the IRP Conferences, with weighted average compliance for the review period.*
MES	V.B.2.c	treatment plan updates are performed consistent with treatment plan meetings.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2009:** • *Ensure monitoring instructions regarding the identification by the IRP team of some one to be responsible for scheduling the IRP meetings in accordance with the required time frames.* • *Monitor the treatment plan reviews using the process observation tool based on at least 20% sample during the next review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

			Findings: SEH indicated that the Clinical Administrators are responsible for this requirement as reflected in their position descriptions and the facility's IRP manual. In its self-report, the facility acknowledged that the IRPs are not yet meeting expected standards regarding their content and that a contract was recently awarded to an outside consultant to assist the facility in this area. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during this review period (RM, SS, AWB, AC, TN, MT, GKW, AW, LM and JR). The review found compliance in all cases regarding the frequency of the reviews. **Compliance:** Substantial. **Current recommendations:** 1. *Monitor the treatment plan reviews using the process observation tool based on at least 20% sample during the next review period.* 2. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.B.3	individuals are informed of the purposes and major	**Current findings on previous recommendations:**

		side effects of medication;	**Recommendation 1, September 2009:** *Implement a mechanism to provide individuals with information in the Medication Information Manual.* **Findings:** During this review period, the facility reported the following actions: 1. The Office of Consumer Affairs has finalized its Medication Information Manual. The Manual provides the individuals with an adequate guide and education regarding various classes of psychiatric medications. The facility did not present information regarding the use of this Manual. 2. Each individual was provided with a Medication Card that outlined their medications and any allergy information. The facility's physicians were reportedly responsible for updating the information on this card. 3. Medication Education groups were provided to the individuals. There was no confirmation that this process was implemented. However, the facility developed a process of Consumer Satisfaction Survey to verify implementation. **Recommendation 2, September 2009:** *Continue the process of Consumer Satisfaction Surveys and provide a summary of results.* **Findings:** SEH was in the process of completing a survey. Results were unavailable at the time of this tour.

			Recommendation 3, September 2009: *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instruction regarding this requirement.* **Findings:** SEH reported a plan to update its Psychiatric Update (Reassessments) audit tool to include a prompt to provide information about the individual's need for medication education. **Recommendations 4 and 5, September 2009:** • *Monitor this requirement using clinical chart audit based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** The facility was in the process of developing a self-assessment tool and has yet to implement this tool. **Compliance:** Partial. **Current recommendations:** 1. *Continue the process of Consumer Satisfaction Surveys and provide a summary of results.* 2. *Provide information regarding medication education groups provided during the interval, including number of groups*

			scheduled, number of groups held, number of individuals determined to be in need for medication education and number of individuals receiving medication education.
MES	V.B.4	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • Same as in V.D.1, V.D.2 and V.D.3. • Same as in V.D.4 and V.D.5. **Findings:** Same as in the subsections regarding goals/objectives (V.D.1, V.D.2 and V.D.3) and interventions (V.D.4 and V.D.5). The facility acknowledged lack of information regarding the specificity and individualization of the written IRP. **Compliance:** Noncompliance. **Current recommendations:** 1. Same as in V.D.1, V.D.2 and V.D.3. 2. Same as in V.D.4 and V.D.5.
MES	V.B.5	the medical director timely reviews high-risk situations, such as individuals requiring repeated use of seclusion and restraints;	**Current findings on previous recommendations:** **Recommendation 1, March 2009:** Same as in XII.E.2. **Findings:** Same as in XII.E.2. **Recommendation 2, March 2009:**

			Provide documentation of the Medical Director's review of the use of seclusion and/or restraints during the reporting period. **Findings:** SEH has recently modified its process to implement this requirement. Given the low incidents of seclusion/restraints, the facility has revised triggers for the review to also capture any individual with three or more incidents of any type, including, but not limited to, perpetrators and victims of assaults, unauthorized leaves and certain medication refusals. The revised process required: a) notification by the risk manager; b) Medical Director's review, meeting with the IRP team and recommendations (within three business days of the notification); c) follow-up by the Clinical Administrator and d) Tracking of implementation by the Performance Improvement Department. The revised process was appropriate to this requirement. The facility has yet to provide information regarding implementation of this process. **Compliance:** Same as in XII.E.2. **Current recommendations:** 1. *Same as in XII.E.2.* 2. *Provide documentation of the Medical Director's review of high risks as outlined in the facility's revised process.*
RB	V.B.6	mechanisms are developed and implemented to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing, timely, and adequate assessments by the treatment team to enable the courts to review effectively modifications in the individual's legal status;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Maintain current level of practice. **Findings:**

			A review of the 10 most recent Forensic Review Board (FRB) submissions found over 90% compliance. **Recommendation 2, September 2009:** Track percentage of cases presented to FRB every six months. **Findings:** This process continues, and data indicated that the timeline for case presentations was being completed more rapidly this year than last year. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
MES	V.B.7	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Same as in V.E.3, V.E.4 and V.E.5. **Findings:** Same as in V.E.3, V.E.4 and V.E.5. **Recommendation 2, September 2009:** Same as in VIII. **Findings:** Same as in VIII. **Compliance:** Partial.

			Current recommendations: 1. Same as in V.E.3, V.E.4 and V.E.5. 2. Same as in VIII.
MES	V.B.8	an inter-unit transfer procedure is developed and implemented that specifies the format and content requirements of transfer assessments, including the mission of all units in the hospital; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Implement corrective actions to ensure that the transfer assessments meet requirements of the facility's policy.* **Findings:** Since the last review, SEH has developed and piloted a new template to be used for documentation of the medical assessments upon the transfer of individuals to outside medical facilities. The facility plans to incorporate this template in AVATAR. If properly implemented, this template includes adequate prompts that can improve the quality of the assessments. **Recommendations 2 and 3, September 2009:** • *Monitor this requirement using the inter-unit transfer assessment tool based on at least 20% sample during the next review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:**

SEH presented self-assessment data using the Patient Transfer Monitoring Tool (August 2009 to December 2009). The data was based on presence or absence of documentation and did not address the quality or accuracy of the information. The facility did not aggregate the data and sampling methods as recommended, but the sample size appeared to be adequate. The data demonstrated little to no improvement in the implementation of this requirement. For example, the rates varied from 12% to 40% (psychiatric transfer assessments), 40% to 88% (general medical transfer assessment) and 20% to 67% (general medical acceptance assessment). Regarding the transfers to outside medical facilities, the facility monitored only non-emergency transfers and has yet to monitor emergency medical transfers, which represent the higher percentage of inter-hospital medical transfers.

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

Initials	Dates of inter-unit transfer
TVB	12/8/09
LR	12/9/09
RAH	12/14/09
LC	12/17/09
BH	1/3/10
RH	2/17/09
EW	3/3/10
CH	3/20/10

The review found substantial compliance in three charts (TVB, LR and RAH), partial compliance in one (BH) and noncompliance in

			four (LC, RH, EW and CH). In the charts that met compliance, there was evidence of proper implementation of the facility's new template of Transfer Summary. **Compliance:** Partial, improved compared to the last review. **Current recommendations:** 1. *Monitor this requirement addressing both quality and accuracy of information based on at least 20% sample during the next review period.* 2. *Ensure the medical transfers address both emergency and non-emergency transfers.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.B.9	to ensure compliance, a monitoring instrument is developed to review the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes, and transfer and discharge summaries, and a review by the physician peer review systems to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action. This requirement specifically recognizes that peer review is not required for every patient chart.	SEH presented an outline of its plans to continue self-auditing in the future. The following outlines the areas of auditing and corresponding sample method and an estimate of sample sizes per month: 1. IRP Observations: two observations per unit (per admission for comprehensive IRP) =26 per month; 2. Clinical Chart Audit (planned): two IRP per unit =26 per month; 3. Comprehensive Initial Psychiatric Assessment: 20% of admissions =8 per month; 4. Patient Transfers: 20% of transfers (inter-unit=1 and inter-

			hospital=4) per month; 5. Tardive Dyskinesia: 100% sample = six cases per month to review all individuals with the diagnosis); 6. Initial Psychological Assessments: 20% sample =8 per month); 7. Other Psychological Assessments: one per practitioner= 14 per month; 8. Psychological Risk Assessments: 1 per practitioner =7 per month; 9. PBS plans/guidelines: 100% sample =3 per month; 10. Initial Rehabilitation Services Assessment: two per practitioner =14 per month; 11. Nursing Assessment Initial Assessments: 20% of admissions =8 per month; 12. Nursing Update : four per unit =52 per month; 13. Social Work Initial Assessment: 20% of admissions =8 per month; 14. Social Work Update: One per practitioner per month =14; 15. Social Worker Discharge Barriers follow Up: 20% of individuals on list =6; 16. Seclusion/Restraints: 100% sample of logs =6 per month; 17. Nursing Side Rail Audit: 100% of cases (as applicable) per month =10 per month; 18. Discharge Record Audit: 10% of discharges =5 per month; 19. Adequacy of discharge interventions: 50% sample =27 per month; 20. Involuntary medications: 20% of individuals given involuntary medications =6 per month and 21. Therapeutic Progress notes: one review of notes per group leader/individual therapist =109 notes per month. For information regarding each type of audit, please refer to the corresponding section of the Agreement.

			Compliance: Partial (pending development of the clinical chart audit tool and implementation of all self-assessment tools). **Current recommendation:** Present specific summary information regarding any changes/revisions in the auditing tools and corresponding sample sizes that were presented in the current Audit Plan.

	C. Case Formulation		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is based on case formulation for each individual based upon an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:	Please see sub-cells for findings and compliance.
MES	V.C.1	be derived from analyses of the information gathered including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Revise the IRP Manual to provide instruction that the present status section of the Case formulation includes a review by the team of the social skills/functional status. Specific examples should be provided to facilitate implementation.* **Findings:** SEH IRP Manual Case Formulation instructions were revised to improve the presentation of data regarding the individual's present status. The revised instructions included prompts to address the individual's functional status as part of the review of symptoms. This was a step in the right direction, but reviews by this expert consultant found evidence of inadequate implementation of this instruction. **Recommendations 2-4, September 2009:** • *Develop and provide a training module regarding the Interdisciplinary Case Formulation to ensure that the formulation properly meets the principles of individualized recovery-focused planning. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.*

			• *Provide a summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* • *Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.* **Findings:** As mentioned earlier, the Clinical Administrators at SEH have received training on the development of the Case Formulation. The facility reported that 82% (14/17) attended this training, which consisted of one (1.5 hour) session on November 19, 2009. In addition, the IRP manual and instructions regarding the present status section of the case formulation were modified to ensure a review of the following areas: a) symptoms, including functional status; b) cognitive status; c) medical/physical status; d) updated risk assessment; e) cultural factors f) use of restrictive interventions; g) behavioral guidelines/plan h) psychological testing; i) response to treatment; j) new/resolved needs; k) criteria for discharge and l) recommendations for a discharge setting. The modified instructions also eliminated the use of the "list of needs" to avoid duplicative and parallel processes in the establishment of the individuals' needs (see findings by this expert consultant in the report 4). In general, these updates/revisions addressed the findings of deficiency that were outlined by this expert consultant in this cell in report #4. The facility has yet to revise the instructions to ensure proper review of the individuals' progress towards discharge and discussion of discharge barriers. The facility did not present data regarding training of the core IRP team members on proper implementation of this

			requirement. **Recommendations 5-7, September 2009:** • *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* • *Monitor this requirement using the Clinical Chart Audit tool based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH has yet to implement these recommendations. However, the facility has made significant modifications to its IRP Observation auditing tool (February 2010) to reflect the presentation, during the IRP team conference, of information related to the present status of the individuals. By design, this tool is not intended to address the quality or accuracy of the reviews. Based on this tool, the facility presented self-assessment data (December 2009 and January 2010). The following is an outline of the indicators and corresponding compliance rates (for each month of review): 1. Current symptoms (95% and 100%); 2. Functional status (89% and 88%); 3. Current risk factors (89% and 94%); 4. Current interventions (84% and 88%); 5. Response to interventions (84% and 76%);

			6. Results of recent testing/rating scales (39% and 90%); 7. Discharge criteria (63% and 87%) and 8. Input from IRP team members on the present status (84% and 100%). The facility reports a plan to implement the Clinical Chart Audit in two phases, with phase one focusing on the Clinical Formulation/Update. **Other findings:** Reviews by this expert consultant found improved format for the documentation of the case formulation in the 6 P format and relative improvement in the delineation of the individuals' needs (by eliminating the separate and parallel process of needs assessment). However, the content of information was inadequate, particularly in the following areas: 1. The present status review of interventions and response; 2. The present status review of all applicable risk factors and triggers during the review period; 3. The present status review of the use of restrictive interventions; 4. The present status review of individualized discharge criteria, progress towards discharge and barriers to discharge; 5. Linkages within the 6 Ps of the case formulation; 6. Linkages between the case formulation and the disciplinary assessments; 7. Linkages between the case formulation and the foci, objectives and interventions of the IRP. **Compliance:** Partial.

			Current recommendations: 1. *Ensure that IRP Manual provides sufficient instruction, with adequate examples, regarding the IRP team's review of the social skills/functional status.* 2. *Develop and provide a training module for the IRP team core members regarding the Interdisciplinary Case Formulation. The module should include lesson plans, process outcomes and post-tests and review and revisions of treatment objectives and interventions.* 3. *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* 4. *Provide aggregated data about results of competency-based training of all core members of the treatment team regarding the principles and practice of Case Formulation.* 5. *Revise the Clinical Chart Monitoring Form to include complete indicators and operational instructions regarding this requirement.* 6. *Monitor this requirement using the Clinical Chart Audit tool based on at least 20% sample during the review period.* 7. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted mean for the review period.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.C.2	include a review of clinical history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	**Current findings on previous recommendations:** **Recommendation, September 2009:**

			Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.3	include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, possible side effects, and targeted review dates to reassess the diagnosis and treatment in those cases where individuals fail to respond to repeated drug trials;	**Current findings on previous recommendations:** **Recommendation, September 2009:** Same as above. **Findings:** The facility had audit data (August 2009 to February 2010) based on the use of the Comprehensive Psychiatric Assessment and the Psychiatric Update (Reassessment) audit tools. The data focused on the presence and adequacy of the pharmacological plan of care as part of the comprehensive psychiatric assessment (compliance rates varied from 67% to 100%) and the psychiatric reassessment (88% to 100%). **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.4	consider biochemical and psychosocial factors for each category in Section V.C.2., supra;	**Current findings on previous recommendations:**

			Recommendation, September 2009: Same as above. **Findings:** As mentioned above, the facility was in the process of development of the Clinical Chart audit tool to assess the requirements in V.C.4 to V.C.7 (as part of the Clinical Formulation). **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.5	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	**Current findings on previous recommendations:** **Recommendation, September 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.6	enable the treatment team to reach determinations about each individual's treatment needs; and	**Current findings on previous recommendations:** **Recommendation, September 2009:** Same as above.

			Findings: Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
MES	V.C.7	make preliminary determinations as to the setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge whenever possible.	**Current findings on previous recommendations:** **Recommendation, September 2009:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.

	D. Individualized Factors		
		By 24 months from the Effective Date hereof, SEH shall establish policies and/or protocols to provide that treatment planning is driven by individualized factors. Specifically, the treatment team shall:	Please see sub-cells for findings and compliance.
MES	V.D.1	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's level of functioning) that build on the individual's strengths and address the individual's identified needs;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Revise the IRP Manual to ensure the following:* *a) An IRP focus to address social skills/functional impairments;* *b) Operational guidance, including adequate clinical examples, are provided to facilitate the following:* *i. Development of foci, objectives and interventions based on learning outcomes;* *ii. Linkages within the IRP (assessments to case formulation to foci to objectives to interventions);* *iii. Linkage between Mall interventions and IRP objectives;* *iv. Strength formulation for IRP purposes;* *v. Revisions of Foci, objectives and interventions to reflect the individual's changing needs; and* *vi. Strategies to overcome barriers to the individual's adherence.* **Findings:** During this review period, SEH made some revisions to the IRP Manual, including additional examples of foci, objectives and interventions, updated tip sheet for completing objectives and new prompts to address the individuals' functional status/social skills as part of the review of the present status section of the case formulation. The hospital considered the recommendation to address functional status/social skills as a dedicated focus,

			but elected to address this area within the current designated focus areas. This expert consultant reviewed the revised IRP Manual and found some improvement in the new examples of objectives, interventions, the updated tip sheet for completing objectives and formulation of individuals' strengths compared to the last review period. However, more work is needed to ensure the following: 1. The focus statements clearly delineate the individuals' needs but are not confused with objectives. 2. The objectives adequately and consistently utilize learning outcomes and are attainable and measurable and/or behavioral. 3. The interventions clearly specify the name of the provider, the frequency of the intervention and what staff will do to assist the individual in achieving objectives. 4. There is a mechanism to document the individual's progress in Mall interventions and link these interventions to the IRP objectives. 5. The strengths are linked to interventions. 6. The foci, objectives and interventions aremodified, in a timely and appropriate manner, in response to the changing needs of the individuals and 7. Interventions are developed and updated to overcome lack of individuals' adherence to the IRP. **Recommendations 2-5, September 2009:** • *Develop and implement a training module focused on the development of Foci, Objectives and Interventions. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of*

			treatment objectives and interventions. • *Ensure that IRP training/mentoring addresses the findings of deficiency outlined in this section.* • *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* • *Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions.* **Findings:** As mentioned earlier, SEH provided training to its Clinical Administrators as the initial authors of the IRP document. The training addressed foci, objectives and interventions in two 1.5 hour sessions (January 14 and February 4, 2010). The trainings were attended by 87% (13/15) and 73% (11/15) of the administrators, respectively. The facility acknowledged that more work is needed to provide training to the IRP team core members. **Recommendations 6 and 7, September 2009:** • *Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least 20% samples during the review period.* • *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

			Findings: As mentioned earlier, the facility was in the process of a phased development of a Clinical Chart Audit tool, beginning with a tool to address the Case Formulation. Plans were underway to begin monitoring in May, 2010. SEH presented data (December 2009 and January 2010) on the participation by different disciplines in the processes of discussing interventions, reporting on the individuals' progress and recommending alternative interventions. However, the data were based on the IRP Observations and did not address the content of the plans as specified in this requirement. **Recommendation 8, March 2009:** *Ensure that the self-report contains a summary outline of the following:* *a) Cognitive remediation interventions that are currently provided and plans to increase these interventions and* *b) Specifics regarding changes in Mall interventions based on the initial cognitive screening of individuals and data from the Clinical Profile of Inpatient Population.* **Findings:** SEH presented information regarding the type of current core groups provided to individuals with cognitive impairments. The core groups for individuals with dementias included Cognitive Stimulation, Reality Orientation, Multi-sensory stimulation, Exercise and Reminiscence groups. For individuals with Mental Retardation, the groups included Money Management, Social Skills, Basic Life Skills and Behavior Management. The facility reported a significant increase in the number of individuals attending groups that offered cognitive remediation

			(23 to 30% of the census during the period of September 2009 to May 2010 compared to 8% of the census during the period of February 2009 to August 2009). SEH reported that a functional assessment was conducted by the Psychology department for all individuals at the facility during this review period. The assessment focused on the level of cognitive status and the results were reportedly considered in TLC group assignments. **Recommendation 9, September 2009:** *Finalize and implement an Emergency Medical Response Procedure. In addition to the current elements in the procedure, include standards to ensure the following:* *a) Composition of the response team;* *b) Immediate availability of sufficient number of trained and competent staff to be available at the scene of the emergency, including units and Mall areas;* *c) Requirements for periodic competency-based training of staff;* *d) Formalized documentation of events during the actual code and code drills utilizing a flow sheet that provides systemic review of the following types of information:* *i. Staff member who discovered the emergency;* *ii. Nature of the emergency;* *iii. Condition of the individual upon discovery;* *iv. Circumstances of emergency response activation;* *v. Immediate first aid provided;* *vi. Personnel and equipment arrival, including timing and roles;* *vii. Information regarding outside responders;* *viii. Timing of CPR;* *ix. Staff performing CPR;* *x. Information regarding use of airway/oxygen maintenance,*

			intubation, circulation/cardiac interventions and use of AED; *xi. Documentation of the individual's vital signs;* *xii. Observations of the individual and medications administered;* *xiii. Outcome of the response, including transport; and* *xiv. Family notification.* *e) Documentation of the physician's and nurse's evaluations upon the transport of the individual to an outside facility;* *f) Timely and appropriate evaluation of the performance of staff, equipment and other systems during the actual emergency and the emergency response drill, including, but not limited to, the following:* *i. Timeliness of the response;* *ii. Adequacy of the numbers of team members present;* *iii. Adequacy, timeliness, appropriateness, and functionality of equipment and supplies;* *iv. Quality of the assessment of the individual;* *v. Appropriateness of interventions;* *vi. Any complications that the individual may have suffered during the actual emergency response; and* *vii. Team members' performance of their assigned functions, including leadership of the response team.* *g) Requirement that procedures for managing equipments and supplies related to the medical emergency response are continuously updated, including, but not limited to, the following:* *i. Automatic External Defibrillator (AED), including inventory sheet and* *ii. Guidelines for competing the AED Inventory Sheet;* *iii. Emergency kit and equipment/supplies procedure, including Emergency Kit inventory sheet and Emergency Kit and equipment security, checks and documentation of*

			the checks; *iv. Nasopharyngeal pathway;* *v. Oropharyngeal pathway;* *vi. Oropharyngeal suctioning; and* *vii. Oxygen therapy.* *h) Medical emergency code drills are performed unannounced.* *i) Medical emergency drills utilize scenarios that adequately cover the range of possible emergencies.* *j) The oversight function regarding the medical emergency response (actual and drills) includes an inter-disciplinary review, including, but not limited to, both the Medical Director and the Nurse Executive.* *k) Reports of the above-mentioned review of the actual emergencies and the emergency drills are submitted for regular review by the Medical Executive Committee and that the committee provides recommendations for any systemic corrective actions required at that level, as indicated.* **Findings:** In response to this recommendation, SEH made significant revisions in its Policy #116.1-09, Emergency Medical Response on April 7, 2010. The revised policy adequately addressed the most essential elements in this recommendation. If properly implemented, this policy can improve the structure and functioning of the medical emergency response system at the facility. The facility has yet to implement this policy. **Recommendation 10, September 2009:** *Finalize a policy and procedure regarding the provision of medical care to individuals in urgent and non-urgent situations. In addition to the current elements in the procedure, include standards to ensure the following:* *a) Timeliness and documentation requirements regarding*

			medical attention to changes in the status of individuals to include documentation using a SOAP format; and *b) Timeliness and documentation requirements regarding periodic routine reassessments of the individuals, including assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks;* **Findings:** In response to this recommendation, SEH developed draft new Policy #209-10, General Medical Services, dated April 7, 2010. The draft policy adequately addressed this recommendation. In addition, in response to a recommendation that was made to the facility in previous communication, SEH developed (April 7, 2010) draft policy #208-10, Seizure Management. This draft policy adequately addressed the recommendation. The facility has yet to finalize and begin implementation of these two policies. **Recommendation 11, September 2009:** *Revise Policy #111.2-08, Patient Transfers, regarding return transfers. Include parameters for documentation by the accepting physician of the following:* *a) A review and assessment of the individual's status and the care provided at the outside facility; and* *b) A plan of care that outlines interventions needed to reduce the future risk for the individuals.* **Findings:** SEH revised its policy #111.2-08 (August 26, 2009) and adequately addressed this recommendation. **Recommendation 12, September 2009:**

			Develop and implement a procedure regarding consultations and laboratory testing to provide standards regarding the following: *a) Communications of needed data to consultants;* *b) Timely review and filing of consultation and laboratory reports; and* *c) Follow-up on consultant's recommendations.* **Findings:** SEH did not adequately address this recommendation or specify if other formalized mechanism exists to ensure consistent implementation of elements in this recommendation. **Other findings:** Chart reviews by this consultant found that the facility has made improvements in the content of the IRPs in the following areas: 1. Formulation of the individuals' strengths, life goals and cultural preferences and 2. Delineation of the practitioners providing interventions and the nature and timeframes in these interventions. However, the facility hast yet to correct the deficiencies that were mentioned in the previous report in this section regarding the content of foci, objectives and interventions The following are chart examples of deficiencies in the statements of the focus of hospitalization: 1. "Will maintain a positive outlook about his life ahead of him" (JV) 2. "Will optimally function and manage his mental illness as evident by successfully remaining in the community,

			accepting and taking his medications as ordered and attending and participating in his day and substance abuse program" (DLB); 3. "Will experience improved health and wellness" (LL); 4. "Will need psychiatric stabilization because (summary of history of the present illness and current mental status examination)" (DLB); 5. "Will experience fewer episodes of violence/aggression" (VG) and 6. "Will have greater ability to manage the symptoms of hallucinations and delusions that lead to irritability by participating in all aspects of his treatment and discussing his feelings with staff" (CL). In addition, this expert consultant also reviewed the charts of individuals diagnosed with seizure, cognitive, and substance use disorders. The purpose of the review was to assess whether the IRP included appropriate diagnosis, foci, objectives and interventions to address the individuals' identified needs. These reviews found that the facility has maintained some progress in the following areas: 1. Review of the present status of some individuals diagnosed with seizure and cognitive disorders; 2. Documentation of objectives that included some learning outcomes in individuals with seizure disorders and of interventions that aligned with some of these outcomes (e.g. SS) and 3. Documentation of interventions that were appropriately tailored to the individual's level of cognitive functioning in some individuals diagnosed with a cognitive disorder. However, the review found a pattern of persistent deficiencies

			the must be corrected to achieve compliance with requirements of this Agreement (V.D.1 to V.D.6). The following are examples: 1. Individuals diagnosed with seizure disorders (LL, DT, KP, JJ, DLB, ND, JH, DT, TJ, SS and RCM): a) The present status section of the case formulation did not address seizure activity (LL, DT, KP and TJ); b) There was no update of the present status section in the chart of DLB; c) The IRP did not document foci, objectives or interventions to address seizure disorder (JV, ND and LL); d) The IRP did not identify an objective related to seizure management (JH, DT and TJ); e) The focus statement, objectives and interventions were focused on participation in the management of the disorder and medication adherence without apparent connection to the actual needs of the individuals (SS). f) The objectives did no appear to be appropriate to the individual's level of cognitive impairment (SS) g) None of the charts reviewed included the morphological diagnosis of the seizure disorder. This information is important to determine the proper selection of the anticonvulsant medications. h) The IRPs did not include focus, objectives and/or interventions to assess the risks of treatment with older anticonvulsant medications, and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals were receiving phenytoin (SS, DLB and RCM). Some of these individuals (e.g. RCM) were also diagnosed with cognitive dysfunction, which increased the risk of this practice. 2. Individuals diagnosed with cognitive disorders (AS, DLB, BA,

VG, CL, TT, RCM, PH, TR, TW, EG, ML, TJ, PH and DT).

a) There was no documentation of a focus statement or objectives or interventions to address diagnoses of Dementia of the Alzheimer's Type with late onset (AS), Vascular Dementia (DB, BA, VG, CL and TT), Dementia Due to Head trauma or HIV Disease (RCM and PH), Dementia Due to Head trauma or HIV Disease or Huntington's' Disease (TR and TW), Dementia NOS (EG) and Mild Mental Retardation, with no Axis I Diagnosis (DT).

b) The intervention related to a diagnosis of Vascular dementia was not matched to an objective under focus I (AB). On the other hand, the review of current factors that may present barriers (under focus 3) mentioned dementia w/o objectives/interventions (AB)

3. Individuals diagnosed with substance use disorders (SS, JV, LL, TJ, DLB, RCM): The objective for the substance use disorder was not aligned with the stated stage of change in all charts reviewed.

This expert consultant reviewed the charts of 10 individuals who were transferred to an outside facility for medical care during this reporting period. The review focused on procedures that facilitate the delivery of medical care that meets the individual's physical needs. The following outlines these reviews:

Initials	Date of transfer	Reason for transfer
CG	1/29/10	R/O Neuroleptic Malignant Syndrome
DA	11/6/09	Unresponsive Diabetic
MH	11/9/09 and 12/3/09	R/O Intestinal Obstruction

SS	1/4/10	Grand Mal Seizure
AWB	2/12/10	Unresponsiveness
PW	1/27/10	Hyponatremia
DJ	11/30/09	Hypoalert
SH	1/4/10	Hyponatremia
TW	12/3/09	Seizures
CB	10/16/09	Lithium toxicity

In general, the reviews found medical care to be timely and adequate, including timely and appropriate consultations as follow up on unresolved issues following outside hospitalization (e.g. TD). Overall, there was evidence of improved practice since the last review. However, the reviews also found a number of process deficiencies in nursing and medical care that required corrective actions. The following are examples:

1. The current system of documentation in AVATAR makes it exceedingly difficult for practitioners who are not the attending physicians to identify and track the type and timeliness of medication changes. This can have serious negative consequences during the management of urgent/emergent situations. Subsequent to this review, the facility made adequate corrections to address this finding.
2. The nursing documentation of a change in the condition of an individual who experienced abdominal pain (R/O obstruction) did not include an adequate assessment (MH). There was no documentation of a timely physician assessment in response to the nurse's notification of this change. There was no documentation of a psychiatric/discharge assessment to address the risks of ongoing treatment with an antipsychotic medication with strong anticholinergic effects for this individual.
3. There was no documentation of an acceptance medical

			assessment from the facility to outline a plan of care informed by the work up of a delirium during outside hospitalization (CS). 4. The discharge assessment from the outside facility was unavailable in several charts. 5. The nursing assessment of an individual who was experiencing grand mal seizure did not include an adequate assessment (SS). There was no evidence of a behavioral plan/guideline to address medication non-adherence in this individual. 6. The nursing assessment of other individuals who reportedly experienced seizure activity was inadequate (AWB and TW). 7. The documentation of a physician's response to a critical laboratory findings was delayed (PW). 8. There was no evidence that an adverse drug reaction (lithium toxicity at a level that was potentially lethal) was reported or investigated (CB). 9. There was evidence of unacceptable delay in reporting and responding to a critical level of lithium 2.6 (2/13/09). This individual was transferred to an outside facility on 2/16/09 and fortunately his condition was successfully treated without complications (CB). There appeared to be inadequate tracking by nursing staff of the clinical condition of this individual regarding the manifestations of lithium toxicity during the three days preceding his outside transfer. During this review period, the facility has improved the oversight of medical services and appointed a new supervisor of the General Medical Officers, who recently initiated a variety of policies/procedures (see findings under recommendations #9 and #10 above) and appropriate templates to improve the documentation of assessments of individuals upon their transfer to outside facilities and the documentation of routine quarterly reassessments of all individuals who required ongoing medical

			care. If properly implemented, these tools can improve the facility's practice regarding the above mentioned process deficiencies. **Compliance:** Partial. **Current recommendations:** 1. *Revise the IRP Manual to ensure the following:* a) *The IRP teams adequately address the individuals' functional/social skills needs.* b) *The focus statements clearly delineate the individuals' needs but are not confused with objectives.* c) *The objectives adequately and consistently utilize learning outcomes and are attainable and measurable and/or behavioral.* d) *The interventions clearly specify the name of the provider, the frequency of the intervention and what staff will do to assist the individual in achieving objectives.* e) *There is a mechanism to document the individual's progress in Mall interventions and link these interventions to the IRP objectives.* f) *The strengths are linked to interventions.* g) *The foci, objectives and interventions are modified, in a timely and appropriate manner, in response to the changing needs of the individuals and* h) *Interventions are developed and updated to overcome lack of individuals' adherence to the IRP.* 2. *Provide training to IRP core members focused on the development of Foci, Objectives and Interventions. The training should include lesson plans, process outcomes and post-tests, and should address review and revisions of*

			treatment objectives and interventions. 3. *Provide summary outline of the participating disciplines in the above training and the training process (didactic, observation, feedback to teams) and content.* 4. *Provide aggregated data of results of competency-based training of all core members of the treatment team regarding the principles and practice of Foci/Objectives/Interventions.* 5. *Monitor the requirements in V.D.1 through V.D.6 using clinical chart audit tools based on at least 20% sample during the review period.* 6. *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates and weighted average compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 7. *Ensure that the self-report contains a summary outline of the following:* a) *Number and types of Cognitive remediation interventions that are currently provided and plans to increase these interventions and* b) *Specific information regarding the assignment of Mall groups to individuals based on initial cognitive screening of the individuals.* 8. *Finalize and implement the Emergency Medical Response Policy #116.1-09.* 9. *Provide information regarding any systemic reviews by the facility of the code blue emergencies and drill emergencies, any performance improvement issues that were identified and corrective actions that were initiated during these*

			reviews. 10. *Finalize and implement policy #209-1, General Medical Services.* 11. *Finalize and implement policy #208-1, Seizure Management.* 12. *Finalize and implement policy #111.2-08, Transfers of Individuals in Care and address/improve the format of documentation of the assessment of individuals upon their return transfer from outside facilities.* 13. *Ensure adequate mechanisms regarding the following:* a) *Timely availability of Discharge Assessments from outside facilities;* b) *Communications of needed data to consultants;* c) *Timely review and filing of consultation and laboratory reports; and* d) *Follow-up on consultant's recommendations.*
MES	V.D.2	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	**Current findings on previous recommendation:** **Recommendation, March 2009:** *Same as above.* **Findings:** Same as above. In addition, the current IRP format provided for treatment, rehabilitation and enrichment activities. **Other findings:** The facility did not present self-assessment data to address implementation of this requirement. **Compliance:** Partial. **Current recommendations:**

			Same as above.
MES	V.D.3	write the objectives in behavioral and measurable terms;	**Current findings on previous recommendation:** **Recommendation, March 2009:** *Same as above.* **Findings:** Same as above. **Other findings:** As mentioned earlier, the facility planned to implement a phased approach to the use of a Clinical Chart Audit, including indicators to assess implementation of this requirement. Chart reviews by this expert consultant found examples, in a few charts, of relative progress in the formulation of treatment/ rehabilitation objectives since the last review as follows: 1. "Able to respond appropriately to reality based conversations initiated by staff for a minimum of 3-5 minutes which will be designed to focus on his strengths (music and aspects of the legal system" (ND) and 2. "Will maintain maximum cognitive functioning as evidenced by picking out his clothes daily and participating in day/time orientation (MK)"; Overall, however, the review found the same pattern of deficiencies in the content of treatment/rehabilitation objectives that was described in the previous report. The following are some chart examples: 1. "Will return to baseline functioning as evidenced by stable

			mood and thinking to allow day program" (JV); 2. "Will attend individual psychotherapy session focused on depression treatment, trauma as evidenced by (blank) (JH); 3. "Will minimize the effect of her symptoms on herself and others as evidenced by more stable mood, consistent compliance with medications, verbalizing her feelings to others and being able to use at least one new coping strategy she has learned in a time of conflict or stress (stage of change is contemplation)" (LL); 4. "Will be psychiatrically stabilized as evidenced by for the next 60 days, discussing the benefit of continuing his medications and therapy both in and outside the hospital so that he may stay out of the hospital or jail" (DLB); 5. "Will consider that changing this behavior would assist her with leaving the hospital and will talk to the staff about her needs in a calm manner as evidenced by conversing in purposeful calm conversation with the treatment team" (AS) and 6. "Will be more independent and accentuate her cognitive abilities as evidenced by attending her day program regularly, participating in activities provided there, socializing with individuals at the program" (LW) These examples illustrate objectives that were over-inclusive, vague, not measurable and/or unattainable. These objectives set the stage for generic interventions and plans that do not address the actual needs of the individuals. **Compliance:** Noncompliance. **Current recommendations:** *Same as above.*

MES (1-3) and RB (4-5)	V.D.4	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	**Current findings on previous recommendations:** **Recommendations 1-3, September 2009:** • *Same as above.* • *Provide additional data using the therapeutic progress notes self-audit based on least 20% sample during the review period.* • *Ensure that the self-report includes an aggregated monitoring data regarding the therapeutic monthly progress notes, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** The IRP format was incorporated in AVATAR, including mandatory fields for the intervention, the person responsible and timeframes for the intervention. In addition, the IRP form was revised to include information regarding interventions for each objective, type of the intervention, frequency, duration and delineation of treatment and rehabilitation/enrichment interventions. The facility reported that the therapeutic monthly progress notes will be completed in AVATAR effective May 2010. Auditing of these notes began in March 2010, and self-assessment data were pending. **Recommendation 4, September 2009:** Develop procedures to ensure that interventions are appropriately aligned with treatment objectives.

			Findings: Although the IRP Manual instructs clinicians in accomplishing this, implementation in a clinically meaningful manner has been hampered by the evident confusion in the IRP documents and the lack of conceptual clarity and good examples in the previous training program. **Recommendation 5, September 2009:** Conduct audit monthly and present results as trended data **Findings:** Audit data will be presented in accordance with information in the facility's Audit Plan (see V.B.9). **Other findings:** Chart reviews by this expert consultant found general evidence of some progress in the following areas: 1. Specifying the person providing the intervention and the frequency/timeframe of the intervention; 2. Delineation of the treatment and skill building interventions and 3. Alignment of a few interventions with the stated objectives (SS). The following is a chart example of some appropriate interventions: "Show her medications, help her say the name of each, help her practice taking the blood sugar level and administering insulin and offer instructions and reminders in chunks of information with appropriate modeling" (LW); However, most charts contained a pattern of persistent deficiencies regarding this requirement as follows:

			1. Too many interventions were generic and did not align with the assessed needs of the individuals. The following are examples: a) "Medication management to monitor and adjust medication" (JV); b) "Individual therapy to help him sustain positive attitude and discuss any anxieties about his future, to discuss possibility of mood symptoms being neurological and how to deal with them, report symptoms to team and Doctor" (JV); c) "Health education with a focus on identifying behaviors that lead to hospitalization, the barriers to medication adherence and to begin to identify her needs that are not being met" (JH) and d) "Health education with a focus on understanding the risk factors of her diagnosis, the treatment available and provide education at a level that patient can comprehend" (JH). 2. There continued to be lack of evidence that Mall interventions were properly linked to the IRP objectives. 3. While all reviewed IRPs had interventions for each objective, they are not currently standardized, and for example, do not clearly indicated the name of the group if a group intervention is indicated. More importantly, however, only 25% of identified group interventions in reviewed treatment plans had accompanying PSR Therapeutic Progress Notes. Additionally, many of the notes that were found did not clearly specify the title of the group, and it often had to be inferred from the body of the note. This latter problem could probably be easily corrected with some adjustment to the progress note form.

			Compliance: Partial. **Current recommendations:** 1. *Same as above.* 2. *Provide additional data using the therapeutic progress notes self-audit based on least 20% sample during the review period.* 3. *Ensure that the self-report includes an aggregated monitoring data regarding the therapeutic monthly progress notes, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted averages of %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 4. Determine the barriers currently existing to proper and timely completion of Therapeutic Mall Progress Notes. 5. Improve Therapeutic Mall Progress Note template to prompt specifically for the name of the group. 6. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	V.D.5	design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Develop and implement a system to track active treatment hours scheduled per week.*

			Findings: The data presented by the hospital did not allow this item to be reviewed. **Recommendation 2, September 2009:** *Develop and implement a system to track attendance and participation by the individuals in scheduled active treatment hours*. **Findings:** The data presented by the hospital did not allow this item to be reviewed. **Recommendation 3, September 2009:** *Provide data regarding the number of active treatment hours per week for all individuals at the facility during the review period*. **Findings:** The data presented by the hospital did not allow this item to be reviewed. **Recommendation 4, September 2009:** *Identify and resolve barriers to individual's attendance at scheduled activities*. **Findings:** No data was presented with regard to this recommendation. **Recommendation 5, September 2009:** *Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives*.

			Findings: This audit tool has not been developed. **Recommendation 6, September 2009:** *Monitor Mall alignment based on at least 20% sample.* **Findings:** Not yet begun. **Recommendation 7, September 2009:** *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** Not yet implemented. **Other findings:** Visits to both the TLC Transitional Mall and the TLC Intensive Mall demonstrated that, despite the logistics involved with the recent move to the new building, mall processes were running fairly smoothly. During three observed time periods, over 90% of individuals in care were in their assigned mall areas within 10 minutes of the start of the hour. Appropriate use of both Comfort and TLC Support Rooms were noted, with greater development of these resources found on the Transitional Mall. Large group activities in the Intensive Mall were somewhat noisy, and staff indicated a plan to potentially subdivide this space.

			Compliance: Partial. **Current recommendations:** 1. Track the percentage of individuals in care who are assigned to 20 hours of clinically appropriate treatment/rehabilitation per week, as well as the percentage of individuals of that group who attend 20 hours of clinically appropriate treatment/rehabilitation per week. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided. 3. Develop a Mall Alignment Monitoring Form, with complete indicators and operational instructions, to assess linkage between active treatment hours and IRP objectives. Present auditing data for this instrument according to instructions in Cell V.B.9.
MES	V.D.6	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through SEH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Same as in V.D.1 through V.D.5. **Findings:** Same as in V.D.1 through V.D.5. **Compliance:** Partial.

			Current recommendations: Same as in V.D.1 through V.D.5.

	E. Outcome-Driven Treatment Planning		
		By 24 months from the Effective Date hereof, SEH shall develop or revise treatment plans, as appropriate, to provide that planning is outcome-driven and based on the individual's progress, or lack thereof. The treatment team shall:	Please see sub-cells for findings and compliance.
MES	V.E.1	revise the objectives, as appropriate, to reflect the individual's changing needs;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals.* **Findings:** The facility's report included the same information that was discussed earlier regarding the training of the Clinical Administrators (see V.A.1 and V.D.1). **Recommendations 2 and 3, September 2009:** • *Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:**

As mentioned earlier, the facility was in the process of implementing the first phase of the clinical Chart Audit, to begin in May 2010. The facility presented data based on the IRP Observation Audit tool (December 2009 and January 2010). The indicators and corresponding compliance rates (no weighted averages were provided) are summarized as follows:

1. The team reviewed progress in meeting objectives (82% and 64%).
2. The team explained what will occur to support individual needs (65% and 84%).
3. The team discussed if individual benefited from therapies (100% and 100%).
4. If the individual did not benefit from therapies, the team revised the related intervention (100% and 100%).

The facility acknowledged that the observation data were limited by the fact that, in many cases, the objective and intervention statements were not specific or realistic.

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

Initials	IRP reviews
DM	12/23/09 and 2/18/10
MK	11/5/09 and 2/23/10
EG	3/26/10 and 5/20/10
SF	1/31/10 and 3/25/10
LW	3/5/10 and 5/18/10
AF	3/30/10 and 5/25/10

In two charts (LW and AF), there was evidence that the

			treatment teams made appropriate revisions in the case formulation, stages of change, goals/foci, objectives and/or interventions in an effort to address the changing needs of the individuals. However, the IRPs of four individuals (DM, MK, EG and SF) did not include evidence of timely review of objectives and interventions, development of objectives/interventions that address the needs of the individual or review in the present status of the individual's response to treatment in order to inform appropriate revisions in the plan. **Compliance:** Partial. **Current recommendations:** 1. *Ensure that the training module regarding the development of foci, objectives and interventions includes guidance with clinical examples on the process of revising foci, objectives and interventions to reflect the changing needs of the individuals.* 2. *Monitor each requirement (V.E.1 through V.E.3) using both process observation and clinical chart audit tools based on at least 20% sample during the review period.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.E.2	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:**

			Same as in V.E.1. **Findings:** Same as in V.E.1 **Recommendation 2, September 2009:** *Implement the schedule of IRP reviews as specified in the revised policy.* **Findings:** The facility assessed its compliance with the timeframes specified in its policy (i.e. IRP reviews by days 7, 14, 30, 60 and every 60 days thereafter). However, except for the data regarding the 60 day reviews, the sample sizes were very limited to produce meaningful data. The data regarding the reviews by 60th day and every 60 day thereafter showed compliance rates ranging from 71% to 100% (August 2009 to January 2010). **Recommendations 3 and 4, September 2009:** • *Ensure that the monthly reviews by the clinical administrator are based on an input from core disciplines.* • *Develop and implement a mechanism to monitor the monthly reviews by the clinical administrators based on adequate indicators and operational instructions.* **Findings:** SEH did not address these recommendations. However, the template for the Psychiatric Update included a prompt for the review of the foci/objectives/interventions. If properly implemented, the psychiatric update is adequate to ensure compliance with this requirement. **Other findings:**

			Chart reviews by this monitor found that the Psychiatric Updates did not adequately implement this requirement (see VI.A.1 and VI.A.7). **Compliance:** Noncompliance. **Current recommendations:** 1. *Same as in V.E.1* 2. *Ensure proper implementation of this requirement as part of the Psychiatric Updates.* 3. *Provide data regarding the implementation of the monthly review of the IRPs as part of the Psychiatric Update Audit.*
MES	V.E.3	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;	**Current findings on previous recommendation:** **Recommendation, March 2009:** Same as in V.E.1. **Findings:** Same as in V.E.1. In addition, the new high risk triggers/Medical Director Review process includes additional prompts to facilitate implementation of this requirement. The facility presented self-assessment data based on tracking by IRP observers (October and December 2009 and January 2010). No operational instructions were provided. The following is a summary of the indicators and corresponding mean compliance rates (weighted averages were not provided): 1. The teams addressed the Restraint/Seclusion episodes (100% in October and December; no episodes occurred in January).

2. The teams addressed the use of Stat medications (75% and 67% in October and December; no use occurred in January 2010).
3. The teams addressed other risk factors (89% to 100%).

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

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

Initials	**S/R**	**IRP reviews**
AR	1/17/10	**Not available in the chart**
MB	2/2/10	2/3/10
RH	12/21/09	1/13/10
TJ	1/6/10	1/14/10
FH	12/11/09	12/16/09

This review found the following:

1. There was no evidence of an IRP review following the use of S/R (AR).
2. In the chart of MB, the initial IRP (2/2/10) did not address the use of S/R that occurred one day prior to completion of the plan. The comprehensive plan was delayed and did not cover the time period that involved the incident.

			3. The IRP reviews did not address the circumstances leading to the use of S/R and/or modifications of objectives and/or interventions to decrease future risk for the individuals (MB, TJ and FH). **Compliance:** Partial. **Current recommendations:** Same as in V.E.1.
MES	V.E.4	provide that the review process includes an assessment of progress related to discharge; and	**Current findings on previous recommendations:** **Recommendations 1 to 5, March 2009:** • *Ensure that the IRP Manual provides adequate clinical examples to facilitate the individualization of discharge criteria.* • *Ensure that the IRP Manual/training includes strategies to increase the motivation of individuals to participate in their IRPs.* • *Implement the training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions* • *Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content.* • *Provide aggregated data regarding results of competency-based training of all core members of the treatment team.*

			Findings: The facility's self-report did not address these recommendations. **Recommendations 6 and 7, March 2009:** • *Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** Plans were underway to begin monitoring using the Clinical chart Audit. IRP Observation data (October and December and January 2010) showed the following mean compliance rates (weighted averages were not provided): 1. The present status section included individualized discharge criteria (63% to 87%). 2. The team discussed discharge plans (76% to 100%). 3. The team reviewed discharge criteria with the individual (93% to 100%). 4. The team discussed discharge planning with the individual (75% to 93%). **Other findings:** As mentioned earlier, chart reviews by this expert consultant found that the present status sections of the clinical

			formulation did not adequately document individualized, measurable and/or attainable discharge criteria and/or discussion by the team of the individual's progress towards these criteria and the barriers towards discharge. Reviewing the charts of six individuals (BP, DE, DM, MP, LR and GS), this expert consultant found a general pattern of deficiencies. The following are chart example of inadequate criteria: 1. "Continued consistent cooperation with treatment, stable mood, less threatening/impulsive behavior" (BP); 2. "Learn ways of coping with anger and stress so expresses issues rather than assaults or threatens, redirectable when agitated" (DE); 3. "Have greater ability to manage underlying feelings of failure, mutism, catatonia and symptoms of depression by being able to communicate her feelings to staff and participate in therapeutic groups " (DM); 4. "Learns other ways of coping with guilt other than fasting to point of self-harm, stripping naked in public or being destructive to property" (MP); 5. "Will need to exhibit the increased insight necessary to develop a recovery plan and safe discharge plan" (LR) and 6. "Learn new coping skills and new social skills to get attention needs met resulting in reduced incidents of loud disruptive behavior such that he does not disturb others" (GS). **Compliance:** Partial. **Current recommendations:** 1. *Ensure that the IRP Manual provides adequate clinical*

			examples to facilitate the individualization of discharge criteria. 2. *Ensure that the IRP Manual/training includes strategies to increase the motivation of individuals to participate in their IRPs.* 3. *Implement a training module dedicated to discharge planning, including the proper formulation of individualized discharge criteria and review and documentation of progress towards discharge. The module should include lesson plans, process outcomes and post-tests, and should address review and revisions of treatment objectives and interventions* 4. *Provide a summary outline of the above training including information regarding participating disciplines and training process (didactic, observation, feedback to teams) and content.* 5. *Provide aggregated data regarding results of competency-based training of all core members of the treatment team.* 6. *Monitor this requirement using both process observation and clinical chart audit tools based on at least 20% sample during the review period.* 7. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	V.E.5	base progress reviews and revision recommendations on clinical observations and data collected.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Same as in Section V.A.1 to V.A.1.5.

			Findings: Same as in Section V.A.1 to V.A.1.5. **Recommendation 2, September 2009:** Same as in V.B.1. **Findings:** Same as in V.B.1. **Recommendation 3, March 2009:** Same as V.E.4. **Findings:** Same as V.E.4. **Other findings:** As mentioned earlier, the facility planned to implement the monthly therapeutic progress note as part of AVATAR effective May 2 010. In addition, the facility reported that the Therapeutic Learning Centers (TLCs) on the civil side have been conducting weekly rounds with the Clinical Administrators of their treatment teams to provide information on the individuals' progress towards treatment objectives and discharge criteria. The facility planned to expand these meetings to all TLCs. The facility's IRP Observation data that were presented in V.E.1 (recommendations 2 and 3) were also relevant to this requirement. Observations by this expert consultant of the IRP team meetings indicated that the teams conducted an adequate review of group therapies when the providers were members of the team. However, the teams did not conduct a data-based review

			of the individual's progress in active treatment provided at the TLC when the providers were not members of the IRP team. Other process deficiencies (see other findings in V.B.1) also contributed to inadequate implementation of this requirement. **Compliance:** Partial. **Current recommendations:** 1. Same as in Section V.A.1 to V.A.1.5. 2. Same as in V.B.1. 3. Same as V.E.4.

	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. The facility's Medical Director has made further efforts to reduce high risk medication uses. 2. SEH has made improvements in its practice in the finalization of provisional diagnoses. 3. SEH has provided self-assessment data based on the Comprehensive Initial Psychiatric Assessment (CIPA), Psychiatric Update and Inter-Unit Transfer audit tools. Although more work is needed to improve data presentation, the facility has reviewed its data and analyzed trends and patterns during this review period. The self-assessment process was candid and thoughtful. 4. The Psychology Department has developed and piloted an auditing tool for all non-IPA assessments/evaluations. 5. Rehabilitation Services Assessments presented some of the best measurable, observable and specific objectives for inclusion in the individual's IRP.

	A. Psychiatric Assessments and Diagnoses		
MES			**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Tyler Jones, MD, Medical Director, Intensive Services Reviewed: 1. Charts of the following 29 individuals: AC, AEH, AF, AO, AW, AWB, DE, DJ, DM, EF, EG, FF, GKW, GS, JR, LF, LM, LS, LW, MK, ML, MR, MT, PS, RM, SS, TN, TR and YS 2. Saint Elizabeths Hospital (SEH) Self-Assessment Report (April 9, 2010) 3. List of all individuals at the facility with their psychotropic medications, diagnoses and attending physicians 4. SEH Policy #602.1-08: Assessments, revised March 30, 2010 5. SEH Policy #601-02: Medical Records, revised April 7, 2010 6. SEH Audit Sample Plan 7. SEH Comprehensive Initial Psychiatric Assessment (CIPA) Audit summary data (June 2009 to February 2010) 8. SEH Operational Instructions for Psychiatric Update Audit Tool, revised April 1, 2010 9. SEH Psychiatric Update Audit summary data (August 2009 to February 2010) 10. SEH Initial Psychological Assessment Monitoring Tool and Peer Review Form, May 21, 2009 11. SEH Initial Psychological Assessment Audit summary data (August 2009 to February 2010) 12. SEH IRP Process Observation data summary (December 2009 to January 2010) 13. SEH Operational Instructions for Co-occurring Disorders Audit, not dated 14. SEH outline of CME activities during this review period

			15. SEH data regarding current psychiatric staffing, including trainees <u>Observed</u>: 1. Team meeting at unit 2B for IRP review of JB 2. Team meeting at unit 1E for IRP review of RH 3. Team meeting at unit 1E for IRP review of LD 4. Team meeting at unit 1E for IRP review of JC 5. Team meeting at Annex A for IRP review of TB 6. Team meeting at unit 1D for IRP review of LL 7. Team meeting at unit 1D for IRP review of JW 8. Team meeting at unit 2D for IRP review of MH 9. Team meeting at unit 1G for IRP review of DJ
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;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Ensure the revised policy regarding Assessments contains the same time frames for completion of psychiatric updates (reassessments) that are outlined in the policy regarding Medical Records.* **Findings:** SEH reported that the revised policies #602.1-08: Assessments (March 30, 2010) and #601-02: Medical Records (April 7, 2010) have been reconciled regarding the time frames for completion of the psychiatric updates (reassessments). However, the time frames in the revised Assessments policy did not address the requirement for weekly notes during the first 60 days of hospitalization, as specified in the Medical Records Policy. **Recommendation 2, September 2009:** *Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.*

			Findings: *Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.* **Recommendations 3 and 4, September 2009:** • *Provide monitoring data regarding both timeliness and content of psychiatric assessments and reassessments based on at least 20% sample during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures.* • *Ensure that the progress report includes a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH presented self-assessment data based on the Comprehensive Initial Psychiatric Assessment (CIPA) Audit Tool (June 2009 to February 2010). The target sample size was 20% and the sample used varied from 10% to 23%. The facility did not present weighted averages of the mean compliance rates for the indicators used. However, the data appeared to indicate compliance rates of at least 90% for the indicators that assessed the timeliness of the assessment and the content of information in each of the following areas: 1. Legal Status; 2. Psychiatric history; 3. History of Presenting Illness; 4. Medical history; 5. Social and developmental history;

			6. Mental status examination; 7. Consistency between diagnosis and clinical presentation. The data showed less than adequate compliance for the indicators that assessed the content of information in the following areas: 1. Information from prior treatment settings; 2. Adverse reactions to medications in psychiatric history; 3. Family history; 4. Completion of substance use assessment; 5. Substance use assessment reflecting stages of change; 6. Strengths of the individual; 7. Completion of AIMS upon admission; 8. Risks associated with prescribed medication regimen and 9. Precautions where appropriate; The facility reportedly initiated an audit tool, to be implemented in April 2010, to assess whether the IRP Objectives and Interventions reflected results of the substance abuse assessment section of the CIPA. SEH presented data based on the Psychiatric Update (Reassessment) Audit Tool (August 2009 to February 2010). The target sample size was based on reviews of two reassessments per psychiatrist per month (the sample used varied from 2% to 9% of the total reassessments). The facility did not present weighted averages of the mean compliance rates for the indicators used. However, the facility's data appeared to indicate adequate compliance rates for the indicators that assessed the content of information in each of the following areas: 1. Completion of the mental status examination; 2. Completion of current medication regimen;

			3. Psychiatric update reflecting the individual's progress; 4. Appropriateness of the pharmacological plan of care to the individuals' progress, including use of stat medications and 5. Completion of risk assessment. The Psychiatric Update data appeared to indicate less than adequate compliance rates for the indicators that assessed the content of information in each of the following areas: 1. Adverse reactions of antipsychotic medications; 2. Ongoing monitoring of adverse reactions of antipsychotic medications; 3. Justification for deferred, R/O or NOS diagnoses; 4. Rationale for polypharmacy; 5. Rationale for using high risk medications (benzodiazepines); 6. Rationale for using high risk medications (anticholinergics); 7. Addressing Stat medications, seclusion and/or restraints; 8. Addressing involuntary medications; 9. Addressing Laboratory results within appropriate levels; 10. Addressing abnormal laboratory results and 11. Review of reassessments, if completed by a trainee. Due to the lack of aggregated weighted averages of compliance rates, it was not possible to assess the adequacy of the overall compliance rates regarding the following: 1. Timeliness of the reassessments; 2. Update of barriers to discharge and 3. Integration of behavioral and pharmacological modalities. Effective April 2010, the Psychiatric Update Audit included an indicator to assess if diagnosis was updated based on information that became available during the hospitalization. Current data did

			not reflect this concept. Regarding this issue, the updated instructions for completion of the Case formulation required the update of any of the "six Ps" of the Case formulation based on the team's review of information that became available subsequent to hospitalization. In December 2009 and January 2010, the facility used the IRP Observation Audit to assess timely completion of the Psychiatric Update prior to the IRP conference (as required by the facility's policy regarding Assessments) and the psychiatrists' participation in the IRP conference. The following is a summary of the indicators used and corresponding mean compliance rates (weighted averages were not presented, more data are needed to assess overall compliance): 1. Completion of the Update 2 to 10 days prior to the IRP conference (84% and 50%); 2. Reporting on the individual's progress during the IRP conference (94% and 94%) and 3. Recommending changes to interventions if progress not evident (58% and 50%). The facility reported that, in general, the quality of the Comprehensive Psychiatric Assessments and the Psychiatric Updates has improved since the last review but acknowledged that the assessments and the updates "are not yet consistently at expected levels." **Other findings:** Chart reviews by this monitor indicated that the assessments and reassessments were, in general, timely but the content of the assessments and reassessments still fell short of compliance with the requirements of the Agreement as illustrated by findings of

			deficiencies in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7. **Compliance:** Partial. **Current recommendations:** 1. *Ensure the revised policy regarding Assessments contain the same time frames for completion of weekly psychiatric updates (reassessments) that are outlined in the policy regarding Medical Records.* 2. *Same as in VI.A.2 through VI.6.a, VI.A.6.c, VI.A.6.d, and VI.A.7.* 3. *Provide monitoring data regarding both timeliness and content of psychiatric assessments based on at least 20% sample and reassessments (based on two updates by each psychiatrist per month) during the review period. The timeliness and content indicators must be consistent with all revised policies and procedures.* 4. *Ensure that the progress report includes a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C.. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
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.);	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Same as VI.A.1.* **Findings:** Same as VI.A.1.

		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;	**Recommendation 2, September 2009:** *Ensure an integrated system of admission risk assessment (psychiatric and psychological).* **Findings:** The facility reported that the potential for discrepant findings from the current risk assessment processes (Nursing Psychiatry and Psychology) is resolved during IRP team's review of the risk data during the comprehensive IRP meeting and/or during subsequent IRP reviews. This explanation was sufficient in view of the recent revisions in the process of the IRP teams' review of the individual's present status (as part of the Case Formulation update). **Recommendations 3 and 4, September 2009:** • *Monitor risk assessment as part of the initial psychiatric assessment, based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH presented self-assessment data based on the CIPA Audit Tool (August 2009 to February 2010). The target sample size was 20% and the sample used varied from 15% to 23%. The facility did not present weighted averages of the mean compliance rates for the indicators used. The compliance rates regarding completion of the psychiatric risk assessment ranged from 56% to 100%. The facility

			analyzed its data and found that significant improvement was needed to ensure that precautions were developed when a risk was noted. The facility presented data that assessed completion of the Psychological Risk Screening. The data were based on the Initial Psychological Assessment Audit (August 2009 to February 2010). The target sample size was 20% and the sample used varied from 9% to 23%. The following is a summary of the indicators used and corresponding mean compliance rates (weighted averages were not provided, The overall all compliance rates appeared to be around 90% for indicator #1, but less than 90% for indicators #2-4): 1. Violence screening checklist completed (83% to 100%); 2. Suicide screening checklist completed (67% to 100%); 3. Violence assessment findings (75% to 100%) and 4. Suicide assessment findings (63% to 100%). **Compliance:** Partial, improved compared to the last review. **Current recommendations:** 1. *Same as VI.A.1.* 2. *Monitor risk assessment as part of the comprehensive initial psychiatric assessment and the initial psychological assessment, based on at least 20% sample during the review period.* 3. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

MES	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Same as in VI.A.1 and VI.A.6. **Findings**: *Same as in VI.A.1 and VI.A.6.* **Recommendation 2, September 2009:** *Develop and implement an indicator in the psychiatric update (reassessments) audit to assess if diagnosis was properly updated in response to a review of new clinical data.* **Findings**: As mentioned earlier, the Psychiatric Update Audit was recently revised to include an indicator to specifically assess if diagnosis was updated based on information that became available during the hospitalization. Current data did not reflect this concept, but auditing of this item began in April 2010. **Recommendations 3 and 4, September 2009:** • *Provide data regarding diagnostic accuracy based on at least 20% sample of psychiatric assessments and reassessments during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

			Findings: SEH presented self-assessment data based on the Comprehensive Initial Psychiatric Assessment (CIPA) Audit Tool (August 2009 to February 2010). The target sample size was 20% and the sample used varied from 15% to 23%. The facility did not present weighted averages of the mean compliance rates for the indicators used. The data showed adequate compliance with the indicator regarding the diagnosis reflecting current clinical presentation. The compliance rates were less than adequate for the following indicators: 1. Diagnosis was completed in all axes (50% to 100%); 2. Substance abuse assessment was completed (63% to 100%) and 3. Stage of change for substance use reflected (proper) assessment (30% to 100%). As a corrective action, the facility's Medical Director initiated a periodic report to track completion of diagnosis in all axes. SEH presented data based on the Psychiatric Update (Reassessment) Audit Tool (August 2009 to February 2010). The target sample size was based on conducting reviews of two reassessments per psychiatrist per month (the sample used varied from 2% to 9% of the total reassessments). The facility did not present weighted averages of the mean compliance rates for the indicators used. However, the data indicated adequate compliance rates for the indicators that assessed completion of the diagnosis section and the justification for continued hospitalization. The compliance rates were less than adequate in the following areas: 1. Justification for R/O or NOS diagnosis (33% to 100%) and 2. Justification for deferred diagnosis on Axis II (0% to 100%).

			Using its IRP Observation tool, the facility presented self-assessment data regarding the IRP teams' review of current diagnoses and discussion of the need to update diagnoses. The data showed compliance rates of 39% (December 2009) ND 90% (January 2010). **Recommendation 5 September 2009:** *Provide a summary of findings by the facility's Medical Director regarding internal survey of diagnosis listed as deferred and/or not otherwise specified, including any corrective actions.* **Findings:** The Medical Director presented data showing that all 333 individuals at the facility (as of April 9, 2010) had an Axis I diagnosis, including "no diagnosis." Of these individuals, 27 had a diagnosis listed as "R/O" (only 7 had this diagnosis for more than 90 days), 100 individuals had diagnosis listed as NOS (46 had this diagnosis for more than 90 days) and 7 individuals had a diagnosis listed as "Deferred" (for more than 90 days). These data appeared to show some progress in the finalization of diagnosis compared to previous reviews. **Other findings:** The facility's Medical Director has continued efforts to monitor individuals receiving deferred Axis I diagnosis and diagnoses listed as R/O and NOS. In addition, the Medical Director has initiated a tracking system to assess proper follow up diagnostic assessments on individuals with a high Prostate Specific Antigen (PSA). In collaboration with the Pharmacy Department, the Medical Director has instituted a system for review of individuals diagnosed with hepatitis C to assess follow up and treatment, including precautions regarding the use hepatotoxic psychiatric medications for these individuals.

This expert consultant reviewed the charts of 21 individuals who have received diagnoses listed as NOS or R/O during this reportable period. The review found substantial compliance in 8 charts (LF, GS-2, AW, SS, EG, TR, LF and PS). The remaining 13 charts ranged from partial to non-compliance. The main deficiencies involved the following areas:

1. Efforts to finalize the diagnosis, as clinically indicated;
2. Adequate assessment and/or tracking of the cognitive impairments, as indicated;
3. Justification for current high risk medication regimens, including the discharge of individuals while receiving these medications without adequate after-care plan and/or
4. Alignment of the diagnostic information in the current IRP with the corresponding psychiatric progress notes.

The following table outlines these reviews:

Initials	**Diagnosis**
DM	Dementia, NOS, (neuropsychological testing 7/1/08)
MK	Dementia, S/P Subdural Hematoma
EG	Dementia, NOS
YS	Dementia NOS R/O Delirium/Organic Mental Disorder
LW	Dementia, NOS
LS	Impulse Control NOS
GS	Impulse Control NOS
AF	Impulse Control NOS
SS	Impulse Control NOS
DJ	Impulse Control NOS
ML	Impulse Control NOS

AO	Impulse Control NOS
MR	Psychotic Disorder NOS
EF	Psychotic Disorder NOS
AW	Psychotic Disorder NOS, finalized to chronic undifferentiated schizophrenia
AEH	Cognitive Disorder, NOS
PS	Cognitive Disorder, NOS
DE	Cognitive Disorder NOS/Mental Retardation, Severity unknown
GS-2	Cognitive Disorder NOS
TR	Depressive Disorder NOS
LF	Neuroleptic-induced Movement Disorder, NOS
FF	Neuroleptic-induced Movement Disorder, NOS

Compliance:
Partial.

Current recommendations:
1. *Same as in VI.A.1 and VI.A.6.*
2. *Implement the revised Psychiatric Update (Reassessments) audit to assess if diagnosis was properly updated in response to a review of new clinical data.*
3. *Provide data regarding diagnostic accuracy in psychiatric assessments (20% sample) and reassessments (two per psychiatrist per month) during the review period.*
4. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
5. *Provide a summary of findings by the facility's Medical Director*

			regarding internal survey of diagnostic accuracy, including, but not limited to, diagnosis listed as deferred , R/O and/or not otherwise specified, including any corrective actions.
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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Same as above. **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;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Same as in VI.A.1 to VI.A.3. **Findings:** Same as in VI.A.1 and VI.A.2. **Recommendation 2, September 2009:** *Develop and implemented corrective actions to address the deficiencies outlined in findings 1-12 above. Ensure that these corrections focus on the following main areas:* *a) Consolidation and reorganization of information regarding substance use history to better the inform the assessment;* *b) An update of the assessment by the seventh hospital day*

			following admission to integrate additional information that became available regarding the history of present illness, psychosocial history and risk assessment as well as any additional relevant clinical data and c) *Provision of specific data to address findings in the mental status, including disturbances of thought content, cognitive examination, current suicidal and homicidal ideations/intent/ plan and insight/judgment*. **Findings:** SEH did not adequately address this recommendation. **Other findings:** This expert consultant reviewed the charts of 10 individuals (SS, RM, AWB, AC, TN, GKW, MT, AW, LM and JR) who were admitted during this review period. The reviews found that the comprehensive initial psychiatric assessments were timely in all cases and the content of information has improved compared to the last review. However, a pattern of deficiencies in content was noted in the following areas (in a few of these areas no information was available in most charts): 1. Accurate information on the stage of change in substance use assessment; 2. Past psychiatric history; 3. Prior substance abuse treatment; 4. Medical history; 5. Psychosocial history; 6. Specifics regarding abnormalities of thought content; 7. Rationale for prescribed medications. **Compliance:** Partial.

			Current recommendations: 1. *Same as in VI.A.1 to VI.A.3.* 2. *Develop and implemented corrective actions to address the deficiencies outlined in findings above.*
	VI.A.6	By 12 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
MES	VI.A.6.a	clinically supported, and current assessments and diagnoses are provided for each individual;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VI.A.1, VI.A.3 and VI.A.6.* **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;	**Current findings on previous recommendations:** **Recommendation 1 September 2009:** *Provide documentation of competency-based training of all trainees, including students and residents regarding issues of patient abuse/neglect.* **Findings:** The facility has addressed this area as part of the section regarding protection from harm.

			Recommendations 2 and 3, September 2009: • *Implement corrective actions to ensure attending physicians provided follow up* • *Provide self-assessment data regarding implementation of this requirement.* **Findings:** SEH presented self-assessment data to assess whether the attending psychiatrists have reviewed the trainees' assessments/reassessments and documented a note signifying this review. The facility's data showed less than adequate compliance with the requirement. The facility recognized that, "in far too many cases, a countersignature was still being used by the attending physicians in place of a specific note." As a corrective action, the AVATAR medical records reports were formatted in a manner that facilitates the supervisors' review of the trainees' submission, including the ability to make changes and add any comments before submitting the document as a final. **Other findings:** During this review period, SEH has maintained its facility-based residency training program in Psychiatry and continued to serve as a training site for forensic psychiatry fellows from Georgetown University and residents. In addition, SEH has continued to serve as a training site for psychiatry residents from Howard University and the Uniformed Services University Schools of Medicine as well as medical students from Georgetown University, George Washington University, Uniformed Services University, Ross University, Howard University and the American University of Antigua.

			Chart reviews by this expert consultant confirmed the facility's findings regarding the practice of the attending physicians countersigning the notes by trainees without providing additional documentation. **Compliance:** Partial. **Current recommendations:** 1. *Provide documentation of competency-based training of all trainees, including students and residents regarding issues of patient abuse/neglect.* 2. *Provide self-assessment data regarding implementation of this requirement.*
MES	VI.A.6.c	differential diagnoses, "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are addressed (with the recognition that NOS diagnosis may be appropriate in certain cases where they may not need to be justified after initial diagnosis); and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4.* **Findings:** Same as in VI.A.1, VI.A.2, VI.A.3 and VI.A.4. **Recommendations 2 and 3, March 2009:** • *Provide further CME training to psychiatry staff in the assessment (and management) of cognitive and other neuropsychiatric disorders.* • *Provide documentation of this training, including dates and titles of courses and names of instructors and their affiliation.* **Findings:** During this review period, SEH provided several CME grand rounds to its medical staff (in March 2009) as follows:

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<tr><th>Title</th><th>Speaker</th><th>Affiliation</th></tr>
<tr><td>Diagnosis and Treatment of Drug-induced Movement Disorders in Psychiatric Patients</td><td>John Stiller, MD</td><td>SEH</td></tr>
<tr><td>Schizophrenia, Treatment Resistance</td><td>Robert Conely, MD</td><td>University of Maryland</td></tr>
<tr><td>The Psychiatry of AIDS</td><td>Glenn Treisman, MD</td><td>John Hopkins University</td></tr>
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Other findings:
Same as in VI.A.3.

Compliance:
Partial, improved compared to the last review.

Current recommendations:
1. Same as in VI.A.1, VI.A.2, VI.3 and VI.A.4.
2. Provide further CME training to psychiatry staff in the assessment (and management) 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.
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<tr>
<td>MES</td>
<td>VI.A.6.d</td>
<td>each individual's psychiatric assessments, diagnoses, and medications are clinically justified.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2009:
Same as in VI.A.1 through VI.A.6.a and VI.6.c

Findings:
Same as in VI.A.1 through VI.A.6.a and VI.6.c</td>
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			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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Refine the template for the psychiatric update to address PRN medication use.* **Findings:** SEH elected not to include a field to address the use of PRN medication because the hospital's policy required that only Stat medications be given if an additional psychiatric medication was indicated. Although the policy's requirement was appropriate, this recommendation was made because the hospital's policy was not consistently followed by the practitioners (during the previous review period). The facility presented data based on the Medication Monitoring and Chart review Audit showing that PRN (psychotropic) orders were used only once during this review period (August 2009 to February 2010). However this report conflicted with other reports provided by the facility regarding the use of PRN psychotropic medications (see section X.F.1). **Recommendation 2, September 2009:** *Ensure consistent implementation of the new template for the psychiatric update.* **Findings:** SEH reported that the template for the Psychiatric Update was implemented in all units of the facility. The instructions for this

			template were completed and accessible to staff on the intranet. The facility planned to incorporate this template within AVATAR during the next review period. **Recommendation 3, September 2009:** *Develop and implemented corrective actions to address the deficiencies outlined [in this cell in the previous report]. Ensure that these corrections focus on the following main areas:* *a) Interval history is consistently addressed;* *b) PRN medications are reviewed and regular treatment is adjusted, as clinically appropriate, based on this review;* *c) The sections regarding special risks of treatment (benzodiazepines, anticholinergics, antipsychotics and polypharmacy) as well as use of restrictive interventions are properly completed;* *d) The assessment section adequately addresses current risk factors as well as risks/benefits of treatment and* *e) There is timely and appropriate referral for behavioral interventions when indicated and integration of pharmacological and behavioral interventions as applicable.* **Findings:** The facility's data based on the Psychiatric Update Audit has addressed the above-mentioned items. The facility's data and findings by this expert consultant (see other findings below) indicate that more work is needed to ensure adequate corrections. **Recommendation 4, September 2009:** *Same as in VI.A.1.* **Findings:** *Same as in VI.A.1.*

			Other findings: This consultant reviewed the charts of 10 individuals (SS, RM, AWB, AC, TN, GKW, MT, AW, LM and JR) who were admitted during this review period. The reviews found a pattern of deficiencies in the following areas: 1. Clinical flow of information in the reassessments; 2. Individuals' progress during the interval of review; 3. Information regarding rating instruments, when clinically indicated; 4. Specifics regarding current target symptoms; 5. Specifics regarding abnormalities of thought content; 6. Rationale for prescribed medications; 7. Consideration of behavioral interventions, when indicated and 8. Plan of care based on a review of the individuals' progress. **Compliance:** Partial. **Current recommendations:** 1. *Develop and implemented corrective actions to address the deficiencies outlined in findings above, including streamlining of the information in the updates to improve clinical flow;* 2. *Same as in VI.A.1.*

	B. Psychological Assessments		
RB			**Methodology:** Interviewed: Richard Gontag, PhD Reviewed: 1. Psychology Evaluation Policy 2. Psychology Evaluation Audit Tool and Instructions 3. Initial Psychological Assessment Monitoring Tool and Instructions 4. Audit Data from IAP 5. Medical Records: KB, JF, NH, DA, GS, SF, JR, LS, GD, JP, AA, KH, JH, FH, SS, EC, DM, CD, TS, AW, JR, ML, BW, MW, FF, KY, LD, JB, MS, AWB, SS, BG and MK
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Present all auditing data in trended fashion and not as six-month summaries. **Findings:** Auditing data is currently only available on the Initial Psychology Assessment (IPA). These data were presented as trended data. Trends appeared to indicate that timely completion appeared to be getting worse between April 2009 and March 2010, although an increase to 80% in March 2010 may mark the beginning of a positive upward trend. An auditing form has been piloted for other psychological assessments but was reported to to undergoing revisions. **Recommendation 2, September 2009:** Develop a FTE for neuropsychology.

			Findings: This has been accomplished through the hiring of an additional half-time position. **Recommendation 3, September 2009:** Complete the roll out for additional audit tools. **Findings:** No specific plan for the implementation of the audit for other psychological assessments was provided. **Other findings:** The DOJ psychology content expert reviewed the 10 most recent psychological evaluations (other than IPAs) that were provided in the advance documents. Six of these were psychological evaluations concerned with general psychological functioning other than the assessment of risk. Those six evaluations were reviewed with the current auditing tool that has been piloted. Scoring was either Met or Not Met and percentage compliance to the instructions for psychology evaluations was computed on the basis of 34 separate indicators as per the monitoring tool. Overall compliance scores ranged from 76-85%. Of note, none of these six evaluations was completed within the 30 day timeframe stipulated in policy. **Compliance:** Partial. **Current recommendations:** 1. Determine the barriers to the timely completion of IPAs, both Part A and Part B and implement appropriate corrective action plan. 2. Implement the audit of all other psychological assessments including neuropsychological assessments according to the instructions in Cell V.B.9.

			3. Continue to present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
	VI.B.2	By 24 months from the Effective Date hereof, all psychological assessments shall:	Please see sub-cells for findings and compliance.
RB	VI.B.2.a	expressly state the purpose(s) for which they are performed;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** A review of the last 10 psychological and neuropsychological evaluations submitted with the advance document request found that this standard continues to be met. However, the hospital will only have confidence that this standard can continue to be met by implementing an auditing process for all psychological assessments, something that has only been piloted to date. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Begin auditing process according to instructions in Cell V.B.9. 3. Present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target

			population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.b	be based on current and accurate data;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** A review of the last 10 psychological and neuropsychological evaluations submitted with the advance document request found that this standard continues to be met. However, the hospital will only have confidence that this standard can continue to be met by implementing an auditing process for all psychological assessments, something that has only been piloted to date. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Begin auditing process according to instructions in Cell V.B.9. 3. Present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.c	provide current assessment of risk for harm	**Current findings on previous recommendation:**

		factors, if requested;	**Recommendation, September 2009:** Maintain current level of practice. **Findings:** In both the Risk Assessments and the IPAs reviewed, appropriate attention was paid to risk factors, and the hospital's data on the from the IPA audit demonstrated substantial compliance with regard to this item. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Begin auditing process for Risk Assessments according to instructions in Cell V.B.9. 3. Present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.d	include determinations specifically addressing the purpose(s) of the assessment; and	**Current findings on previous recommendation:** **Recommendation, September 2009:** Revise guidelines for Recommendations section of IPA to include recommendation of specific groups from the Mall Catalogue. **Findings:** The instructions were not revised. Additionally, because of the time

			lag frequently found between the completion of Part A and the completion of Part B, recommendations made after completion of Part B were typically not available to the IRP team for treatment planning purposes in a timely fashion. On the other hand, non-IPA psychological evaluations that were reviewed demonstrated in all cases that the referral question was appropriately addressed by the evaluation. **Compliance:** Partial. **Current recommendations:** 1. Revise the guidelines for Recommendations section of IPA to include recommendation of specific groups from the Mall Catalogue for both parts A and B. 2. Begin auditing process for non-IPA psychological evaluations according to instructions in Cell V.B.9. 3. Present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.2.e	include a summary of the empirical basis for all conclusions, where possible.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current level of practice. **Findings:** A review of the last 10 psychological and neuropsychological evaluations submitted with the advance document request found that this standard continues to be met. However, the hospital will only have confidence

			that this standard can continue to be met by implementing an auditing process for all psychological assessments, something that has only been piloted to date. **Compliance:** Substantial. **Current recommendations:** 1. Maintain current level of practice. 2. Begin auditing process for non-IPA psychological evaluations according to instructions in Cell V.B.9. 3. Present auditing data in trended format. 4. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VI.B.3	By 24 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at SEH shall be reviewed by qualified clinicians and, if indicated, referred for additional psychological assessment.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Implement timeline. **Findings:** All individuals who need such assessments have been identified, reviewed by a qualified clinician and referred for additional assessment where appropriate. **Recommendation 2, September 2009:** Begin auditing process. **Findings:**

			No longer applicable. **Compliance:** Substantial. **Current recommendations:** None needed.
RB	VI.B.4	By 24 months from the Effective Date hereof, appropriate psychological assessments shall be provided, whenever clinically determined by the team.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current level of practice. **Findings:** While all individuals still needing IPAs due to the fact that their date of admission preceded implementation of the new IPA process have been identified, no plan has been presented as to by what time those individuals will have a completed psychological assessment in their medical record. With regard to other types of psychological assessments/evaluations, data was presented that indicated that for the past several months, all evaluations have been completed within the 30-day requirement set forth in policy when ***mean time to completion*** was used as the measure. This is, however, not an appropriate manner in which to measure this aspect of the Agreement. Rather, data should be presented in terms of the **percentage of assessments per month that were completed within the 30-day time limit**. Presenting the data in this format will underscore the problems found on review of the timeliness of completion of these assessments during the May tour, as not one of the six reviewed psychological assessments was completed within the appropriate time period and only 20% of the reviewed neuropsychological evaluations were completed within a 30 day period.

			Finally, it was indicated that the ***mean time to completion*** had shown a decline over the period of the reported data, and it was suggested by the Psychology Chief that this was likely due to the fact that trainees are relied upon for completion of many of these assessments. The idea expressed was that, as trainees gain skill over time, they show an improvement in their ability to complete these assessments more efficiently. This is no doubt true, but the hospital will need to sort out training needs from the clinical needs of the individuals in their care to determine appropriate priorities when these two issues do not readily converge. **Compliance:** Noncompliance. Note that VI.B.3 above was changed to Substantial Compliance in agreement with the hospital that the identification process referenced in that cell has been completed. That change forces this cell to have a rating of Noncompliance due to the fact that no timeline for completing the assessments identified in Cell VI.B.3 has been developed and due to the lack of a better auditing process to overcome problems with the timeliness for the completion of psychological assessments more generally. **Current recommendations:** 1. Present data on the timeliness of psychological assessments as the percentage of assessments per month that were completed within the 30-day time limit. 2. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance

			with plans of correction. Supporting documents should be provided.
RB	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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Implement process for assuring 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. **Findings:** This process was begun but the form was only found in one reviewed record, and it was signed but not filled out. Implementation of an auditing tool will allow this process to be easily monitored and necessary improvements to be made. **Recommendation 2, September 2009:** Begin auditing process. **Findings:** Auditing has not begun. **Recommendation 3, September 2009:** Present all results as trended data. **Findings:** Auditing has not begun. **Compliance:** Partial. **Current recommendations:** 1. Begin auditing process according to instructions in Cell V.B.9..

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

	C. Rehabilitation Assessments		
RB			**Methodology:** Interviewed: Crystal Robinson, MT-BC Reviewed: 1. Medical Records: TS, AW, JR, ML, BW, MW, FF, KY, LD, JB, DJ, JW, JC 2. Rehabilitation Service Assessment Self-Audit Results
RB	VI.C.1	When requested by the treatment team leader, or otherwise requested by the treatment team, SEH shall perform a rehabilitation assessment, consistent with the requirements of this Settlement Agreement. Any decision not to require a rehabilitation assessment shall be documented in the individual's record and contain a brief description of the reason(s) for the decision.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Complete a Needs Assessment for RS staffing and provide a staffing plan specific to the RS Department with indications of when outstanding positions will be filled. **Findings:** The hospital has agreed to complete the staffing for the RS Department, but was able to provide no timeline for filling the 5 current vacancies. **Recommendation 2, September 2009:** Present SRA audit data both for all patients and broken down by division. **Findings:** With the move to the new hospital, there are no longer two divisions, so this recommendation is no longer relevant. **Recommendation 3, September 2009:** Present all auditing results as trended data.

			Findings: Data has been presented as trended data. **Recommendation 4, September 2009:** Develop guidelines for all clinical disciplines concerning the minimum number of mall treatment groups that must be provided by each discipline per week. **Findings:** These guidelines have been developed. **Other findings:** While auditing data from the RSA shows generally positive trends in compliance with this provision of the Agreement, auditing data has been inconsistent over the past six months with some elements of the RSA being under 30% over more than one month. **Compliance:** Partial. **Current recommendations:** 1. Maintain current level of practice in those areas where significant progress has been achieved, and develop a corrective action plan for those areas of the RSA that clinicians are having more trouble completing in the expected manner. 2. Present a summary of the aggregated monitoring data for the RSA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

RB	VI.C.2	By 24 months from the Effective Date hereof, all rehabilitation assessments shall:	Please see sub-cells for compliance findings.
RB	VI.C.2.a	be accurate as to the individual's functional abilities;	**Current findings on previous recommendation:** **Findings:** Both the hospital's data and a review of records on the May 2010 tour are in accord that this element is accurately found in over 90% of RSAs. **Other findings:** The RS Department cooperated with Mall Services to functionally assess all individuals prior to their assignment to groups in the treatment malls. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VI.C.2.b	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	**Current findings on previous recommendation:** **Findings:** Both the hospital's data and a review of records on the May 2010 tour are in accord that this element is not being well assessed in the RSA on a regular basis. Indeed, data trends appear to show a decline in the quality of the RSA with respect to this element between August 2009 and February 2010. **Compliance:** Partial.

			Current recommendation: Determine what obstacles prevent RS staff from accurately completing this section of the RSA and institute appropriate corrective action plan.
RB	VI.C.2.c	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	**Current findings on previous recommendations:** **Findings:** Data trends regarding this element of the RSA, along with medical record review during the May 2010 tour, found that this element was trending in the right direction, but was not consistent over the past six months, for example falling to only 43% in 12/09 and to 75% in 11/09. **Compliance:** Partial. **Current recommendation:** Continue current level of practice with attention to data trends and the development of corrective action plans if necessary.
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.	**Current findings on previous recommendations:** **Findings:** Data presented by the hospital indicated that this indicator was trending in the appropriate direction and was above 80% for 5 of the past 7 months. Additionally, chart reviews conducted during the May 2010 monitoring tour found that suggested objectives for the IRP contained in the RSA consistently met the criteria for being behavioral, measureable and concrete. **Recommendation 2, September 2009:** Revise instructions for Recommendations section of SRA to include recommendations for specific groups from the Mall Catalogue.

			Findings: This was not done. **Compliance:** Partial. **Current recommendations:** 1. Maintain current level of practice. 2. Revise instructions for Recommendations section of SRA to include recommendations for specific groups from the Mall Catalogue.
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Continue current practice for mall services for post-trial patients and on-unit services for pre-trial patients. **Findings:** Completed **Recommendation 2, September 2009:** Provide a date by which SRAs will be completed on all previously admitted patients. **Findings:** The RS Department has completed the assessment of all individuals admitted prior to the implementation of the new RSA. **Compliance:** Substantial. **Current recommendations:**

			None needed.

	D. Social History Assessments		
RB			**Methodology:** Interviewed: 1. Harriett Moore, LCSW 2. Clo Vidoni Clark, PhD Reviewed: 1. Medical Records: TS, AW, JR, ML, BW, MW, FF, KY, LD, JB 2. SWIA Audit Data Observed: 1. IRP Conference for DJ, 05/25/10 2. IRP conference for JC 263925, 05/26/10 3. IRP Conference for JW 268184, 05/27/10
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	**Current findings on previous recommendation:** **Recommendation, September 2009:** Demonstrate that a proper sample size was used for each audit. **Findings:** Sample size will be determined by instructions in Cell V.B.9. **Other findings:** Data indicates that the SWIA is not showing acceptable levels of compliance in many areas. Those areas where substantial progress is being made and maintained are limited to: Description of Discharge Barriers; Identification of Skills Needed at Discharge and Descriptive Identification of Discharge Needs. No analysis of these findings was provided by the hospital. **Compliance:**

			Partial. **Current recommendations:** 1. Identify barriers to acceptable completion of the SWIA and impairment corrective action plan. 2. Present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	VII. Discharge Planning and Community Integration		
MLS		Taking into account the limitations of court-imposed confinement and public safety, SEH, in coordination and conjunction with the District of Columbia Department of Mental Health ("DMH") shall pursue the appropriate discharge of individuals to the most integrated, appropriate setting consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the District and the needs of others with mental disabilities.	**Summary of Progress:** 1. The hospital has continued to reduce its inpatient census. 2. Since the last review, there has not been significant progress in addressing the needs of individuals with housing and/or nursing home barriers; the number of individuals considered "resistive to discharge" has increased. 3. The establishment of regular "Community Integration Meetings" involving high level DMH, SEH and Community agencies to review "discharge ready individuals" is one mechanism to ensure ongoing review. In order for this meeting to be effective, there must be clarity with regard to attendance, chairmanship, documentation including minutes and follow up procedures with specific implementation dates and identified staff responsibilities. 4. There continues to be a lack of clarity among IRP team members about the proper flow from individually specific discharge criteria to appropriate foci of hospitalization, measurable and behavioral objectives and appropriate interventions. 5. There is a lack of clarity and role confusion concerning the arrangement of community services and supports for discharge ready consumers among SEH social workers, DMH and community agencies (CSAs). The (draft) SEH Discharge Planning Process must be finalized, implemented and monitored for compliance. 6. The hiring of SEH peer specialists to work with "resistive" SEH consumers is a positive step if their roles are clearly understood and supported by hospital staff. 7. The hospital discharge plan of care instructions is a reasonable tool to convey discharge information and to provide a means of monitoring compliance. The discharge plan of care must be provided to the CSA or other primary community agency in addition to the consumer being discharged as well as to DMH. 8. The SEH Social Work department requires significant attention given their key role in discharge planning with regard to sufficient

			staffing, understanding of community resources and receiving support in mitigating barriers to discharge for consumers. 9. There is no identified process for resolving clinical disagreements between hospital and community agencies with regard to discharge planning/community placements.
MLS			**Methodology:** Interviewed: 1. Jana Berhow, Director of Integrated Care, DMH 2. Josh Greene, Clinical Director, Pathways 3. Jack Kline, Clinical Director, Community Connexions 4. Harriet Moore, Social Work Supervisor/Director, SEH 5. Clo Vidani-Clark, Director of Treatment Programs, SEH 6. Andres Marquez-Lara, Director of Consumer Affairs, SEH 7. Katrina Carter, Social Worker, Admissions Unit, SEH Reviewed: 1. The charts of current and discharged consumers: JM, JH, LB, AH, JA, YS, NM, HH, EC, SA, MJ, SA, JT, RH, AH, TT, CB and DH 2. The discharge audit/log for post thirty day discharges of JM, RH and SA 3. SEH Compliance Report Tab #1, Coaching Guidelines 4. SEH Compliance Report Tab #2, IRP Consultant Contract 5. SEH Compliance Report Tab #8 IRP Monitoring Observation Tools 6. SEH Compliance Report Tab #9 IRP Audit Report 7. SEH Compliance Report Tab #62 Barriers to Discharge 8. SEH Compliance Report Tab #67 Discharge Audit Tool 9. SEH Compliance Report Tab #68 Discharge Audit Results 10. SEH Compliance Report Tab #69 Treatment Programming Information 11. SEH Compliance Report Tab #72 Discharge Weekly Meeting Activity Log

			12. SEH Compliance Report Tab #73 DMH Hospital Discharge Support Audit Results 13. SEH Compliance Report Tab 78 Resistive Patients Tracking Audit 14. SEH Compliance Report Tab #45 Discharge Planning/Community Integration Self Auditing Tool with indicators and operational instructions 15. SEH Compliance Report Tab # 46 List of individuals who met discharge criteria and are still hospitalized 16. SEH Compliance Report Tab #47 List of individuals who have met discharge criteria in the last six months 17. DMH Continuity of Care Form for Consumers Admitted to SEH 18. SEH Pilot Monitoring Tool for Discharge Plan of Care 19. DMH Draft Division of Integrated Care Standard Operating Procedures, dated 5/10/2010 <u>Observed</u>: 1. DMH-SEH Community Integration Meeting 2. Team Meeting of 1D for IRP review of MJ 3. Team Meeting of Annex for IRP review of RH 4. Treatment Learning Community during transition time (end of day) and during active period (late morning)xxx
MLS	VII.A	By 12 months from the Effective Date hereof, SEH, in conjunction and coordination with DMH, shall identify at admission and consider in treatment planning the particular factors for each individual bearing on discharge, including:	**Previous Recommendations, September 2009:** 1. Revise IRP training program to ensure that it contains conceptual clarity on how to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measurable and behavioral objectives and appropriate interventions. 2. Assure that training includes how to clearly document these processes in the IRP. **Current Findings:** 1. The previous recommendations have not been implemented.

			2. The IRP process does not clearly reflect a focus on the specific interventions that support discharge; the focus continues to rely primarily on psychiatric symptomatolgy. There must be specific training with regard to how to develop effective discharge plans – the development of specific consumer objectives and skills, identification of measurable interventions, participation in specific activities that develop these skills, transitioning to community services and discharge. All of these interventions and activities need to have specific timelines. Once the training is implemented, monitoring guidelines must be developed and practice observed/coached. **Current Recommendations:** 1. Previous recommendations must be implemented immediately. 2. The hospital must develop and implement training for clinical staff with regard to how to develop effective discharge plans. 3. The hospital must develop monitoring guidelines to ensure that the training occurs. 4. The hospital must provide coaching to ALL unit staff with regard to how to develop appropriate discharge plans. **Compliance:** Non-compliance
MLS	VII.A.1	those factors that likely would result in successful discharge, including the individual's strengths, preferences, and personal goals;	**Previous Recommendations, September 2009:** 1. Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measurable and behavioral objectives and appropriate interventions. 2. Assure that training includes how to clearly document these

			processes in the IRP. 3. Modify audit tools to reflect this training. **Current Findings:** 1. The IRP does include a section that documents the identification of an individual's strengths, preferences and personal goals. 2. Previous recommendations have not been implemented. 3. There was some evidence at two IRP meetings that the treatment teams identify personal goals and preferences. However, these factors were not integrated within the clinical and behavioral interventions at the IRP meetings. **Current Recommendations:** See VII.A **Compliance:** Non-compliance
MLS	VII.A.2	the individual's symptoms of mental illness or psychiatric distress;	**Previous Recommendations, September 2009:** 1. See VII.A.1. **Current Findings:** 1. SEH focuses on individual symptoms of mental illness, but does not integrate the assessments into specific behavioral and clinical interventions designed for effective discharge planning. 2. The weakness of the IRP process is the lack of integration of the assessment and diagnosis, including symptoms of mental illness, into identifying specific behavioral and clinical interventions that ready individuals for transitioning to the community and discharge planning. **Current Recommendations:**

			See VII.A. and VII.A.1 **Compliance:** Partial
MLS	VII.A.3	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previous unsuccessful placements, to the extent that they are known; and	**Previous Recommendations, September 2009:** See VII.A.1. **Current Findings:** 1. See VII.A, VII.A.1 and VII.A.2 2. The hospital and DMH monitor barriers to discharge in several ways, including the high level Community Integration Meeting and the creation of multiple discharge ready lists. 3. There is a lack of agreement among DMH, SEH and community providers as to roles, processes and procedures to ensure successful community discharge. 4. Individuals with mental retardation with funding identified continue to wait for community placements. **Current Recommendations:** 1. Implement previous recommendations. 2. SEH and DMH must focus on: housing placement issues; resistive to discharge and nursing home barriers. 3. DMH must advocate with DDS/DMR to accelerate discharges of individuals with mental retardation. 4. SEH must specifically identify "resistive to discharge" issues including but not limited to: staff ambivalence, family ambivalence, disagreement between the community and hospital, client reluctance and identify specific strategies for addressing each issue. A monitoring tool must be developed to ensure appropriate resolution of each individual consumer issue. 5. The Community Integration meeting must clarify membership/attendance, chairmanship, maintain minutes

			and follow up processes with specific staff roles and timelines. This meeting should serve as the forum to identify clinical disagreements and barriers to placement between the community and SEH regarding discharge plans. 6. The multiple lists of consumers ready for discharge, discharge logs and barriers to discharge must be consolidated into one log utilized by all relevant parties with discharge barrier identified, action steps, timelines and staff identified. 7. SEH Hospital Discharge Planning process must be finalized immediately, implemented and agreed to by DMH, its certified community providers and SEH staff. **Compliance:** Partial
MLS	VII.A.4	the skills necessary to live in a setting in which the individual may be placed.	**Previous Recommendations, September 2009:** See VII.A. and VII.A.1. **Current Findings:** 1. The previous recommendations have not been implemented. 2. According to the hospital's own report and based upon this consultant's observations and record reviews, IRPs do not reflect a focus on interventions that will support discharge. Data from November and December, 2009 discharge audits show poor documentation and/or provision of transitioning assistance and psychosocial rehabilitation to support successful skills for community living. 3. The new hospital's Treatment Learning Community (TLC) structure provides a physical plant that should allow for the design and operation of activities for psychosocial rehabilitation and community integration. 4. There is no clear linkage of individual skills necessary for community integration with specific TLC

			activities/programs. 5. There is not a coherent system of transitioning consumers from the hospital to the community and the skills necessary to be successful. **Current Recommendations:** 1. See VII.A , VII.A.1, VII.A.2 and VII.A.3 2. SEH must promptly identify the specific treatment and/or rehabilitation goals for each activity/program provided at the TLC. Each and every program must correspond to a specific, individual skill, behavior or symptom. 3. Working with DMH and community agencies, SEH must identify and implement transitional activities for individuals considered discharge ready.. These activities must include transportation to and from SEH and community programs. **Compliance:** Non-compliance.
MLS	VII.B	By 12 months from the Effective Date hereof, SEH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be a participant in the discharge planning process, as appropriate.	**Previous Recommendations, September 2009:** 1. See VII.A. and VII.A.1. **Current Findings:** 1. The hospital has made progress in incorporating the individual into the IRP process with regard to their personal goals and treating the individual with respect and dignity. 2. See all earlier findings (entire section VII.A) with regard to IRP process and discharge planning. 3. There is a difference between consumer attendance and participation. As witnessed by this expert, treatment teams are at the early stages of actively engaging the consumer in the IRP meetings.

			Current Recommendations: 1. Coaching on how to actively engage the consumer in the discharge planning process must be extended to all treatment teams and must focus on individual engagement. 2. Treatment teams must encourage the individual to actively participate in the team process. 3. Treatment teams must actively solicit the engagement of relevant and identified stakeholders, including family, community agencies and peer specialists in this process. **Compliance:** Partial
MLS	VII.C	By 12 months from the Effective Date hereof, SEH shall ensure that each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:	**Previous Recommendations, September 2009:** 1. See VII.A. and VII.A.1 **Current Findings:** 1. The IRP contains a section (Focus 6) entitled Community Integration. The needs to be addressed and objectives must be written in measurable, specific objectives with specific timelines. The interventions must directly correlate to the treatment objectives that lead to discharge. **Current Recommendations:** 1. See all of section VII.A. and VII.B recommendations **Compliance:** Partial
MLS	VII.C.1	measurable interventions regarding his or her particular discharge considerations;	**Previous Recommendations, September 2009:** 1. See VII.C. 2. Clarify how discharge criteria are to be presented in the IRP. **Current Findings:**

			1. The interventions in the IRP do not reflect the specific community intervention objectives. Only one record reviewed had measurable objectives that were specific and the interventions listed correlated back to the objectives. 2. SEH staff involved in IRP need training or coaching to differentiate between "skill building" and "treatment" interventions. **Current Recommendations:** 1. See VII.A, VII.A.1 and VII.C 2. The TLC activities need to clearly identify the learning, skill building or treatment goals for each activity in order for SEH staff to appropriately identify the individuals to attend which activities and for what purpose. **Compliance:** Partial
MLS	VII.C.2	the persons responsible for accomplishing the interventions; and	**Previous Recommendations, September 2009:** 1. The IRPs reviewed clearly indicated staff responsible for specific interventions. 2. Continue audit process. 3. If compliance rate does not increase, determine and address barriers to successful completion of this item. **Current Findings:** 1. Records reviewed and IRP meetings observed indicate that specific staff are identified. **Current Recommendations:** 1. Treatment interventions and rehabilitation services must be implemented in response to specific treatment goals. See earlier recommendations around IRP processes.

			Compliance: Substantial
MLS	VII.C.3	the time frames for completion of the interventions.	**Previous Recommendations, September 2009:** 1. Same as VII.C.2 **Current Findings:** 1. There are no time frames noted for the completion of specific interventions. These timeframes are open ended as noted in the records and as observed in the IRP processes. The presumption is that the timeframe is either 30 or 60 days (until the next IRP meeting). 2. There is no sense of urgency in the implementation of interventions to accelerate community placements. **Current Recommendations:** 1. The IRP format must include specific timeframes for completion of interventions. 2. A monitoring tool must be developed to monitor the implementation of time specific interventions. **Compliance:** Non-compliance
MLS	VII.D	By 12 months from the Effective Date hereof when clinically indicated, SEH and/or DMH shall transition individuals into the community where feasible in accordance with the above considerations. In particular, SEH and/or DMH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	**Previous Recommendations, September 2009:** 1. Develop and implement an auditing tool that monitors progress in the establishment and success of these skills-based interventions. 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. 4. Report as trended data analysis. 5. Provide target dates for all above recommendations. **Current Findings:**

			1. There are no established auditing tools that monitor progress towards developing the skills necessary for transitioning into the community. Previous recommendations have not been implemented. 2. There is no coherent plan or process in place that delineate the steps to transitioning individuals from the hospital to community. Now that the hospital has moved into its new building, it must focus on the psychosocial rehabilitation services that are necessary to facilitate appropriate skill development, transitioning activities and discharge to the community. 3. The hiring of peer specialists may be an important component to helping individuals transition, but only if their role is incorporated and understood within the hospital and community. 4. The focus at SEH has been on discharge rather than transition. Both are necessary to ensure successful community integration. **Current Recommendations:** 1. See all of section VII.A 2. The hospital must focus on creating psychosocial rehabilitation services that facilitate an individual's successful discharge to the community. 3. These services must be linked to specific, individual skills that are delineated in the IRP. **Compliance:** Non-compliance
MLS	VII.E	Discharge planning shall not be concluded without the referral of an individual to an appropriate set of supports and services, the conveyance of information necessary for discharge, the	**Previous Recommendations, September 2009:** 1. Develop requirements for a SW progress note to follow each of these meetings regarding patients resistive to discharge.

		acceptance of the individual for the services, and the discharge of the individual.	2. Expand the auditing tool for the form to include an audit of the SW progress note. **Current Findings:** 1. A social work note is one small, albeit important part of appropriate discharge planning. 2. The hospital social work department is understaffed to perform its functions relative to community integration and discharge planning. At the time of this survey, the social work department had 7 FTE vacancies; two FTEs had recently been approved for hiring. 3. According to the hospital's own report and this consultant's review of records and observations, there is no documentation that reflects an internal hospital feedback loop of the decisions made at the Community Integration Meetings are distributed to the social work and clinical administrators and to others involved in community integration and discharge decisions. This lack of clarity has led to the development of multiple lists of individuals and fragmented strategies to identify and resolve "barriers" to community integration. 4. The hospital identified that in a record review of 4 cases, there was "no documentation that the community case manager work with the hospital to effect discharge". Based upon this consultant's interviews, observations both in the community and hospital, and record reviews, there is a significant lack of shared responsibility for discharge planning between community agencies and hospital social workers. Hospital social workers are directly arranging for community supports and services for individuals without the support of CSAs and other certified providers and without full understanding of the range and specialty of community supports.

			5. There is no process identified to resolve clinical disagreements between CSA and other community providers and hospital social work staff to ensure integrated transitioning and discharge planning for individuals. 6. There is no process to ensure that hospital social work staff receive current and updated information on the range and type of community services available, the skill level needed for each service type and clinical appropriateness. 7. DMH and SEH have implemented various strategies to work on discharge planning (peer specialists, Community Integration Meeting); however, these initiatives are not implemented in an organized and coherent manner so that all parties fully understand how each strategy or initiative fits together into the successful discharge of individuals. **Current Recommendations:** 1. SEH social work department must have a sufficient level of staffing to meet the clinical needs, including discharge planning of individuals. The hospital must clarify the organizational structure, number and roles of social work in the new hospital setting. 2. SEH's Hospital Discharge Planning Process (draft 4/2010) must immediately be reviewed, revised and implemented. SEH, DMH and its certified providers must be in agreement with each respective role. 3. SEH Social Work Department must incorporate orientation to community services and develop (or receive) written materials describing the range of community services and supports available for individuals as well as the skills and clinical appropriateness of individuals for each service type. 4. Under the leadership of DMH, a process for resolving clinical (and administrative disputes) between its community agencies and SEH must be developed immediately. A quality

			assurance mechanism must be developed and implemented to identify systemic or individual issues. **Compliance:** Non-compliance
MLS	VII.F	By 12 months from the Effective Date hereof, SEH and/or DMH shall develop and implement a quality assurance/improvement system to monitor the discharge process and aftercare services, including:	**Previous Recommendations, September 2009:** 1. Complete training of auditors. 2. Update tracking system as appropriate. **Current Findings:** 1. DMH has developed and implemented a system of monitoring of individuals 30, 60 and 90 days post discharge. This process commenced in January, 2010 and continues. See VII.F.1 findings and recommendations. **Compliance:** Substantial
MLS	VII.F.1	developing a system of follow-up with community placements to determine if discharged individuals are receiving the care that was prescribed for them at discharge; and	**Previous Recommendations, September 2009:** 1. Work with MHA to revise audit so that all aspects of the Agreement relative to discharge and follow-up of discharged patients are included in the audit tool. 2. Provide target dates and timelines for completion of this process as it was supposed to have been completed within 12 months of the signing of the Agreement. **Current Findings:** 1. A monitoring system has been developed by DMH to follow individuals 30, 60 and 90 days post discharge. This monitoring is triggered based on DMH receiving a completed discharge plan of care. SEH has a pilot audit tool for the discharge plan of care (adopted in March 2010). 2. The DMH audit tool has been implemented since the last survey/visit of September 2009. The SEH monitoring tool

			is in pilot stages, is in the process of revision and at the time of visit had only been utilized for one record. 3. Of four recently (April discharged) requested reviews, only three could be provided by DMH. There was no discharge plan of care received by DMH for one individual. 4. The SEH monitoring tool for discharge plan of care is a pilot. **Current Recommendations:** 1. The monitoring tool must include a check off that confirms that the discharge plan of care was submitted to DMH. 2. The monitoring tool for the discharge plan of care must be implemented on a very timely basis for all records in order to ensure that there is follow up on all discharges. A process for ensuring compliance must be developed. 3. SEH must review and finalize promptly the pilot monitoring tool for discharge plan of care (adopted March 2010) and the Discharge/Outplacement Quality Assessment tool to ensure consistency, eliminate any redundancies and/or to achieve any efficiency in implementation. **Compliance:** Partial
MLS	VII.F.2	hiring sufficient staff to implement these provisions with respect to discharge planning.	**Previous Recommendations, September 2009:** 1. Hire the necessary staff to ensure that this item can be accomplished. **Findings:** 1. See VII.F.1 2. There is sufficient staff to implement monitoring/quality assurance activities within SEH. **Compliance:**

			Substantial

	VIII. Specific Treatment Services		
MES, RB and LDL			**Summary of Progress:** 1. SEH has maintained substantial compliance with the requirement regarding psychiatric staffing levels. 2. Although still short of substantial compliance, SEH has made relative progress in decreasing certain types of high risk medication uses (e.g. polypharmacy and use of benzodiazepines for individuals suffering from cognitive impairments). 3. Although more is needed to improve data aggregation and analysis, SEH has made progress in self-assessment of medication use practices using a variety of adequate monitoring tools. The self-assessment report included a candid assessment of current status and some corrective measures needed to move towards compliance. 4. SEH has improved compliance by its practitioners with the current policy regarding the use of emergency medications, including the documentation of face-to-face assessments upon this use. 5. SEH has improved the content of its medication guideline regarding the use of clozapine. 6. SEH has implemented adequate data collection tools to capture adverse drug reactions and medication variances. 7. Although more work is needed to increase reporting of adverse drug reactions (ADRs), SEH conducted an adequate intensive case analysis of one ADR that met severity threshold for this analysis. 8. Although more work is needed to improve variance reporting, SEH conducted an adequate analysis of the root causes of medication variances related to documentation of the administration of medications. The analysis resulted in useful information that can improve medication room practices if properly implemented.

			9. The treatment malls are operating with a high degree of efficiency despite the recent move to the new building. 10. Psychology has instituted an Initial IRP Behavioral Intervention to help increase the capacity for providing timely behavioral interventions when requested by the IRP team, but overall implementation of behavioral services continues to be hampered by the fact that the PBS team has not been fully constituted. 11. SEH is to be commended for the well planned and executed move to the new building. The extensive preparation of both individuals in care and staff was evident during the tour. 12. The CNE has led significant changes in nursing management, including the addition of after-hours house supervisors and two ADONs. In addition, he has led enhanced role clarification for Nursing Managers in the "houses" (units). In numerous instances, he was acutely aware of and anticipated observations of concern. In a pro-active manner he shared plans/efforts to address issues. 13. In a meeting with all of nursing leadership, it was apparent that they were extremely timely in actively problem solving operational issues that were understandably emerging in the new building unit and TLC areas. They are committed to moving forward and sensitive to the challenges associated with integrating staff from former civil and forensics units. 14. The CNE has established a Director of Nursing Education and Research under whose leadership significant advancements have been made in competency based training. The advancements include the development and utilization of a nursing skills lab with well articulated goals for each of the learning stations. 15. The CNE expressed the belief that the nursing department is on the cusp of significantly accelerated improvement. As I noted in the exit conference, there were many indications of

			progress. Nevertheless, post visit document review revealed a number findings for which recommendations are made in this report. Addressing the findings through the recommendations offered or through other actions selected by SEH will support the significantly accelerated improvement that the CNE expects. 16. SEH has increased the NCHPPD to 5.37 and also reported that at least one RN worked on each unit/each shift since January, 2010. 17. During the past six months, SEH has conducted competency based training for 100% of the nursing staff who administer medications. This achievement is not only commendable, but it clearly resulted in the significant improvement in the medication administrations that were observed. 18. Seclusion and restraint rates for both individuals in care and events continue to be well below national benchmarks. 19. The Infection Control Coordinator continues to provide leadership for program development and encourage the necessary attention to infection control in all aspects of hospital operations from supplies, through employee health, and treatment for individuals in care.
RB			**Methodology:** <u>Interviewed</u>: 1. Clo Vidoni-Clark, Ph.D. 2. Crystal Robinson, MT-BC <u>Reviewed</u>: 1. Medical Records: TS 923428; AW 84451; JR 149453; ML 212898; BW 144735; MW 128311; FF 92120; KY 923997; LD 920360; JB 121259; DJ 920621; JW 268184; JC 263925 2. Therapeutic Learning Centers: Overview and General

			Operations 3. Schedules for TLC Transitional and Intensive Malls <u>Toured</u>: 1. TLC Transitional Mall 2. TLC Intensive Mall

	A. Psychiatric Care		
MES		By 24 months from the Effective Date hereof, SEH shall provide all of the individuals it serves routine and emergency psychiatric and mental health services.	**Methodology:** Interviewed: 1. Bernard Arons, MD, Medical Director 2. Ermias Zerilassie, Chief Pharmacist Reviewed: 1. Charts of the following 35 individuals: AAM, BP, CDC, CH, DB, DE, DM, FH, GD, GJF, GS, JC, JL, JMH, JT, JV, LF, LRC, MB, ML, MP, PJ, PS, PT, QV, RCM, RH, RM, RN, TB, TJ, VG, WC, WM and WTK 2. SEH Self-Assessment Report (April 9, 2010) 3. SEH database regarding individuals receiving benzodiazepines 4. SEH database regarding individuals receiving anticholinergic treatments 5. SEH database regarding individuals receiving polypharmacy 6. SEH database regarding individuals receiving treatment with New Generation Antipsychotic medications 7. SEH regarding individuals diagnosed with Tardive Dyskinesia 8. SEH Policy #602.1-08: Assessments, revised March 30, 2010 9. SEH Policy #601-02: Medical Records, revised April 7, 2010 10. SEH Audit Sample Plan 11. SEH Comprehensive Initial Psychiatric Assessment (CIPA) Audit summary data (June 2009 to February 2010) 12. SEH Operational Instructions for Psychiatric Update Audit Tool, revised April 1, 2010 13. SEH Psychiatric Update Audit summary data (August 2009 to February 2010) 14. SEH Initial Psychological Assessment Monitoring Tool and Peer Review Form, May 21, 2009 15. SEH Initial Psychological Assessment Audit summary data

			(August 2009 to February 2010) 16. SEH IRP Process Observation data summary (December 2009 to January 2010) 17. SEH Operational Instructions for Co-occurring Disorders Audit, not dated. 18. SEH Risk Trigger Event System, revised March 19, 2010 19. SEH Medication Guideline regarding Clozaril (clozapine), revised March 2010. 20. SEH Medication Guidelines regarding (other) New Generation Antipsychotic medications 21. SEH Adverse Drug Reaction (ADR) Incident Report, revised September 1, 2009 22. SEH Instructions for Completing the ADR Report Form and Assessment (not dated) 23. SEH summary data regarding ADRs (August 2009 to February 2010) 24. SEH tracking log including description of all ADRs and actions taken to address the reactions (March 2009 to February 2010) 25. SEH ten completed ADR Incident reports 26. SEH Pharmacy and Medication Report, February 2010 27. SEH Intensive Case Analysis regarding ADR of Ste4ven Johnson Syndrome, February 2010 28. SEH DUE instrument and operational instructions: polypharmacy, January 13, 2010 29. SEH DUE instrument and operational instructions: Benzodiazepines and persons with substance use disorders, January 13, 2010 30. SEH DUE instrument and operational instructions: Benzodiazepines and persons with cognitive disorders, January 13, 2010 31. SEH DUE instrument and operational instructions: persons age sixty and over, January 13, 2010

			32. SEH Reported Medication Variances (Marcy 2009 to September 2010) 33. SEH ten completed Medication Variance Incident reports (using the revised template) 34. Chief Nurse Executive Memorandum, Individuals in Care who refuse medications, vital signs or treatment, January 29, 2010 35. SEH draft revision of Policy #206-09, Medication Ordering and Administration, April 26, 2010 36. SEH Improving the Documentation of Medication Administration, not dated 37. SEH Improving the Accuracy of Medication Variance Reporting, Advanced Leadership Workshop, Six Sigma Project 38. SEH Mortality review completed during this period regarding the unexpected death of an individual (REH) 39. SEH Operational Instructions for Co-occurring Disorders Audit, not dated 40. SEH list of all current psychiatrists at SEH with their case loads and FTE status 41. SEH Tardive Dyskinesia (TD) Audit summary data, August 2009 and March 2010 42. Minutes of the SEH P&T Committee meetings (August 12, September 16, October 13, November 12 and December 9, 2009 and January 20 and February 17, 2010) 43. SEH Pharmacy Drug Interventions and Recommendations, August 2009 to March 2010 44. SEH Pharmacy Drug Alerts, August 2009 to February 2010 45. SEH Psychiatry caseload summary data, March 22, 2010. <u>Observed</u>: 1. Team meeting at JHP-1 for IRP review of xx 2. Team meeting at JHP-6 for IRP review of xx

			3. Team meeting at JHP-6 for IRP review of xx 4. Team meeting at JHP-8 for IRP review of xx 5. Team meeting at JHP-8 for IRP review of xx 6. Team meeting at RMB-1 for IRP review of xx 7. Team meeting at RMB-4 for IRP review of xx 8. Team meeting at RMB-7 for IRP review of xx 9. Team meeting at RMB-8 for IRP review of xx
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;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c.* **Findings:** Same as in VI.A.1, VI.A.2, VI.A.4, VI.5, VI.A.6.a and VI.A.6.c. **Recommendation 2, September 2009:** *Same as in VI.A.7.* **Findings:** Same as in VI.A.7. **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 updates (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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VI.A.7.* **Findings:** Same as in VI.A.1 and VI.A.7. The relevant indicators are as follows: 1. Psychiatric update reflecting the individual's progress; 2. Appropriateness of the pharmacological plan of care to the individuals' progress, including use of stat medications; 3. Completion of risk assessment; 4. Ongoing monitoring of adverse reactions of antipsychotic medications; 5. Addressing Stat medications, seclusion and/or restraints; 6. Addressing involuntary medications; 7. Addressing abnormal laboratory results; 8. Assessing barriers to discharge and 9. Review of reassessments, if completed by a trainee. **Compliance:** Partial. **Current recommendations:** *Same as in VI.A.7.*
MES	VIII.A.	timely and justifiable updates of diagnosis and	**Current findings on previous recommendation:**

	1.c	treatment, as clinically appropriate;	**Recommendation, September 2009:** Same as in VI.A.7. **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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VI.A.7.* **Findings:** The facility's data are presented in VI.A.1 and V.A.7. The following are the relevant indicators: 1. CIPA Audit: Risks associated with prescribed medication regimen and 2. Psychiatric Update Audit: a) Documentation of adverse reactions of antipsychotic medications; b) Ongoing monitoring of adverse reactions of antipsychotic medications; c) Rationale for polypharmacy; d) Rationale for using high risk medications (benzodiazepines); e) Rationale for using high risk medications

			(anticholinergics); f) Addressing Stat medications, seclusion and/or restraints and g) Addressing abnormal laboratory results. **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) including appropriate and timely monitoring of individuals and interventions to reduce risks;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VI.A.7.and VI.A.2.* **Findings:** Same as in V.B.5, VI.A.7, VI.A.2. The relevant indicators are as follows: 1. CIPA Audit: Completion of risk assessment and 2. Psychiatric Update Audit: a) Addressing Stat medications, seclusion and/or restraints; b) Addressing involuntary medications; and c) Completion of risk assessment. In addition, as mentioned earlier (V.B.5), the facility made appropriate revisions in its Risk Trigger Event System (March 19, 2009) to facilitate implementation of this requirement. **Compliance:** Partial.

			Current recommendations: *Same as in V./B.5, VI.A.7.and VI.A.2*
MES	VIII.A.1.f	documentation of, and responses to, side effects of prescribed medications;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VI.A.7.* **Findings:** Same as in VI.A.1 and VI.A.7. The relevant indicators are the following: 1. CIPA Audit: Risks associated with prescribed medication regimen and 2. Psychiatric Update Audit: a) Listing of adverse reactions of antipsychotic medications; b) Ongoing monitoring of adverse reactions of antipsychotic medications; c) Addressing laboratory levels at appropriate levels; and d) Addressing abnormal laboratory results. **Compliance:** Partial. **Current recommendations:** Same as in VI.A.1 and VI.A.7.
MES	VIII.A.1.g	documentation of reasons for complex pharmacological treatment; and	**Current findings on previous recommendation:** **Recommendations 1-3, September 2009:** • *Same as in VI.A.7.*

			• *Provide monitoring data based on the Medication Monitoring Form (items related to intra and interclass polypharmacy) based on at least 20% sample during the review period.* • *Ensure that the progress report includes a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** As mentioned in sections VI.A.1, VI.A.7 and VIII.A.2.a.i, the facility's data showed that compliance with the documentation of rationale for polypharmacy and other high risk medication uses (benzodiazepines for individuals with substance use disorders and anticholinergics for individuals with cognitive disorders) was inadequate. However, the facility has decreased the overall use of polypharmacy during this review period. For example, the number of individuals receiving three or more antipsychotic medications has decreased from 22 in July 2009 to 11 as of February 28, 2010. In addition, the facility's data based on the monthly audits of all medication regimens by unit (Medication Monitoring Form) showed relative improvement (August 2009 to February 2010 compared to January to July 2009) in the documentation of rationale for polypharmacy, intra-class of three or more medications (80% vs. 73%) and polypharmacy, inter-class of four or more medications (67% vs. 14%). **Compliance:**

			Partial, improved compared to the last review. **Current recommendations:** 1. *Same as in VI.A.7.* 2. *Provide monitoring data based on the Medication Monitoring Form (items related to intra and interclass polypharmacy) during the review period.* 3. *Ensure that the progress report includes a summary of the aggregated monitoring data including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Same as in VI.A.7.* **Findings:** Same as in VI.A.7. **Recommendations 2-4, September 2009:** • *Ensure that corrective actions include monitoring indicators to assess the following:* *a) Face-to-face assessment of the individual following the administration of Stat medications;* *b) The prescription of PRN medications for specified behavioral indications;* *c) Critical review by practitioners of the use of PRN/Stat medications during the interval, including the*

			circumstances leading to the use, the individual's response and the appropriateness of the medication order; *d) The adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval* • *Provide monitoring data based on 20% sample during the review period and ensure that the data address this requirement.* • *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH's data based on the Psychiatric Update Audit were presented in V.A.7. The following are the relevant indicators: 1. Appropriateness of the pharmacological plan of care to the individuals' progress, including use of stat medications; 2. Addressing Stat medications, seclusion and/or restraints and 3. Addressing involuntary medications. As mentioned earlier, the overall compliance rates were inadequate. Although the data showed relative improvement on these indicators during this review period, other facility data (based on the Medication Monitoring Form) showed that practitioners were not adequately documenting a critical review of Stat medication uses during their monthly updates

			As mentioned in VI.A.7, the facility's data (Medication Monitoring Form) indicated adequate compliance by practitioners with the policy requirement to limit additional psychiatric medication use to Stat applications. However, these data conflicted with other reports by the facility (see section X.F.1). The above findings and other findings (below) indicate that the facility has yet to implement adequate corrective actions to ensure: a) a face-to-face assessment of the individual following the administration of Stat medications; a critical review by practitioners of the use of Stat medications during the interval, including the circumstances leading to the use, the individual's response and the appropriateness of the medication order and c) the adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of Stat medications during the interval. **Other findings:** This expert consultant reviewed the charts of five individuals (ML, MB, RH, TJ and FH). The review found evidence of adequate face-to-face assessment, including the rationale for using these medications and a plan to adjust regular medications based on this assessment, in two cases (MB and TJ). However, in three cases (ML, RH and FH), the assessment was limited to the rationale for using the medications and did not Address implications for regular treatment. The choice of the medications appeared to be appropriately aligned with the target symptoms and the established diagnosis in all cases, except one (FH). These findings indicate relative improvement in this area compared to the last review period, but more work is needed to ensure that the assessments address treatment and/or diagnostic implications of Stat medication uses.

			Compliance: Partial, improved compared to the last review. **Current recommendations:** 1. *Same as in VI.A.7.* 2. *Implement corrective actions to ensure the adjustment of regular medications and the update of diagnosis, as clinically appropriate, based on the review of PRN/Stat medications during the interval.* 3. *Provide monitoring data based on the Psychiatric update Audit.* 4. *Ensure that the self-report includes a summary of the aggregated monitoring data, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VIII.A.2	By 18 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols to ensure system-wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use. In particular, policies and/or protocols shall address:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a	monitoring of the use of psychotropic medications to ensure that they are:	Please see sub-cells for findings and compliance.
MES	VIII.A.2.a.i	clinically justified;	**Current findings on previous recommendations:**

			Recommendation 1, September 2009: *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).* **Findings:** Same as in VI.A.2.b.i and VI.A.2.b.iv. **Recommendation 2:** *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* **Findings:** Same as in VI.A.2.b.i and VI.A.2.b.iv. **Recommendations 3-5, September 2009:** • *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). The indicators must address the justification of high-risk medication, including the proper assessment of risks and benefits and attempts to utilize safer treatment alternatives.* • *Provide monitoring data regarding high risk medication uses, based on at least 20% sample during the review period.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting*

			documents should be provided. **Findings:** SEH presented data based on the Psychiatric Update Audit (target sample was two reviews by psychiatrist per month and sample used varied from 2% to 9% of total reassessments). These data were discussed in VI.A.1 and VI.A.7. The data indicated relative improvement during this review period, but less than adequate compliance rates in the following areas (weighted average rates were not provided): 1. Rationale for polypharmacy: 50% to 100%; 2. Rationale for benzodiazepines use for individuals with substance use disorders: 40% to 100%; 3. Rationale for anticholinergics' use for individuals with cognitive disorders: 67% to 100%) and 4. Monitoring of side effects of antipsychotic medications: 56% to 95%. A more complete data set was presented using the Medication Monitoring Tool. These data compared medication practices during the period of August 2009 to February 2010 (46% sample) to the period of January to July 2009 (38% sample). The following is a summary of the data in each area of practice that showed progress since the last review: 1. Polypharmacy: a) Percentage of individuals prescribed three or more intra-class medications decreased from 6% to 2%. b) Percentage of individuals receiving four or more inter-class medications has decreased from 3% to 1%. c) Documentation of rationale for using three or more intra-class medications improved from 73% to 80%.

			d) Documentation of rationale for using four or more inter-class medications improved from 14% to 67%. 2. Benzodiazepines (lorazepam, clonazepam, diazepam or alprazolam): a) Percentage of individuals prescribed benzodiazepines and suffering from cognitive disorders decreased from 36% to 11%. b) Documentation of rationale (risks vs. benefits) for using these medications has improved from 8% to 24%. c) Documentation of a current valid indication for use has improved from 68% to 98%. 3. Anticholinergics (benztropine, trihexyphenidyl or diphenhydramine): a) The use of medications for individuals with cognitive disorders has decreased from 19% to 6%. b) The documentation of rationale (risks vs. benefits) of treatment has increased from 0% to 40%. c) The documentation of a current valid indication for use has improved from 88% to 99%. d) The documentation of side effects of treatment has improved from 5% to 22%. 4. New generation Antipsychotics (clozapine, olanzapine, risperidone and quetiapine): a) The documentation of the risk of Diabetes Mellitus has improved from 8% to 25%. b) The monitoring of weight (BMI) by the IRP team has improved from 15% to 64%. c) Percentage of individuals receiving these medications who developed Diabetes mellitus has decreased from 19% to 17%. d) Laboratory testing occurred as per facility's medication guidelines occurred in 98% of the cases (no data were available for the previous period). In those incidents

			when testing did not occur, the pharmacists followed up with practitioners in three our of four cases. 5. Medication use in geriatric individuals: a) Percentage of individuals receiving medications that can cause delirium has decreased from 58% to 26%. b) Laboratory monitoring (creatinine clearance) has improved from 37% to 93%. However, there was evidence of lack of progress in a variety of important areas, including: 1. Polypharmacy: The facility did not present data regarding individuals receiving two intra-class agents. 2. Benzodiazepines use: a) The overall use of benzodiazepines for more than 90 days has increased from 22% to 73%. b) Percentage of individuals receiving benzodiazepines and suffering from substance use disorders has increased from 15% to 19%. c) The data regarding use of benzodiazepines in presence of substance use disorder appeared to contradict the data that the facility presented regarding the total number of these individuals (as of April 9, 2010). However, the facility's self-report was silent on this matter. 3. Anticholinergics: The use of medications for individuals suffering from Tardive Dyskinesia has increased from 5% to 8%. 4. New Generation Antipsychotics: a) The data appeared to indicate that percentage of individuals diagnosed with Diabetes Mellitus and receiving these medications for more than 90 days has increased from 47% to 72%. b) The percentage of individuals with a diagnosis of

			Diabetes mellitus and receiving these medications and who had a BMI of greater than 30 has increased from 8% to 25%. 5. Medication uses in geriatric individuals: No significant change was reported in the percentage of individuals at risk of falls due to possible side effects of current medications (around 50%) and in individuals receiving medications on the Beers list (that outline Potentially Inappropriate Medications for the Elderly) (around 22%). **Other findings:** This expert consultant reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic Medications for individuals diagnosed with cognitive disorders and/or tardive dyskinesia; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. This expert consultant also reviewed the charts of 18 individuals receiving the above types of medication uses. The following is an outline of these review followed by findings regarding compliance (diagnoses are listed only if they signified conditions that increase the risk of use). These findings were based on documentation of the justification for use, monitoring the individuals for the risks of use, attempts to use safer medication alternatives and risk benefit analysis of the use. **<u>Benzodiazepine use</u>**

Individual	Medication(s)	Diagnosis
BP	Lorazepam	Mild Mental Retardation and Cocaine and Alcohol Abuse
DE	Lorazepam	Mental Retardation, Severity Undetermined and Polysubstance Dependence
DM	Lorazepam	Dementia
MP	Lorazepam	Polysubstance, by history
LR	Clonazepam	Polysubstance Dependence and Dementia NOS
GS	Clonazepam	Polysubstance Dependence
VG	Lorazepam	Vascular Dementia NOS

This review found compliance in two charts (BP and MP), partial compliance in one (GS) and noncompliance in three (DE, LR and VG).

Anticholinergic use

Individual	Medication(s)	Diagnosis
CD	Benztropine and amantadine	R/O Dementia NOS (ruled out)
PT	Benztropine	Cognitive Disorder NOS, by history
WTK	Benztropine	Borderline Intellectual Functioning
LR	Benztropine (discontinued), amantadine and clozapine	Dementia NOS

This review found compliance in one chart (PT), partial

compliance in one (LRC) and noncompliance in two (CD and WTK).

Polypharmacy use

Individual	Medication(s)	Diagnosis
JV	Risperidone, buspirone, escitalopram, lamotrigine and sertraline partial	
RN	Quetiapine, risperidone consta, topiramate, fluoxetine, divalproex, invega	partial
LF	Risperidone, aripiprazole, quetiapine, trazodone, fluvoxamine **(anafranil**) and benztropine	?
AAM	Ziprasidone, risperidone, haloperidol and bupropion	partial
CH	Clozapine, quetiapine and lithium	compliant
QV	Olanzapine, quetiapine and lithium	compliant
JL	Ziprasidone, risperidone and benztropine	compliant

This review found compliance in three charts (CH, QV and JL) and partial compliance in four (JV, RN, LF and AAM).

This expert consultant reviewed the charts of 12 individuals who were receiving treatment with new generation antipsychotic medications, most of whom were diagnosed with metabolic disorders. The reviews are outlined as follows:

Individual	**Medication(s)**	**Diagnosis**
JT	Clozapine,	Hypertension

	quetiapine and aripiprazole	
PJ	Clozapine	Diabetes Mellitus
TB	Clozapine	Diabetes Mellitus and Hypertension
GD	Olanzapine	Diabetes Mellitus and Hypercholesterolemia
JC	Olanzapine	Hyperlipidemia
DB	Olanzapine	None documented
JV	Risperidone	None documented
RN	Risperidone and quetiapine	Diabetes Mellitus, Obesity and Hyperlipidemia
WM	Risperidone	None documented
RM	Risperidone	Hypercholesterolemia and Hyperprolactinemia
TJ	Quetiapine	Diabetes Mellitus

This review found that SEH has improved the monitoring of serum prolactin levels for individuals at risk. In addition, the facility has maintained adequate practice (in general) in the following areas:

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

However, there were several deficiencies that must be corrected in order to achieve substantial compliance. The following are examples:

			1. There was no documentation of serum lipids in the past year in an individual receiving clozapine and quetiapine (JT). The psychiatric progress notes indicated that monthly serum lipids were being monitored, but there was no evidence that this monitoring occurred. 2. The frequency of monitoring for serum lipids during the past year for individuals diagnosed with Diabetes Mellitus and receiving clozapine was inadequate (TB and PJ). 3. There was no evidence of monitoring for the risk of pancreatic dysfunction in some individuals receiving clozapine (TB), olanzapine (DB), risperidone (WM), 4. There was no documentation of monthly psychiatric updates since August 2009 for an individual receiving risperidone (JV) and since November 2009 for another individual receiving quetiapine and diagnosed with Diabetes Mellitus (TJ). 5. The psychiatric update (February 2010) did not address significant elevation of serum triglyceride at >500 (January 2010) in an individual receiving risperidone and quetiapine, and diagnosed with Diabetes Mellitus, Obesity and Hyperlipidemia. 6. There was no documentation of clinical assessment regarding the risk of endocrine dysfunction in a female individual diagnosed with Hyperprolactinemia apparently secondary to risperidone treatment (RM). **Compliance:** Partial. **Current recommendations:** 1. *Same as in VI.A.2.b.i (individualized medication guidelines) and VI.A.2.b.iv (drug utilization evaluation).*

			2. *Implement corrective actions to correct the deficiencies outlined by this consultant regarding the use of benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications.* 3. *Provide monitoring data regarding high risk medication uses, based on at least 20% sample during the review period.* 4. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*
MES	VIII.A.2.a.ii	prescribed in therapeutic amounts, and dictated by the needs of the individual;	Same as above.
MES	VIII.A.2.a.iii	tailored to each individual's clinical needs and symptoms;	Same as above.
MES	VIII.A.2.a.iv	meeting the objectives of the individual's treatment plan;	Same as above.
MES	VIII.A.2.a.v	evaluated for side effects; and	Same as above.
MES	VIII.A.2.a.vi	documented.	Same as above.
MES	VIII.A.2.b	monitoring mechanisms regarding medication use throughout the facility. In this regard, SEH shall:	Same as above.

MES	VIII.A.2.b.i	develop, implement and update, as needed, a complete set of medication guidelines that address the medical benefits, risks, and laboratory studies needed for use of classes of medications in the formulary;	**Current findings on previous recommendations:** **Recommendations 1-3, September 2009:** • *Fully implement the revised guidelines.* • *Finalize the individualized psychotropic medication guidelines to address findings 1-3 by this expert consultant [in this cell in the previous report].* • *Ensure that the medication guidelines are continually updated based on professional practice guidelines, current literature and relevant clinical experience.* **Findings:** Since the last review, the facility has updated its medication guideline for the use clozapine. The updated guideline comports with current generally accepted standards and adequately addressed findings by this expert consultant in the previous report regarding the following: 1. The use of clozapine for individuals suffering from severe forms of tardive dyskinesia and 2. Guidance regarding clozapine use (interpretation of blood levels, monitoring for the metabolic risks, interactions with diet and tobacco and strategies for use in individuals who fail to respond satisfactorily). The facility has made some appropriate revisions of its guideline regarding the use of new generation antipsychotic medications (NGAs) other than clozapine. However, the facility has yet to develop individualized monitoring standards regarding the metabolic risks associated with various NGAs. **Compliance:** Partial; improved compared to the last review.

			Current recommendations: 1. *Fully implement the revised guidelines and develop and implement individualized monitoring standards (frequency and type of testing) for each NGA medication on the formulary.* 2. *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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** *Same as in VIII.A.1.h.* **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 to the medical staff; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2009:** • *Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the prescribing practitioners.* • *Present documentation of review by the P&T Committee of drug alerts.*

			Findings: SEH presented data regarding eight drug alerts that were issued between August 2009 and February 2010. The alerts were posted on the intranet and the facility's Pharmacy and Therapeutics Committee. The alerts addressed the following topics: 1. Suicidal behavior and ideations and antiepileptic drugs; 2. Safety labeling changes approved by FDA for olanzapine and glipizide; 3. Change in Heparin USP Monograph; 4. Interaction between clopidogrel and omeprazole; 5. Potential association between fosamprenavir calcium and myocardial infarction and dyslipidemia; 6. Risk of neural tube birth defects following prenatal exposure to valproate; 7. Drug safety of erythropoiesis stimulating agents and 8. Potential serious interactions between the antiviral agents saquinavir and ritonavir. In addition, the facility presented data regarding other Pharmacy interventions that were communicated to the medical staff between August 2009 and march 2010. The interventions were adequate in number and area of review. **Compliance:** Substantial. **Current recommendations:** 1. *Present aggregated data regarding all drug alerts that were communicated by the Pharmacy department to the prescribing practitioners.* 2. *Present documentation of review by the P&T Committee of*

			drug alerts.

MES	VIII.A.2.b.iv	provide information derived from Adverse Drug Reactions, Drug Utilization Evaluations, and Medication Variance Reports to the Pharmacy and Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Adverse Drug Reactions (ADRs): Ensure that the self-report contains summary information to address the following:* *a) Full implementation of the revised ADR data collection system;* *b) Number of ADRs reported during the review period compared with the number during the previous period;* *c) Classification of ADRs by outcome category compared with the number during the previous period.* *d) Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;* *e) Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:* *i. Date of the ADR;* *ii. Description of the ADR;* *iii. Outline of ICA recommendations; and* *iv. Outline of actions taken in response to the recommendations.* *f) Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.* **Findings:** SEH implemented its revised ADR reporting process in

			September 2009 and completed training of the medical staff during this review period. The ADR reports were tracked monthly and reviewed by the Pharmacy and Therapeutics Committee. The facility aggregated its ADR data from August 2009 to February 2010 as requested. The data showed that 30 ADRs were reported (compared to 44 during the prior review period). SEH acknowledged that underreporting of ADRs continued to be a challenge. The facility presented some information regarding the outcome of these ADRs, but the aggregated information was not specific. The most serious ADR involved the occurrence of Steven-Johnson Syndrome, a potentially fatal skin disease possibly secondary to carbamazepine treatment. This individual required hospitalization and follow up care with dermatology. An intensive case analysis was completed to address this reaction. The analysis was adequate. Although minutes of the Pharmacy and Therapeutics Committee reflected a review of ADRs, there was no evidence of adequate analysis of patterns and trends and of corrective actions based on this analysis. The facility conducted an audit of its practice regarding ADR reporting and found 14 cases in which auditors concluded that an ADR should have been reported but no report was initiated. In addition, this expert consultant found that one individuals (CB) suffered from potentially lethal lithium toxicity during this review period but no ADR report and/or investigation occurred **Recommendation 2, September 2009:** *Drug Utilization Evaluation (DUE): Ensure that the self-report contains summary information about the following:* *a) Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the*

			medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. *b) Completed DUEs, with a summary outline of the following:* *i. Date of each DUE;* *ii. Description of each DUE including methods used;* *iii. Outline of each DUE's recommendations; and* *iv. Outline of actions taken in response to the recommendations.* c) *Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns*. **Findings:** During this review period, SEH initiated two DUEs to assess the use of polypharmacy and benzodiazepines. The facility presented DUE instruments that contained adequate indicators and operational instructions to assess the use of benzodiazepines for individuals with substance use disorders, with cognitive disorders and for elderly individuals. The facility's DUE regarding polypharmacy included a definition of intra-class polypharmacy that did not comport with current accepted standards. Results of this DUE were unavailable at the time of this review. The facility presented preliminary results of its benzodiazepine DUE and the results showed widespread deficiencies in the documentation of practitioners' rationale for the use of these medications in high risk situations; corrective actions were underway.

			SEH did not present follow up information regarding the finalization of its previously mentioned proposal for a protocol regarding the clinical and laboratory monitoring of individuals receiving divalproex (regarding the risk of pancreatitis). **Recommendation 3, September 2009:** *Medication Variance Reporting (MVR): Ensure that the self-report includes a summary information of the following:* a) *Full implementation of the revised data collection system;* b) *Total number of actual and potential variances during the review period compared with numbers reported during the previous period;* c) *Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;* d) *Number of variances by critical breakdown point;* e) *Clinical information regarding each variance (category E or above) and the outcome to the individual involved;* f) *Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and* g) *Outline of ICAs, including description of variance, recommendations and actions taken.* h) *Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances;* i) *Evidence of corrective actions to address patterns and trends identified in medication variances.* **Findings:** SEH implemented the revised Medication Variance Incident Report. Based on this tool, the facility presented data regarding actual and potential variances and critical breakdown points

			categories of variances. However, the total number of variances by actual and potential occurrence and by category/type during the review period (August 2009 to February 2010) was not aggregated and compared to the previous review period, as requested in the recommendation. The facility's self report did not present clinical information for each variance that had an outcome category of E or above as requested. The facility reported that one individual expired during hospitalization (in January 2010), which was possibly related to a medication variance related to an individual's refusal of a medication and the failure to renew an order to immediately notify a physician when the individual refuses the medication. This case will be discussed under mortality reviews below. SEH presented a review of patterns of variance reporting. However, the review did not address variances during this review period. Instead, the review covered variances during the period of March 2009 to February 2010. This review showed that 33% of variances were prescribing, 13% administering, 10.5% transcribing/documenting, 5% dispensing and 1% monitoring. This was essentially the same pattern reported during the last review period. However, the facility did not present corrective actions to address the most common type of variances. The facility's review showed a significant increase in reporting of variances by Nursing, but most of the variances were still reported by Pharmacy. The facility conducted an analysis of medication variances using Six Sigma approach. Using appropriate methods, the analysis addressed the accuracy of variance reporting and focused on

			variances related to documenting the administration of medications. The analysis identified root causes of variances related to documentation of administration and proposed a number of corrective actions. This information was reportedly being used by Nursing in setting up the medication room procedures in the new hospital building. **Recommendation 4, September 2009:** *Mortality review: Ensure that the revised policy regarding mortality review address the performance of an independent external medical mortality review and the integration of information form this review in the final level interdisciplinary review.* **Findings:** The facility did not address the recommendation regarding the integration of information form the external review in the final level of interdisciplinary review. During this review period, the facility's Mortality and Morbidity Committee reviewed deaths of four individuals who died between August 2009 and March 2010. Of the four deaths, only one was unexpected. This expert consultant reviewed the mortality records regarding this individual (REA). The facility's process included an adequate outline of contributing factors and corresponding corrective actions. The corrective actions included, but were not limited to: a), disciplinary action involving nursing failure to notify the physician of the refusal of an individual of a life sustaining medications; b) instruction by the Chief Nurse Executive regarding the management of "individuals in care who refuse medications, vital signs or treatment" and c) draft revision of the facility's policy, Medication Ordering and Administration to address order renewal and medication refusal

			issues. However, the process was limited due to the fact that results of the postmortem examination were still pending and there was no available report of an external independent review (in violation of the facility's policy). **Compliance:** Partial. **Current recommendations:** 1. *Adverse Drug Reactions (ADRs): Ensure that the self-report contains summary information to address the following:* a) *Corrective actins to increase reporting of ADRs;* b) *Total number of ADRs reported during the review period (specify dates) compared with the number during the previous period (specify dates);* c) *Classification of ADRs by probability category (doubtful. Possible, probable and definite) compared with the number during the previous period;* d) *Classification of ADRs by severity category (mild, moderate and severe) compared with the number during the previous period;* e) *Clinical information regarding each ADR that was classified as severe and description of the outcome to the individual involved;* f) *Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. Also provide summary outline of each analysis including the following:* i) *Date of the ADR;* ii) *Brief Description of the ADR;* iii) *Outline of ICA findings and recommendations; and* iv) *Outline of actions taken in response to the recommendations.*

			g) *Summary of the facility's analysis of trends and patterns regarding ADRs during the review period and of corrective/educational actions taken to address these trends/patterns.* 2. *Drug Utilization Evaluation (DUE): Ensure that the self-report contains summary information about the following:* a) *Performance of DUEs based on the facility's individualized medication guidelines, including criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance.* b) *Completed DUEs, with a summary outline of the following:* i) *Date of each DUE;* ii) *Description of each DUE including methods used;* iii) *Outline of each DUE's recommendations; and* iv) *Outline of actions taken in response to the recommendations.* c) *Analysis of DUE data to determine practitioner and group patterns and trends and provide summary of corrective/educational actions taken to address these trends/patterns*. 3. *Medication Variance Reporting (MVR): Ensure that the self-report includes a summary information of the following:* a) *Total number of actual and potential variances during the review period compared with numbers reported during the previous period;* b) *Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual, with totals during the review period compared with the last review period;* c) *Number of variances by critical breakdown point with totals during the review period compared with the last*

			review period;; d) *Specific clinical information regarding each variance (category E or above) and the outcome to the individual involved;* e) *Summary information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; Also provide summary outline of each analysis including the following:* i) *Date of the variance;* ii) *Brief Description of the variance;* iii) *Outline of ICA findings and recommendations; and* iv) *Outline of actions taken in response to the recommendations and* f) *Evidence of review and analysis by the Pharmacy and Therapeutics Committee of medication variances;* g) *Evidence of corrective actions to address patterns and trends identified in medication variances.* 4. *Mortality review: Ensure that the facility integrates results of the independent external medical mortality review in the final level interdisciplinary review.*
MES	VIII.A.3	By 36 months from the Effective Date hereof, SEH shall provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for not more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.	**Current findings on previous recommendations:** **Recommendation, September 2009:** *Maintain compliance with this requirement in all acute care and long-term care units in the facility.* **Findings:** SEH has submitted documents regarding psychiatric staffing levels showing that current level of staffing comports with this requirement.

			Compliance: Substantial. **Current recommendation:** *Maintain compliance with this requirement in all acute care and long-term care units in the facility.*
MES	VIII.A.4	SEH shall ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, SEH shall:	**Current findings on previous recommendation:** **Recommendation, September 2009:** Same as in V.A.2.e and VI.A.7. **Findings:** Same as 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.	By 24 months from the Effective Date hereof,	**Current findings on previous recommendation:**

	5	SEH shall review and ensure the appropriateness of the medication treatment.	**Recommendation, September 2009:** Same as in VI.A.7 and all subsections of VIII.A.1 and VIII.A.2. **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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Same as in V.D.1 and VI.A.5.* **Findings:** Same as in V.D.1 and VI.A.5. **Recommendation 2, September 2009:** *Ensure implementation of substance recovery services consistent with the transtheoretical model of change.* **Findings:** The current template for the CIPA and the IRP Manual contained requirements for completion of the stages of change as part of the CIPA and for identification of the stages relevant to the IRP objectives and interventions. However, data from the CIPA Audit tool (see below) showed inadequate implementation of the stages of change.

			Recommendations -5 September 2009: • *Ensure that substance abuse self-assessment indicators also address the following:* a) *There is at least one objective related to the individual's stage of change;* b) *The interventions are appropriately linked to the objective and are aligned with the Mall schedule;* c) *The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.* • *Provide monitoring data (to address the above mentioned indicators) based on at least 20% sample during this review period. The data should include and initial screening and the IRP management of substance use disorders.* • *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* **Findings:** SEH reported a plan to initiate monitoring using the Co-occurring Disorders Self-Audit in April 2010. This audit included indicators to assess the development of substance use objectives, the identification of the stage of change, the linkage between the stage of change and the interventions and the development of discharge criteria that address substance use. Using the CIPA Audit (target sample of 20% and sample used varied from 15% to 23%), the facility presented self-assessment data (August 2009 to February 2010). The data indicated

			compliance rates of less than 90% with the two indicators that addressed this requirement. The following is a summary of the data (no weighted average rates were provided): 1. Completion of substance use assessment: 60% to 100% and 2. Substance use assessment reflecting stages of change (33% to 100%). **Other findings:** See this monitor's findings in V.D.1 regarding the evaluation and management of substance use disorders at SEH. **Compliance:** Partial. **Current recommendations:** 1. *Provide monitoring data (to address the above mentioned indicators) based on at least 20% sample during this review period. The data should address initial screening and the IRP management of substance use disorders.* 2. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.* 3. *Same as in V.D.1 and VI.A.5.*
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	**Current findings on previous recommendations:** **Recommendations 1-3, September 2009:** • *Develop and implement corrective actions to correct the*

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<td>psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.</td>
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deficiencies outlined by this consultant regarding the monitoring and management of individuals suffering from TD.

Provide monitoring data based on a review of a 100% sample during the review period.
Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

Findings:
The facility identified 39 individuals as having a diagnosis of Tardive Dyskinesia (as of April 9, 2010).

The facility presented data regarding completion of AIMS upon admission (CIPA Audit). The data (August 2009 to February 2010) showed compliance rates that varied from 25% to 100%. Using the Tardive Dyskinesia Peer review Form, the facility reviewed a 100% sample, but the review was limited to two months: August 2009 and March 2010 during the review period. Based on this audit, the data showed relative improvement compared to August 2009. The following is a summary of the data regarding compliance rates (%C):

<table>
<tr><td>Indicator</td><td>August 2009</td><td>March 2010</td></tr>
<tr><td>Individuals receiving AIMS twice a year</td><td>36%</td><td>92%</td></tr>
<tr><td>Evidence of neurology consultation</td><td>57%</td><td>72%</td></tr>
<tr><td>Consideration of (safe) medication choices</td><td>50%</td><td>87%</td></tr>
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Presence of IRP interventions related to TD	43%	69%
Justification of use of first generation antipsychotic agent	57%	75%
Indications for anticholinergics documented	No data	63%

Other findings:
This monitor reviewed the charts of eight individuals (WC, JC, GJF, PS, JMH, RM, JT and RCM) who had current diagnoses of Tardive Dyskinesia (TD). This review found that SEH has maintained some progress as follows:

1. The admission AIMS tests were completed in all the charts reviewed;
2. The periodic AIMS tests were completed in accordance with policy in the charts of WC, PS, GJF and RM.
3. The psychiatric progress notes provided adequate tracking of AIMS testing in the charts of WC and GJF.
4. The IRP documented a diagnosis of TD in all the charts reviewed;
5. The IRP included objectives and interventions related to TD in the charts of JC, PS, JMH and RCM.
6. There was no evidence of unjustified long-term use of anticholinergic medications in the charts of WC, JC, GJF, PS and JT.

However, the review showed a number of deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples:

1. The psychiatric progress notes did not provide adequate

			tracking of the status of TD in the charts of JC, PS, RM, JT and RCM. 2. The IRP did not include diagnosis, focus or interventions to address the diagnosis of TD in the charts of WC, GJF, RM and JT. 3. The periodic AIMS tests were not documented as required in the charts of JC, JMH and RCM. 4. The IRP objectives related to TD were unattainable in the charts of JC, PS, JMH and RCM. 5. There was no documentation to justify the long-term use of anticholinergic medications in the charts of JMH, RM and RCM. **Compliance:** Partial. **Current recommendations:** 1. *Provide monitoring data based on a review of a 100% sample during the review period (March 2010 to August 2010)..* 2. *Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators, corresponding mean compliance rates (%C) and weighted average %C. The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.*

	B. Psychological Care		
RB		By 18 months from the Effective Date hereof, SEH shall provide adequate and appropriate psychological supports and services to individuals who require such services.	**Methodology:** Interviewed: 1. Richard Gontang, PhD 2. Richard Boesch, PhD Reviewed: 1. Policy and Procedure for Behavioral Intervention Programs 2. Monitoring Form for Behavioral Interventions 3. Training materials and rosters for competency-based behavioral training 4. Implementation and fidelity data for individuals receiving behavioral interventions 5. List of all individuals in need of PBS plan 6. Medical Records: CL, SS, DJ, AH, AA, GS, KP, MP
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;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Complete the staffing of the PBS team with at least one RN and two PNAs, although it is likely that more plans could be more efficiently developed if the staff also includes two data entry personnel.

			Findings: The PBS team remains incomplete. There is no nurse and there is no data analyst. **Recommendation 2, September 2009:** Complete the two PBS plans that are currently in development. **Findings:** Only one PBS plan was completed. Two additional individuals have active Behavior Guidelines. **Other findings:** Under the direction of the Chief of Psychology and the PBS psychologists, a practice of developing Initial IRP Behavioral Interventions (IIRPBI) has been recently implemented with the hope that this will increase the capacity at the team level for integrating behavioral and psychiatric interventions. This is a positive development, but the current IIRPBIs are uneven in quality and their formatting is not sufficiently standardized, especially as regards documentation requirements, both for individual clinicians and for success or failure of the IIRPBI. Psychology has asked that monitoring of the IPA for inclusion of appropriate screening and referral of individuals in need of behavioral interventions be a part of the new Clinical Chart Audit, although data presented by the hospital indicated that this is being captured in the IPA Audit. That data shows that this indicator is being generally met. A significant number of individuals in care remain on the waiting list for the development of behavioral interventions. **Compliance:** Noncompliance

			Current recommendations: 1. Complete the formation of the PBS team. 2. Standardize the format for IIRPBIs. 3. Provide specific instructions in policy for how the success or failure of an IIRPBI is to be documented in the medical record. 4. Develop a process for monitoring IIRPBIs. 5. Determine how IPA assessment of the need for behavioral interventions is to be monitored and present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B.1.b	ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, documentation of which reinforcers for the individual were chosen and what input the individual had in their development, and the system for earning reinforcement;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Re-start training with consultant. **Findings:** Training will begin in June 2010. **Recommendation 2, September 2009:** Implement 6-10 PBS plans and at least 10 Behavioral Guidelines by 05/01/10. **Findings:** Only 1 PBS plan and 2 Behavioral Guidelines (BG) were implemented by 05/01/10. **Other findings:**

			The existing PBS plan and BGs provided an appropriate functional analysis, including the proper use of reinforcers. **Compliance:** Partial. **Current recommendation:** Complete the formation of the PBS team.
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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Re-start training with consultant. **Findings:** Training will begin in June 2010. **Other findings:** The existing PBS plan and BGs used least restrictive alternatives and did not use aversive contingencies. **Compliance:** Partial. **Current recommendation:** Complete the formation of the PBS team.
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,	This cell repeats cell VIII.B.1.a

		and individuals on multiple medications;	
RB	VIII.B.1.e	ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately and implemented appropriately; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Re-start work with consultant. **Findings:** Training will begin in June 2010 **Recommendation 2, September 2009:** Implement BCC. **Findings:** Not implemented. **Recommendation 3, September 2009:** Develop all necessary audits for PBS plans and Behavioral Guidelines. **Findings:** Audit tools have been developed but not yet implemented. **Recommendation 4, September 2009:** Present audit results as trended data. **Findings:** There is currently no auditing data to present. **Compliance:** Noncompliance. **Current recommendations:** 1. Begin to audit behavioral interventions according to instructions in

			Cell V.B.9. 2. Present a summary of the aggregated monitoring data for all indicators on the SWIA in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
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.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Fill current psychology department vacancies. **Findings:** One vacancy exists for unit psychologists. **Compliance:** Partial. **Current recommendation:** Fill current psychology department vacancies.
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.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Revise guidelines for Nursing Assessment to include recommendations for specific groups from the Mall Catalogue. **Findings:** Guidelines were not revised. **Recommendation 2, September 2009:**

			Continue current practice of developing and using manual-based treatments. **Findings:** This practice is continuing. **Other findings:** Initial assessment from the disciplines (RSA, IPA, SWIA and Nursing Assessment) have not been restructured so that the assessing clinician is asked to recommend specific mall groups for individuals as part of the assessment process. **Compliance:** Partial. **Current recommendation:** Assure that all initial assessments (RSA, IPA, SWIA and Nursing Assessment) specifically indicate recommended groups form the Mall Treatment Catalogue.
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.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Development treatment mall for pre-trial forensic patients. **Findings:** Pre-trial forensic patients now attend the TLC Intensive Mall. **Compliance:** Partial. **Current recommendations:** 1. Develop and maintain a process for certifying the competency of

			group treatment providers. 2. Develop a monitoring tool to assure that clinicians involved in offered group treatment services in the malls are providing those services according to accepted treatment manuals and protocols.
RB	VIII.B.4	By 18 months from the Effective Date hereof, SEH shall ensure that:	Please see sub-cells for findings and compliance.
RB	VIII.B.4.a	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	**Current findings on previous recommendation:** **Recommendation, September 2009:** See cell VIII.B.1.c. **Findings:** See cell VIII.B.1.c. **Other findings:** See cell VIII.B.1.c. **Compliance:** Partial. **Current recommendations:** See cell VIII.B.1.c.
RB	VIII.B.4.b	programs are developed and implemented for individuals suffering from both substance abuse and mental illness problems;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Maintain current level of practice on existing treatment malls. **Findings:** Maintain current level of practice.

			Recommendation 2, September 2009: Ensure that substance abuse treatment is available to pre-trial forensic patients. **Findings:** Substance abuse treatment is being provided for all individuals in care, and in both the TLC Transitional Mall and the TLC Intensive Mall. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
RB	VIII.B.4.c	where appropriate, a community living plan is developed and implemented for individuals with cognitive impairment;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Ensure that the form developed to document the integration of psychological assessments into the IRP is used for neuropsychological evaluations as well. **Findings:** Form was implemented but no completed form was found in any of the reviewed records. Additionally, the results of neuropsychological evaluations specifically requested to aid in placement decisions are not being completed in a timely fashion. **Recommendation 2, September 2009:** Present audit results as trended data. **Findings:** Audit data is not yet available.

			Compliance: Noncompliance. **Current recommendations:** 1. Ensure that the form developed to document the integration of psychological assessments into the IRP is used for neuropsychological evaluations as well. 2. Provide a method to audit this process.
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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Maintain current level of practice. **Findings:** Current level of practice is being maintained. **Compliance:** Substantial. **Current recommendation:** Maintain current level of practice.
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;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Revise IRP training program to ensure that it contains conceptual clarity on to move from the development of individually-specific discharge criteria to appropriate foci of hospitalization, measureable and behavioral objectives and appropriate interventions. **Findings:** New consultant has been hired.

			Other findings: Hospital and content area experts have agreed on how data for this cell will be presented in the future using data from Clinical Chart Audit and IRP Conference Process Audit. **Compliance:** Partial. **Current recommendations:** 1. Continue with training program and present data regarding how many clinical staff have been trained. 2. Present a summary of the aggregated monitoring data for all indicators for this cell in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.
RB	VIII.B.4.f	clinically relevant information remains readily accessible; and	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue to audit and present results as trended data. **Findings:** This recommendation has been eliminated from this cell. **Other findings:** Goals achieved in last review have been maintained. **Compliance:** Substantial.

			Current recommendation: Maintain current level of practice.
RB	VIII.B. 4.g	staff who have a role in implementing individual behavioral programs have received competency-based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Re-start work with consultant. **Findings:** Consultant is to begin work in June 2010. **Recommendation 2, September 2009:** Continue providing overview training in PBS for all clinicians. **Findings:** This process has continued but has been hampered by the fact that the previous consultant contract had expired and the fact that the PBS team has not been fully staffed. **Recommendation 3, September 2009:** Develop and implement auditing process for PBS plans and Behavior Guidelines. **Findings:** Auditing process has been developed but not yet implemented. This recommendation is being dropped from this cell, as it is being monitored in a previous cell. **Recommendation 4, September 2009:** Train nursing staff in the implementation of specific behavioral plans and guidelines, and include this item in audit.

			Findings: Process is ongoing. **Recommendation 5, September 2009:** Present audit results as trended data. **Findings:** No audit data is yet available. **Compliance:** Partial. **Current recommendations:** 1. Fully staff the PBS team. 2. Present data indicating how many clinicians have been trained in behavioral principles. 3. Present a summary of the aggregated monitoring data in the progress report, including the following information: target population (N), population audited (n), sample size (%S), indicators/sub-indicators and corresponding mean compliance rates (%C). The data should be accompanied by analysis of low compliance with plans of correction. Supporting documents should be provided.

	C. 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. Ermias Zerilassie, Chief Pharmacist 2. Bernard Arons, Medical Director Reviewed: 1. SEH data regarding recommendations made by the pharmacists based on drug regimen reviews (August 2009 to March 2010) 2. SEH Worx Intervention Category Definitions
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	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** • *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department. The recommendations should include, but not limited to, the following categories:* *a) Drug-drug interactions;* *b) Side effects;* *c) Need for laboratory testing;* *d) Indications;* *e) Contraindications;* *f) Drug allergy;* *g) Dosage issues;* *h) Polypharmacy;* *i) Drug-food interactions;* *j) Incomplete orders; and* *k) Orders that need clarification.* • *Provide clear operational definitions for all categories of the recommendations.*

Findings:
SEH presented data regarding recommendations made by pharmacists during the period of August 2009 to March 2010. The following is an outline of the categories of these recommendations based on the facility's data:

Type of recommendation	% of total recommendations
Drug allergy	5%
Interaction	2%
Dosage issues	13%
Drug information	6%
Formulary	1%
Order clarification	5%
Order entry	33%
Patient monitoring	8%
Polypharmacy	1%
Provider Clinical Consult	20%
Side effects	1%
Others	5%

The data for August 2009 appeared to overlap with the data that was provided during the previous review period (March to August 2009). However, the data appeared to indicate a significant decrease in the number of these recommendations compared to the previous period (153 compared to 205).

Some of the above categories were either not defined (Provider Clinical Consult) or the definition provided lacked clarity (Drug Information and Formulary).

Recommendation 3, September 2009:

			Develop and implement tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews. **Findings:** The facility presented data showing that 9% of the pharmacists' recommendations were unresolved as of March 2010. However, the facility has yet to implement a system to ensure proper follow up when physicians do not address the recommendations or offer a rationale for not addressing the recommendations. **Recommendation 4, September 2009:** *Develop and implement self-monitoring mechanism regarding the requirements in VIII.C.1 and VIII.C.2.* **Findings:** The facility presented self-assessment data regarding V.III.C.1 but has yet to provide data for VIII.C.1 **Compliance:** Partial. **Current recommendations:** 1. *Provide summary data regarding all recommendations made by pharmacists to prescribing practitioners based on drug regimen reviews by the pharmacy department.* 2. *Provide clear operational definitions for all categories of the recommendations, including Drug Information, Formulary Issues and Provider Clinical Consult.* 3. *Develop and implement tracking and follow-up mechanisms to address all situations in which the physician has not addressed the pharmacist's concerns derived from on drug regimen reviews.* 4. *Provide summary information regarding each recommendation that*

			was not followed by the physician without documented rationale.
MES	VIII.C.2	physicians to consider pharmacists' recommendations and clearly document their responses and actions taken.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Same as above. **Findings:** Same as above. **Compliance:** Same as above. **Current recommendation:** 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. Michael Hartley, CNE 2. Bernard Arons, MD, Director of Medical Affairs 3. Shirley Quarles, Director of Nursing Education and Research 4. Malcomb Cook, Infection Control Coordinator 5. George Tanyi, ADON 6. Kwason Newton LPN 7. Althea Wright RN 8. Reba Brothers RN, NM 9. Ulrich Patterson RN 10. Tonya Williams Mitchell, LPN 11. Irene Stanard, RA 12. Paul Travis RA 13. Josephine Ugochukwu RN, NM 14. Michele Richardson RN 15. Phillip Akwar RN 16. Harold McKnight FPT 17. Caroline Ibijemilusi RN 18. Olufunke Bayulaiye RN 19. Fred Awosika RN 20. Nigist Ketema LPN 21. Ms. Baja RN 22. Antoinette Saunders FPT 23. Detra Linden RN 24. Erdine Luzette King RN 25. Michele Richardson RN 26. Carol Hogan RN 27. Robert Johnson RN NM Note: PT/FPT/RA designation is based on staff self identification of role. Name tags no longer reflect role category.

			Reviewed: 1. Medical records of the following 30 individuals in care: CJB, HH, SS, AJ, LL, LD, MH, AWB, LC, KS, DB, TO, HA, AS, JC, RH, GM, YS, JW, TJ, AF, AHJ, RF, AR, CB, GC, EH, RM, AB, PW 2. SEH Compliance Report 5; April 9, 2010 3. SEH PRISM Report, April 2010 4. SEH Policy: Medical Records, 601-02; revised April 7, 2010 5. SEH, Infection Control Committee, Quarterly Report, 5/13/2010 (for 1/2010 – 3/2010;) and minutes (8/26/09 – 2/24/10) 6. SEH Nursing Department documentation template for physical observation - DRAFT 7. SEH 506, Physical Observation (documentation form); undated 8. SEH: Discipline Forms, Due Dates, and Where to File in Chart; (Updated, May 5, 2010) 9. SEH Nursing Division, Strategic Action Overview 09/09 – 04/10 10. SEH Nursing Assessment Update Audit Results (Mar – Apr 2010) 11. SEH, Nursing Procedure Manual: Guidelines for Nursing Basic Skills and Competency Assessment Process, SDR 302; revised 03/10/2010 12. Nursing Skills Lab Training Curriculum 13. SEH Competency Validation, Comp 402; Position Statement for RN and LPN Practice; revised 3/2010 14. SEH Nursing Department various competency documents including: New Employee 45 Day Competency Assessment; Psychiatric Nursing Skills Checklist; document describing "Executive Practice (Nurse Manager Competencies); Competencies for the Psychiatric Nurse; Standards of Practice and Competencies of Recovery Assistants at SEH; Nursing Orientation Competency Checklist; Medication Administration Competency Checklist; Nursing Pain Management Competency; Dysphagia Assessment/Choking Prevention Competency; Emergency Equipment Maintenance and Operation Competency; Insulin Administration Competency; Shift

			Charge Competency 15. IRP Mannual;4/10 16. Nursing Orientation – undated; program description and schedule 17. Training and Professional Development Course Catalog – undated; hospital wide course listings 18. Nursing Staff Education (table reflecting aggregate percentages of nursing staff trained in identified topics) ; 5-10-2010 19. SEH Nursing Procedure Manual: Guidelines for Nursing Documentation, COC- 302; revised 2/15/10 20. SEH Nursing Policy/Procedure: Physical Observation, NCP 715; revised 3/10/10; and Change in Patient Condition Form 21. SEH Policy: Transfers of Individuals in Care, 111.2-08; revised May 6, 2010 22. SEH Policy: General Medical Services, 208-10; new May 7, 2010; DRAFT 23. SEH Policy: Emergency Medical Response, 16.1-09; revised April 7, 2010 24. SEH Nursing Initial Assessment Audit Results 5-17-10 (for Jan – Apr, 2010) 25. Change in Patient Condition Audit Tool and Instructions 26. SEH Policy: Medication Ordering and Administration, 206-09; revised August 13, 2009 27. SEH Nursing Policy: Using e-MAR for Medication Administration, Med 501; revised 4/2010 28. SEH Nursing Policy: Medication Reconciliation Policy, Med – 501 D; revised 3/2010 29. First Dose Medication Audit Tool 30. SEH Nursing Procedure Manual: Controlled Substance Audit Policy, 801; new issuance 10/01/2009 31. SEH Nursing Procedure Manual: Insulin Administration, Med 604; revised 01/10/2010 32. SEH Nursing Procedure Manual: Guidelines for Choking/Swallowing Assessment, Identifying Triggers, and

			Prevention, NCP 600.2; revised 11/01/2010; and documentation form 300.04.09, Choking/Swallowing Assessment; revised 5/07/09 33. SEH Infection Prevention and Control Department, Annual Report 2009 34. SEH Infection Control Policy, number 10.0; Performance Improvement, Draft, undated. 35. SEH Nursing Procedure Manual, GNA.1; Plan for Provision of Care; revised 03/10/2010 36. SEH Nursing Division, Strategic Action Overview 09/09 – 04/10 37. SEH Corrective Action Plan; May 15, 2010 38. SEH Concept of Operations – Meal Service; printed 4-21-10 <u>Observed</u>: 1. IRP meetings – 1D (14 day and 60 day; MH, LD); 1E (60 day, LL) 2. Various unit operations e.g. interactions, comfort room use, medication administration on: 1 A, B, C, D, E, & G; 2 A & B 3. TLC 4. Change of Shift report on 2 B (D/E); 1 D (N/D)
LDL	VIII.D.1	Ensure that, before they work directly with individuals, all nursing and unit-based staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the individuals' status;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review and staff interviews, I concur. **Recommendation 1, September 2009:** Review the course outlines/content of hospital-wide orientation and nursing department orientation. Develop a list of topics covered in each area and specify this list in the NCS. Determine if these topics address required competencies, including those required in this agreement. For each topic, explicitly state the process used to determine competency. **Findings:** A listing of hospital wide orientation topics and nursing department

			orientation topics was provided. Both the method of instruction and the method of evaluation was specified for each of the nursing orientation topics. Topics, and the associated course outlines that were reviewed, appeared to address the six categories of competencies required by this agreement. However, the actual competency measurement/validation tools did not. As IRP processes strengthen, it may be necessary to evaluate whether or not nursing staff receive sufficient orientation/training on how to monitor symptoms and target variables. In addition, although there were relevant course outlines for orientation/training associated with mental health diagnoses, the actual nursing orientation schedule for RNs and LPNs, as well as the schedule for Recovery Assistants, revealed that it is unlikely that there is sufficient time allotted to this topic. Unit observations reflect the need for improved baseline training as well as a process for real-time learning reinforcement. The *New Employee 45 Day Competency Assessment* specifies numerous competencies, and associated evaluation methods, but does not address the specific competencies for all nursing staff required by this agreement. The *Psychiatric Nursing Skills Checklist*, a self assessment, and the *Competencies for the Psychiatric Nurse* (a list) may include a number of competencies associated with those required by this agreement. However, the relationship between these documents and orientation/training/competency assessment is not clear. **Recommendation 2, September 2009:** Review the course outlines/content of hospital-wide annual update training and nursing department annual update training. Develop a list of topics covered in each area and specify this list in the NCS. Determine if these topics address required annual competencies, including those required in this agreement. For each topic, explicitly

			state the process used to determine if competency has been maintained. **Findings:** A list of hospital-wide annual update training topics was provided. The Nursing Staff Education Report (5/10/10) reported that 28% of the nursing staff were considered "current" in all modules of annual training. It appears that this number only reflects the hospital-wide annual training/competency requirements. Nursing department-specific annual training/competency requirements are not clear, despite several references to annual trainings/competencies in varied nursing documents. The *Guidelines for Nursing Basic Skills and Competency Assessment Process,* (a nursing department document), does not clearly specify the content or process for annual competencies e.g. references both "ongoing" competency assessment and "annual" competency assessment. This document also references an annual competency checklist that was not provided. The Nursing Skills Lab Training Curriculum (a list) includes a number of "competency areas" that are designated as required annually. With some adjustments, this list of topics, coupled with the brief outlines describing 12 "training stations" in the nursing skills lab, could provide the foundation for organizing and articulating an annual (and orientation) training/competency program that could address each of the competency-based training requirements in this agreement. **Recommendation 3, September 2009:** Review all competency assessment tools to determine if competency measures meet the requirements of this agreement and generally accepted practice standards, and if the measures are currently applicable. Assure that RN competencies address RN judgment as it relates to physician order transcription, medication administration,

			seclusion and restraint use, and notifying a physician when a patient's physical status changes. **Findings:** Competency assessment tools/measures do not meet all of the requirements of this agreement for all nursing staff. Course outlines and some competency measures appear to address RN judgment in the above specified areas. **Recommendation 4, September 2009:** Develop a policy that describes 1 – 3 [in this cell in the previous report] and specifies actions taken when a staff member does not achieve or maintain competency. Actions must specify methods to assure that a staff member does provide the related service pending competency achievement. **Findings:** The policy does not adequately address 1 – 3 above. Specifically, it is vague (e.g. description of orientation), does not contain all required information (e.g. annual competency assessment requirements), and contains conflicting information e.g. the Nurse Manager conducts competency assessments on staff quarterly and annually and the Nursing Education and Research Department conducts annual competency assessments. While the policy describes actions taken relative to employees who fail to achieve competency(in terms of their re-testing), it does not specify how the duty/functional assignment on the unit will be adjusted pending confirmation of the associated competency. **Recommendation 5, September 2009:** Implement the policy.

			Findings: There is some evidence that parts of the policy are in the process of implementation. **Recommendation 6, September 2009:** Identify and resolve barriers to nursing staff attendance at required training to ensure that required training is accomplished by February 1, 2010. **Findings:** Barriers have not been resolved. **Recommendation 7, September 2009:** Report aggregate percentages of staff who attended training. **Findings:** Aggregate percentages of training attendance were reported. See below. **Recommendation 8, September 2009:** Report aggregate percentages of staff who achieved or maintained competency. **Findings:** Aggregate percentages of staff who achieved or maintained competency were not reported. **Recommendation 9, September 2009:** Add content to the physical assessment curricula related to GI issues (bleeding, bowel obstruction), infection, and delirium. **Findings:** This content was added.

			Recommendation 10, September 2009: Review and consider addressing other comments in the findings [in this cell in the previous report], especially those related to more effective use of and integration of nurse educators. **Findings:** Conversations with the Director of Nursing Education and Research, as well as documents describing the Nursing Skills Lab, suggest that efforts are underway to more fully utilize and integrate the nurse educators. However, documents do not clearly differentiate nursing education and Nurse Manager roles and functions. **Recommendation 11, September 2009:** Consider accessing assistance to quickly develop/write necessary policies so that refinements can be quickly accomplished and implementation proceed at an increased pace. **Findings:** The SEH Compliance Report did not address this recommendation and did not report alternative approaches to address the pace and quality of nursing policy and procedure development. Policies, program descriptions, and competency tools continue to need refinement and integration. It is quite likely that the status of these documents negatively impacts systematic implementation. **Other findings:** Actions have been taken in response to most recommendations. The following table reflects some progress in training nursing staff. SEH is to be commended for key areas in which they have trained 100% of the nursing staff.

Training Topic	9/2009	5/2010
Therapeutic Communication	**76%**	**80%**
Mental Health Diagnoses* RN/LPN	77%**	75%
Mental Health Diagnoses* Paraprofessionals	77%**	82%
Diabetes RN/LPN	53%**	75%
Diabetes Paraprofessionals	53%**	81%
Choking and Swallowing	32%	100%
Physical Assessment – Gen Survey/Critical Thinking	48%	80%
Medication Administration	NR	100%
Vital Signs Paraprofessionals	49%	100%
R/S	32%	91%
CPR	NR	87%
Stages of Change	38%	80%
Non-violent Crisis Intervention Training	63%	66%
Abuse and Neglect	NR	64%
Annual Training	NR	28%

Notes:
* 2009 report specified Schizophrenia; 2010 report did not specify
* * Combined report for RN/LPN, FPT, PNA, MHC
NR = Not Reported

There are many documents that discuss training and competencies in various levels of detail. Some of these documents appear duplicative and/or the relationship among them is not clear. The content of some

			documents is generic, e.g. Recovery Assistants' competencies, and contains content that does not fully relate to the specific services required by the individuals at SEH. There is not one over-arching nursing document that addresses all aspects of competency based training in a clear and concise manner. This may contribute to the finding that although a number of new competency assessment tools have been developed, overall the program and tools are not well aligned or integrated. They also do not fully address the six categories of competency based training required by this agreement. **Compliance:** Partial. **Current recommendations:** 1. Select an approach i.e. policy, procedures, program description that will result in a clear description of the content and structure of nursing orientation and annual training, the methods to determine competency, the responsible parties, and the process to assure that staff only perform functions for which they have been deemed competent. Assure that the associated competency assessment/validation tools are aligned, described/attached, and that they address the six categories of competency based training required by this agreement for all nursing staff. 2. Resolve barriers to nursing staff completion of required trainings. 3. Train all nursing staff on all mental health diagnoses and associated nursing interventions. 4. Report aggregate percentages of staff who achieved or maintained competency.
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	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur.

		responses, or lack thereof, to medication and behavioral interventions;	**Recommendation 1, September 2009:** Assure that the nursing assessment policy/procedure addresses: the process for linking the assessment to the initial IRP, the process for using "screens", and the process for evaluating/updating information that emerges during the time interval between admission and the IRP. **Findings:** This recommendation was not addressed in the SEH Compliance Report and no documentation was provided to show that this was done. Although the Comprehensive Initial Nursing Assessment form and guidelines were provided, there was no accompanying nursing assessment policy or procedure. In the absence of a clear policy or procedure, chart reviews continue to reflect that the provision is not fully met. Chart reviews revealed that the nursing assessment is missing information/ contains conflicting information, does not consistently link to the IIRP, actions following positive "screens" are not evident, and relevant information that emerges during the time interval between admission and the IRP is not integrated into the IRP. **Recommendation 2, September 2009:** Finalize the monitoring tool, begin audits, act to resolve trends and monitor the effectiveness of actions. **Findings:** Five months of IRP audits revealed that the Comprehensive Initial Nursing Assessment (CINA) was timely (100%), although the Nursing Update was not (38 – 42%). No analyses/trend identification, or actions associated with the latter finding were presented. RN attendance at IRPs has improved (83% in August, 2009; 94% in January, 2010), although attendance by paraprofessional staff was

			reported to be an average of 32%. Findings relative to the quality of the participation revealed that nursing interventions are still not adequately addressed in the IRP. **Recommendation 3, September 2009:** Develop a policy and template for nursing progress notes that meets the documentation requirements in this agreement. **Findings:** A policy was developed and a station in the nursing skills lab is devoted to supporting improvement in staff documentation skills. The required time frames and some content in the nursing policy/procedure conflict with the hospital Medical Records policy. SEH will need to determine if there is sufficient content in the nursing policy/procedure to enable staff to know what documentation must be done and how it must be done. **Other findings:** There was a discrepancy between the numbers of CINA and Nursing Assessment Update audits reported as completed in the SEH Compliance Report (2/0) and the numbers of audits reflected in the table of results (4/2). It is not clear if the discrepancy is based on concern about the reliability/validity of some audit findings. Nevertheless, findings generally correspond with those associated with my own chart reviews. For over three months, the adequacy of nursing interventions in the CINA ranged from 0% - 25%. Although the findings ranged from 60 – 80% in April, the sample was only 12%. In the charts that I reviewed, CINA boxes were usually checked, however, there was sometimes conflicting information and there was rarely an accompanying narrative that reflected a synthesis of the data findings that would inform priorities for care and treatment. IIRPs did not address all relevant

			information, including the need to address positive risk findings. SEH Nursing Assessment Update Audit Results (5% sample, March and April) reflect that the form is completed in most instances. However, there are no audit questions to address the quality of the update. In the records that were reviewed, the information on this form was rarely helpful in terms of understanding the individual's progress in treatment and/or current treatment needs. The structure and the content of the form is inconsistent with what is needed in a nursing progress note/reassessment. The CNE indicated that he envisions that the Nursing Assessment Update and the Nursing Progress Note will be combined into one document. Toward that end, he will be making revisions to existing templates and documentation requirements. It will be important to assure that the templates support documentation of both data/information and synthesis of the information in order to evaluate the individual's response to treatment, current status, and implications for IRP modifications. Nursing documentation in the records continues to be redundant, does not contain required information, and does not consistently meet the requirements established in the nursing department and hospital policies for timeliness or quality. Response to interventions, including medications, was inconsistently documented. There was consistent documentation when an individual in care did not respond to interventions, especially those associated with agitation or threatening behavior, however the content reflected a lack of understanding of mental illness and associated symptoms e.g. "refused redirection", "did not listen", "physically abusive and threatening…several physical altercations that ended with broken glasses and scratches", "demanding attention". Similar staff verbalizations were observed on the unit. In the IRP meetings that I attended, both the RN and Recovery Assistant participated and seemed to be knowledgeable about the

			individual. However, contributions were often anecdotal and not consistently focused on summary information that addressed IRP goals and included relevant quantifiable data e.g. vital signs. Contributions sometimes reflected a lack of understanding of mental illness and associated symptoms, with an associated inability to formulate suggestions for interventions. **Compliance:** Partial. **Current recommendations:** 1. Identify barriers and take actions to reduce redundant documentation and increase the consistency with which required documentation is in the records. 2. Identify and take actions to assure integration of relevant assessment data into the IIRP. 3. Monitor the effectiveness of actions taken. 4. Train all nursing staff on all mental health diagnoses and associated nursing interventions. 5. Develop a structure and process for nursing leadership to analyze various audit findings, document actions to address findings, and evaluate the effectiveness of those actions.
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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Refine the Physical Observations nursing policy. **Findings:** The policy was revised on 3/10/2010.

			Recommendation 2, September 2009: Implement the forms and policies/procedures. **Findings:** Implementation of the revised policy was not yet evident in the records that were reviewed. **Recommendation 3,September 2009:** Revise the SEH Draft Policy: Medical Response, Emergent/Urgent/ Non Urgent to at a minimum address: assessment data that the RN will provide to the MD; joint determination of the level of urgency of a physical status change; expected response times based on the level of urgency (emergent, urgent, and non-urgent); RN and MD follow up actions; assessments and documentation prior to transfer to an ED or acute care hospital; assessments, notifications, and documentation upon return from an ED or acute care hospitalization. **Findings:** There is a new draft policy that addresses these components. However, in one place the policy says that the response time for urgent situations is 30 minutes; in another place, the policy says the response time is one hour. **Recommendation 4, September 2009:** Consider developing templates to document nursing assessments for physical status change, and transfers to and from EDs or acute care hospitalizations. **Findings:** A template has been developed to provide structure for the nursing assessment and communication to the physician when an individual's physical status changes. It includes some of the documentation requirements for transfer, but not all of those listed in the hospital policy.

			Recommendation 5, September 2009: Develop a monitoring instrument; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. **Findings:** A monitoring instrument was provided, however monitoring has not begun. **Recommendation 6, September 2009:** Monitor change of shift report to assure that all of the current requirements are necessary and can be accomplished in the designated time period. **Findings:** Modifications were reported, but are not entirely clear based on the procedures and forms provided. **Other findings:** In the records that were reviewed, there was more consistent documentation of vital signs and other routine medically necessary measurements. However, documentation for non-routine physical care needs e.g. wound care, implementation of precautions, was variable in quality and inconsistently present. For example, wounds were inconsistently described, making it impossible to determine the degree to which the wound was healing. In the records of individuals whose physical status had changed and/or who were transferred to and from acute care hospitals or emergency rooms, documentation was variable (CJB, HH, SS, AJ, JC, RH, GM). In most instances, physician notification of the status

			change/status upon return was timely. With some notable exceptions, nursing assessment of status change/status upon return was often incomplete e.g. assessments did not include vital signs, time of transfer/return not documented, assessments upon return from transfer did not relate to the reason for the transfer/evaluation findings. With few exceptions, IRPs did not address nursing interventions for medical/physical conditions. The change of shift reports that were observed were comprehensive, contained specific information relative to the individual, and included information and implications for the oncoming shift. Staff were professional, attentive, and made relevant contributions/asked relevant questions. **Compliance:** Partial. **Current recommendations:** 1. Finalize the hospital policy that addresses medical services and then develop/refine/align a nursing policy/procedure accordingly. 2. Consider revising the template to document nursing assessments for physical status change so that it is more clearly focused on assessments necessary for the particular physical status change. 3. Consider developing additional templates for nursing documentation for transfers to and return from EDs or acute care hospitalizations. If another template is not developed, eliminate administrative information on the current form (e.g. "did accompanying staff member require relief"), and assure that the current form includes all documentation requirements detailed in the hospital transfer policy. Consider developing a nursing transfer policy/procedure.

			4. Develop/revise the monitoring instrument and include qualitative criteria; monitor documentation of changes in physical status and transfers; analyze trends; take action when improvement opportunities are identified; monitor the effectiveness of actions taken. 5. Identify and take actions to resolve barriers to more complete documentation of non-routine nursing interventions for physical care.
LDL	VIII.D.4	Ensure that nursing staff document properly and monitor accurately the administration of medications;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** See VIII.A.2.b.iv. **Findings:** See VIII.A.2.b.iv. **Recommendation 2, September 2009:** See VIII.D.5. **Findings:** See VIII.D.5. **Recommendation 3, September 2009:** Monitor the patient response to the first dose of medication. **Findings:** First dose response was not consistently documented in the records. **Other findings:** The SEH Compliance Report indicated that the first dose response is

			monitored for 15 minutes following administration, with follow-up every 30 minutes for the next 2 hours. This requirement does not appear in any of the policies/procedures provided and the staff did not seem to know about this. Neither the hospital policy nor the nursing procedure address specifics relative to expectations for monitoring response to a first dose of medication. The design of the new medication rooms provides greater security for medications, better working space, a dedicated computer, and an environment with limited distractions for the staff member preparing and administering medications. This is a significant improvement from the past. Understandably, the nursing staff who administer medications are still experimenting with the safest and most efficient use of space and equipment in the med rooms. Issues that need to be addressed include, but are not limited to: medication window adjustments; relocation of the refrigerator locks that are currently at the bottom of refrigerators on the floor; and relocating paper towel dispensers to an area immediately proximate to the sink. While the issues may seem minor on the surface, they are not. There is a sufficient body of evidence in the literature that the environment in which meds are prepared and administered influences the number of medication errors. Once the nursing staff have experience in using the new rooms, they should have an opportunity to propose solutions. Identified issues should be resolved in a timely manner due to their potential impact on safety and infection control. **Compliance:** Partial. **Current recommendations:** 1. Identify and resolve barriers to documenting first dose response. 2. Assure that the hospital and nursing policies/procedures relative to medication administration are aligned and clearly communicate

			expectations relative to first dose response. 3. Refine the medication administration environment.
LDL	VIII.D.5	Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Refine medication administration policy to assure it fully aligns with hospital policy, and provides clear direction regarding steps, and the order of the steps, that must be followed to support accurate medication administration. **Findings:** See VIII.D.4 There are still mis-alignments between the nursing policy/procedure and hospital policy relative to medication administration. The medication variance definition in the nursing policy/procedure is missing one component of the hospital definition and it adds other components that are not in the hospital definition. Steps to check medication packets against the e-MAR are not specified. **Recommendation 2, September 2009:** Re-train all nursing staff who administer medication. Measure and document competency. Include a review of medication variance reporting during this training. **Findings:** 100% of the staff were retrained and competency was measured. The competency assessment tool is very detailed and contains some requirements that are not specified in the nursing policy/procedure. Medication variance reporting was included in the retraining, although nursing reporting of medication variances remains low. SEH reports

			that nursing reporting of medication variance has increased to a high of 30% in February, 2010. **Recommendation 3, September 2009:** Resolve continuing issues in the Medication Ordering and Administration policy. **Findings:** See Recommendation 1 above. **Recommendation 4, September 2009:** Explore barriers to nursing reporting medication variances. **Findings:** SEH established a Six Sigma team to conduct an analysis of data relating to medication variance. Their review included an identification of reporting barriers. **Other findings:** Medication administration observations showed considerable improvement, with a number of nursing staff following most aspects of the SEH policy/procedures as well as expectations specified in the medication administration competency assessment tool. It is not clear why the hospital policy addressing medication administration still includes "Certified Medication Givers" when the nursing policy specifies that only RNs and LPNs are authorized to administer medications. This must be resolved in order to assure that all relevant classifications of workers receive competency based training for medication administration. **Compliance:** Partial.

			Current recommendations: 1. Assure that the hospital and nursing policies/procedures relative to medication administration are aligned. 2. Resolve issues associated with "Certified Medication Giver".
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;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation, September 2009:** See VIII.D.4 and VIII.D.5. **Findings:** See VIII.D.4 and VIII.D.5. **Other findings:** Failures to document in the e-MAR are not consistently reported. Although some chart reviews revealed failures to document routine medications, there was a more pervasive pattern of omissions relative to the administration of one time medication and/or evaluation of first dose response, as well as reason for/response to PRN and/or STAT medications. During medication administration observations, most nursing staff were observed to document immediately after administering the medication. This is likely to reduce the potential for blanks in the e-MAR. However, e-MAR documentation sometimes takes considerable time, contributing to agitation among the individuals in care who are waiting to receive medication. The nursing staff are actively experimenting with strategies to limit potential for agitation and described some creative approaches.

			Compliance: Partial. **Current recommendation:** See VIII.D.4 and VIII.D.5
LDL	VIII.D.7	Ensure that staff responsible for medication administration regularly ask individuals about side effects they may be experiencing and document responses;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation, September 2009:** Develop a mechanism for staff who administer medications to document inquiries relative to side effects and patients' responses. **Findings:** The SEH Compliance Report did not directly address this recommendation, other than to note that this is to be documented in the e-MAR. The report did not reveal any alternative actions taken by SEH to address this issue. There continued to be little evidence in the record, on the e-MAR or elsewhere, that this provision is met. Some staff members administering medication were observed asking individuals about side effects and/or provided relevant education about side effects. **Other findings:** During one medication administration observation, the RN made clinically astute observations about a subtle change in an individual's status and appropriately held medications pending consultation with the physician. Teaching about side effects was also observed. **Compliance:** Partial.

			Current recommendation: Involve nursing staff who administer medications in identifying the barriers to documenting their queries and education about side effects. Based on their input, consider varied approaches to supporting staff to complete this documentation.
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;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** See VIII.D.1, VIII.D.2, and VIII.D.9. **Findings:** See VIII.D.1, VIII.D.2, VIII.D.3 and VIII.D.9. **Other findings:** See VIII.D.1, VIII.D.2, VIII.D.3 and VIII.D.9. Although some nursing policies/procedures/documents contain quite a lot of general discussion/reference to the qualities of nursing professional practice, for the most part they continue to lack clear, orderly, operational specificity. SEH should consider the degree to which this impacts the consistency with which nursing staff monitor, document, and report the status of symptoms and target variables and the impact this has on the ability of the treatment team to determine the individual's status and appropriately develop/modify the IRP. **Compliance:** Partial. **Current recommendations:**

			1. See VIII.D.1, VIII.D.2, VIII.D.3, and VIII.D.9. 2. Consider accessing assistance to quickly develop/write necessary policies so that refinements can be quickly accomplished and implementation proceed at an increased pace
	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;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** See VIII.D.1, VIII.D.2, and VIII.D.10. **Findings:** See VIII.D.1, VIII.D.2, VIII.D.3, and VIII.D.9 **Recommendation 2, September 2009:** Using the nursing p/p template, revise the Guidelines Choking/ Swallowing Assessment (NCP 600.25), re-titling this as Dysphagia Assessment. Provide clear direction for what information/behavior will trigger an assessment, what the assessment will entail, what referrals will be made, and what interventions will be provided. **Findings:** The CINA does not include dysphagia/choking/swallowing as a part of the risk screen but rather combines choking and nutritional assessment. Further, the nursing procedure, *Guidelines for Choking/Swallowing Assessment and Prevention*, does not provide adequate direction for screening, assessment, and developing specific IRP interventions when individuals are at risk for choking/aspiration.

			For example, the *Choking/Swallowing Assessment* form and procedure mix historical risk factors with current observations that inform risk level; do not provide a structure or process for gathering observational information; do not differentiate between screening and assessment; and the associated competency tool is not well aligned in title or content. **Recommendation 3, September 2009:** Align the Choking/Swallowing Assessment form with the policy. Change the title to Dysphagia Assessment. Review risk factors to assure that all relevant to the population at SEH are included. **Findings:** All relevant risk factors are not included in the procedure and not included on the Choking/Swallowing Assessment Form. **Recommendation 4, September 2009:** Consider accessing assistance to develop a sound policy/procedure for dysphagia. **Findings:** The SEH Compliance Report did not address this recommendation and no documentation was provided to show that identified problems with the policy or procedure associated with dysphagia have been addressed. Policies, forms and competency tools continue to need refinement and integration. It is quite likely that the status of these documents negatively impacts systematic implementation and documentation in medical records. **Recommendation 5, September 2009:** Explore and resolve barriers to RN involvement in developing the IIRP. **Findings:**

			Chart reviews revealed that there are rarely adequate nursing interventions in the IIRP. Although some IIRPs evidenced specific RN input, others were wholly developed by the physician and did not evidence collaboration with the RN. The SEH Compliance Report indicated that by mid-April nursing would be entering interventions in the IIRP. **Other findings:** As SEH has rightfully pointed out, they should make their own decisions about the titles of policies and forms, including those that relate to dysphagia, choking or aspiration. The central issue is that the policies/procedures, forms, and associated competencies must fully address the clinical phenomena that that they purport to address. As it relates to dysphagia, and the risk for choking and aspiration, the policies must provide a mechanism, typically a "screen", to identify individuals at risk; guide a more detailed assessment for those at risk; set expectations relative to the IRP interventions designed to reduce risk; and guide an evaluation of the individual's response/evaluation of plan effectiveness. All associated policies, procedures, forms and instructions for completion need to be aligned. The fact that they are not, most likely accounts for the chart review findings. In the Comprehensive Initial Nursing Assessments that were reviewed, as well as assessments associated with physical status changes, important risk factors did not trigger an additional assessment (SS, LD). Patients were noted to be on "choking precautions" but the reason for this was not necessarily clear, and the policy does not clearly delineate what this involves e.g. some interventions apply to all patients regardless of identified risk. **Compliance:** Partial.

			Current recommendation: Develop and/or refine policies, procedures, forms, training curriculum, and competencies that are aligned with one another and that contain content designed to identify individuals at risk for choking/aspiration/swallowing difficulty and to assure necessary IRP interventions to ameliorate risk.
LDL	VIII.D.9.b	the related symptoms and target variables to be monitored by nursing and other unit staff; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Resolve IRP quality issues. **Findings:** These have not been resolved, although a consultant has been newly engaged to address issues. **Recommendation 2, September 2009:** See VIII.D.1 and VIII.D.2. **Findings:** See VIII.D.1 and VIII.D.2. **Recommendation 3, September 2009:** Revise the nursing documentation policy/procedure. **Findings:** The nursing policy/procedure has been revised. **Other findings:** IRPs rarely contained relevant nursing interventions and rarely specified symptoms and target variables to be monitored by nursing

			staff. SEH reportedly engaged a consultant to assist with IRP issues. **Compliance:** Partial. **Current recommendation:** See VIII.D.1 and VIII.D.2
LDL	VIII.D.9.c	the frequency by which staff need to monitor such symptoms.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** See VIII.D.1 and VIII.D.2. **Findings:** See VIII.D.1 and VIII.D.2 **Recommendation 2, September 2009:** Clarify if the second nurse must be present when the insulin is drawn up. **Findings:** Although the SEH Compliance Report indicates that that the second nurse must be present when the insulin is drawn up, this is not reflected in policy or the competency assessment. Both the nursing policy/procedures for *Using e-MAR for Medication Administration* and the *Insulin Administration* state: "Insulin requires documentation of a second nurse verification signature on the e-MAR". Although the policy/procedures require that a second nurse check the order, the syringe, the dose, and the type of insulin, neither specifies that the second nurse must be present or observe when the insulin is drawn up. This is not a minor detail because it means that when two types of insulin are mixed in one syringe, the doses of each type cannot be

			verified. Although the competency tool for medication administration includes competencies for various routes of administration, it does not address specifics relative to insulin administration. **Other findings:** In one medication observation involving insulin, a second nurse was present when the insulin was drawn up and all relevant checks were performed. **Compliance:** Partial. **Current recommendation:** Consider clarifying the policy relative to the fact that the second nurse needs to be present and observe the nurse drawing up the insulin.
	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;	**Current findings on previous recommendations:** SEH reports substantial compliance. Based on document review and staff interviews, I find partial compliance. **Recommendation 1, September 2009:** Continue to develop reporting mechanisms that are embedded in existing work processes so as not to create additional reporting workload. **Findings:** The Infection Control Coordinator (ICC) reports improvement in the

			reporting of individuals placed in isolation. In addition, the annual report revealed that multiple data sources are being used for surveillance and to identify infections and communicable diseases e.g. laboratory reports. **Recommendation 2, September 2009:** Refine the IC Program description to assure that each requirement in VIII.D.10 is specifically addressed. **Findings:** The SEH Compliance Report did not address this recommendation and it is not clear if SEH has addressed all requirements in the program description. The fact that there is not consistent and timely follow up on the ICC recommendations may reflect a need to further specify expectations in the program description. An Infection Control Performance Improvement policy has been revised but is in draft form. **Recommendation 3, September 2009:** Monitor reporting to assure that all infections are being reported. Determine if reporting responsibilities need to be further specified and modify policies accordingly. **Findings:** See Findings 1 and 2 above. Based on document and record review, positive PPDs are being reported and follow-up has been complete and timely (KS, DB). **Recommendation 4, September 2009:** Include employee health IC data in the IC Committee reviews. **Findings:**

			Since February, 2010, the IC Committee minutes reflect that a reporting form was developed. However, it has not been implemented by employee health and there is no data on employee infections. **Recommendation 5, September 2009:** Purchase safety syringes for IM medications. **Findings:** These were reportedly purchased. **Recommendation 6, September 2009:** Resolve issues associated with N-95 sizes and fit testing or purchase recommended masks to provide protection when droplet precautions are required. **Findings:** An alternative mask has been selected to resolve issues with fit-testing N-95 masks. **Other findings:** SEH has stopped collecting and reporting on blood borne pathogens. According to the Director of Medical Affairs, he has determined that the volume has remained stable for a sustained period of time. Because of this, he has re-directed resources to conduct 100% follow up on whether or not the appropriate clinical actions have been taken when individuals have tested positive for blood borne pathogens e.g. hepatitis and HIV. However, data relative to these reviews were not reported. In one record that was reviewed (AWB) the IRP addressed relevant goals/objectives/interventions for an individual positive for blood borne pathogens. **Compliance:** Partial.

			Current recommendations: 1. Aggregate and report to the IC Committee findings relative to clinical follow up when individuals have tested positive for blood borne pathogens. 2. Aggregate and report to the IC Committee findings relative to positive PPDs, including follow up. 3. Implement the form for reporting employee infections; aggregate and report findings to the IC Committee.
LDL	VIII.D. 10.b	assess these data for trends;	**Current findings on previous recommendations:** SEH reports substantial compliance. Based on document review and staff interviews, I find partial compliance. **Recommendation 1, September 2009:** Continue no less than quarterly data analysis. **Findings:** Quarterly analysis has been conducted and reported to the IC Committee. **Recommendation 2, September 2009:** Assure that the IC Committee minutes specify data assessment. Attach all relevant data displays to the meeting minutes. **Findings:** Some data displays were attached to some minutes. Although there was indication that the IC Committee has experimented with several formats for minutes, trend assessment is not clearly reflected. However, efforts were reportedly underway to strengthen the documentation of the data assessment that was verbally described.

			Recommendation 3, September 2009: Consider allocating administrative support time for program functions (e.g. report and minute preparation), so that the IC Coordinator can focus on program development and implementation. **Findings:** The SEH Compliance Report did not address this recommendation. Although I do not know if the ICC has been able to focus more fully on program development and implementation, the fact that the first quarter 2010 report was prepared on May 13, suggests that this recommendation may merit review or that alternative approaches need to be implemented to resolve issues. **Recommendation 4, September 2009:** Provide IT assistance to develop prioritized IC data sets. **Findings:** The SEH Compliance Report did not address this recommendation. I do not know if IT assistance was provided or if alternatives were explored. There was no evidence of enhanced aggregate data analysis. **Compliance:** Partial. **Current recommendations:** 1. Determine a format for minutes and follow through with planned actions designed to assure that IC Committee functions, from data analysis through follow-up on identified issues, are accurately represented in the minutes. 2. Consider allocating administrative and IT support for program functions (e.g. report and minute preparation), so that the IC Coordinator can focus on program development and implementation.

LDL	VIII.D.10.c	initiate inquiries regarding problematic trends;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review and staff interviews, I concur. **Recommendation 1, September 2009:** Continue data collection and analysis by the IC Committee. **Findings:** See VIII.D.10.b **Recommendation 2, September 2009:** Based on data trends, "drill down" as necessary. **Findings:** There were three investigations conducted in 2009 and an extensive review of an employee needle stick (see below). In addition, there was action taken in response to findings associated with hand-hygiene review. **Other findings:** From October 2009 - January 2010, three investigations were conducted involving: a hospital employee who was potentially exposed to rabies; staff finding a bat in the hospital; and a cluster outbreak of influenza-like illnesses. The investigations were thorough. In response to an employee needle stick, policies were reviewed and recommendations were made. However, it is not clear if the recommendations were implemented. There were also recommendations in response to low adherence to hand-hygiene requirements. Some actions were taken. Based on laboratory findings, there was appropriate follow-up to assure that relevant isolation precautions were ordered as required.

			Compliance: Partial. **Current recommendation:** See VIII.D.10.a, b, e
LDL	VIII.D.10.d	identify necessary corrective action;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation, September 2009:** In the ICPPM, specify the: reporting routes; review responsibility; and responsibility for taking, documenting, and evaluating effectiveness of actions relative to findings from "monthly safety inspections" and "environmental survey" that have implications for IC. **Findings:** There was some evidence in the IC Committee minutes that there was follow up on Environmental Surveys and quarterly Environmental Survey Reports. **Other findings:** See VIII.10.b **Compliance:** Partial. **Current recommendations:** See VIII.10.a,b,e
LDL	VIII.D.10.e	monitor to ensure that appropriate remedies are achieved;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff

			interviews, and unit observations, I concur. **Recommendation, September 2009:** Continue program implementation. Based on findings, evaluate and refine monitoring systems and processes. **Findings:** The IC Committee minutes revealed that there is an effort to monitor and evaluate effectiveness of actions taken. However, items were not consistently closed e.g. assuring MDs order relevant precautions, reporting of PPD conversions. **Other findings:** See VIII.10 a and b. The IC Committee minutes reflect that actions recommended by the ICC are not consistently completed in a timely manner. There is evidence of uneven follow through, and lack of closure, to recommendations that impact surveillance, reporting, and relevant infection control actions e.g. adequate supplies on units, including hand sanitizer, employee infection reporting. **Compliance:** Partial. **Current recommendations:** 1. See VIII.10.a and b. 2. Identify and resolve barriers to timely response to ICC recommendations. 3. Evaluate the clarity with which the IC policies/program description communicate role functions and responsibilities relative to infection control matters, especially those that require

			actions involving multiple departments.
LDL	VIII.D. 10.f	integrate this information into SEH's quality assurance review; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review and staff interviews, I concur. **Recommendation, September 2009:** Specify the linkages between the IC Committee and hospital-wide Quality Assurance/Performance Improvement. When relevant, document the linkages in the IC Committee minutes. **Findings:** A draft Infection Control Performance Improvement policy was reviewed. Linkages and actions relative to the environmental survey findings are described. However, linkages to hospital wide Performance Improvement are not sufficiently specific and these linkages are not evidenced in the PI Committee minutes. **Other findings:** Although the January 27, 2010 IC Committee minutes contain check boxes for copying minutes to the Risk Management and Safety Committee and the SEH Performance Improvement Committee, the check boxes were blank. It is unlikely that copying minutes alone will support the necessary integration. The PI Committee minutes reflect that the ICC was not present for a number of meetings and/or that reports from the IC Committee were not provided. The reasons are not clear. It is worth considering whether integration with QA/PI would support more timely actions on ICC recommendations that require actions involving multiple departments. **Compliance:** Partial.

			Current recommendation: Specify and document the linkages between the IC Committee and hospital-wide Quality Assurance/Performance Improvement.
LDL	VIII.D. 10.g	ensure that nursing staff implement the infection control program.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Finalize nursing IC policies/procedures. **Findings:** These were not provided. **Recommendation 2, September 2009:** Identify and resolve barriers to physicians ordering precautions consistent with IC policy requirements. **Findings:** There was evidence of follow up by the ICC when physicians did not order precautions consistent with requirements. For example, in the IC Committee minutes of January 27, 2010, there was a table showing that eight patients had laboratory findings requiring isolation. Of these eight, two did not have physician orders for precautions and physician follow up was conducted. However, it is not clear if the necessary precautions were ordered. **Recommendation 3, September 2009:** Involve the IC Coordinator to evaluate the degree to which IRP instructions and monitoring address IC issues. **Findings:** Although the SEH Compliance Report did not address this

			recommendation, the ICC indicated that he has independently begun to create resources that will assist nursing staff to develop and implement relevant IRP interventions when individuals have a communicable disease. It is not clear if this action alone will be sufficient to meet the requirements. **Recommendation 4, September 2009:** Develop criteria and instructions for monitoring, implement monitoring, report results to the IC Committee, take actions as required, and evaluate the effectiveness of actions taken. **Findings:** See above findings and VIII.D.10.a – e. **Recommendation 5, September 2009:** Consider monitoring options that would minimize duplication and could build on existing systems. **Findings:** None. **Other findings:** Records revealed inconsistent documentation that precautions were implemented as ordered. Hand hygiene was monitored, actions taken, and the effectiveness of actions is still being evaluated. **Compliance:** Partial. **Current recommendations:** 1. Identify and resolve barriers to documenting implementation of

<table>
<tr><td></td><td></td><td></td><td>precautions.
2. Continue to develop a menu of IRP goals/interventions to support staff to include IC matters in the IRP as relevant.</td></tr>
<tr><td>LDL</td><td>VIII.D.
11</td><td>Ensure sufficient nursing staff to provide nursing care and services.</td><td>Current findings on previous recommendations:
SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur.

Recommendation 1, September 2009:
Immediately ensure at least one RN on duty on all units/shifts.

Findings:
One RN has reportedly been on duty on all units/shifts since January, 2010. However, a review of two weeks of work schedules showed that there were two shifts without RN coverage (see below).

An untitled report shows the average numbers of RNs, LPNs, PNA/FPTs on duty on day, evening and night shift for each month from October 2009 through February, 2010. The following table reflects the average number of RNs on duty per shift for the reporting period.

Average Number of RNs per shift
<table><tr><td></td><td>Days</td><td>Eves</td><td>Nocs</td></tr><tr><td>RMB</td><td>1.3</td><td>1.2</td><td>1.1</td></tr><tr><td>JHP</td><td>1.1</td><td>1.2</td><td>1.0</td></tr><tr><td>Hospital wide</td><td>1.2</td><td>1.2</td><td>1.1</td></tr></table>
Recommendation 2, September 2009:
Determine the number and mix of staff that are needed on duty each day to meet the established standards for NCHPPD and RN mix. Use these numbers as the baseline to express the variance by role</td></tr>
</table>

			classification. **Findings:** There was no evidence that this was done. Variance was not expressed. **Recommendation 3, September 2009:** Continue to use the worked hours and census as the baseline for calculating the actual NCHPPD delivered. **Findings:** An untitled report shows the NCHPPD from October, 2009 – February, 2010. For this reporting period, hospital-wide, SEH reported an average of 5.37 NCHPPD. On JHP, the average was 5.08 and in RMB the average was 5.64. For the two week period of 4/11/10 – 4/25/10, there were two shifts (night, RMB 4 and RMB 5) without at least one RN. The average NCHPPD on each unit ranged from 4.21 – 6.57 with considerable intra-unit variability. On some units/some days the NCHPPD were as low as 3.00 NCHPPD. This much variability generally reflects an insufficient overall number of staff and it merits review. In addition, the variability could reflect that staff scheduled to work on one unit are pulled to another in order to meet minimum staffing requirements and/or changes in acuity/service intensity. SEH needs to monitor the degree to which this is happening because pulling staff across units seriously disrupts continuity of care and the consistent implementation of the IRP. **Recommendation 4, September 2009:** Evaluate whether or not there are sufficient positions to implement the target NCHPPD and RN mix. Develop a short and long term plan to resolve variances.

			Findings: Neither an evaluation of positions nor a short or long term plan to resolve variances was presented. **Recommendation 5, September 2009:** Evaluate the degree to which the 30% RN target will ensure sufficient numbers of RNs on all units to supervise nursing care/services provided by LPNs and Psych Techs, as well as meet the patient requirements for RN direct care/service (including assessing patients, developing IRP interventions, implementing interventions, and evaluating the effectiveness of nursing interventions). The targeted RN mix should take into account the increased medical co-morbidities among patients receiving mental health services, as well as requirements associated with enhanced treatment and rehabilitative activities. **Findings:** The Plan for Provision of Care articulates a goal of 30 percent RN skill mix and 6 NCHPPD. A "Core Staffing Plan" for each unit was referenced, but not provided. Reports provided only address the NCHPPD provided, and the number of RNs on duty, not the RN skill mix. The findings of this review, as well as unit observations, suggest that a 30% RN skill mix is not adequate. **Recommendation 6, September 2009:** Refine and assure integration among the staffing documents, distinguish current from desired staffing capability as necessary, and develop a systematic plan to resolve variances. **Findings:**

			See above findings. **Recommendation 7, September 2009:** Evaluate staffing on a monthly basis to include: average NCHPPD provided by unit, and specified variance; average on-duty RN mix by unit, and specified variance; the number, type, and percent of nursing position vacancies; turnover; overtime use; unscheduled leave use; 1:1 observations. Consider displaying these figures on one or two reports in order to support analysis and identify how these factors influence one another. **Findings:** The SEH Compliance Report did not address this recommendation. There was no evidence that alternative actions were taken to ensure the routine evaluation of nursing staffing that includes relevant variables. It was reported that overtime use was decreased by 40%, although no specific data were presented. It was also reported that 1:1 observations had been decreased by over 50%, although no specific data were presented. **Recommendation 8, September 2009:** Evaluate the findings from the study that examined off unit accompaniment (previously reported to have been undertaken). Determine the relevance of the findings for nursing staffing plans. **Findings:** It is likely that the move to the new building will limit the amount of time that nursing is involved in off unit accompaniment. **Recommendation 9, September 2009:** Relieve the CNE and ADON of PI/RM duties.

			Findings: Both the PI and RM positions were filled in December, 2009. **Recommendation 10, September 2009:** Reconsider the decision to use NMs for baseline training; consider using the Nursing Education Department and/or other staff development resources in the hospital; if the NMs are used, assure a structure for on the unit supervision/coaching. **Findings:** The SEH Compliance Report did not address this recommendation and documents did not reflect alternative actions to clarify baseline training responsibility. See VIII.D.1 **Other findings:** The CNE has a clear vision of the necessary structure for nursing leadership and is systematically taking actions to put this structure in place. He is also keenly aware of budgetary constraints and is very conservative in resource use. Nursing services have been restructured consistent with the plan that was developed prior to the last review. Nursing Managers re-interviewed for their positions, two Assistants to the CNE have been added, and three of the four newly established "off shift" supervisory positions have been filled. All of these positions are critical to provide the consistent leadership needed for all clinical areas. Recruitment is underway for two additional nurse educators who will report to the Director of Nursing Education and Research. These positions are also critical to accomplish the varied orientation, annual training, and staff development activities necessary to support improvement efforts. The nursing *Plan for Provision of Care* states that "All areas where

			nursing care is rendered are developing their own detailed Scope of Care/Services that will be maintained on the units". No review or approval process was described and none of these documents were provided. It is unlikely that the current level of diversity in the population served or services provided (especially in the new building) requires unit based scope of service descriptions. Unit specific documents of this nature have serious implications for everything from job descriptions through orientation/training and competency assessment. SEH is encouraged to seriously re-consider this approach. If the approach is implemented, SEH must immediately establish a mechanism to review and approve units' scope of service descriptions. In addition, SEH must determine and address implications for orientation, training, staff development and competency determinations. Six attachments were referenced in the *Plan for Provision of Care* but were not provided. The plan itself states that nursing delivers "team based nursing care consisting of assessment, interventions and evaluations" but does not specify that the functions of assessment, planning, and evaluations are typically limited to RNs only. It is not known if any of the referenced attachments address this critical matter. Although reports of the average numbers of various nursing classes and NCHPPD were provided, there was no evidence of analysis or evaluation of staffing, no identification of trends, and no descriptions of actions planned to resolve variances. SEH reported that 6 RNs and 3 nursing supervisors were hired during the review period and 23 left employment, including 11 who were terminated due to performance issues. Currently, there are reportedly 3 nurse manager positions, 15 nurse positions, and 6 paraprofessional positions in recruitment or awaiting announcement.

			The SEH Compliance Report indicates that hiring has reportedly been substantially slowed due to "new hiring procedures in place". A "vacancy reduction" effort was referenced in the *Nursing Strategic Action* overview. The CNE is now providing direct oversight to ensure that there are not delays in the recruitment process. Part time positions have reportedly been developed to widen the recruitment pool. This is commendable. Nursing was reportedly substantially more selective in hiring, evidenced in an extensive "behavioral" interview document and the fact that most candidates were interviewed twice. Over 90 candidates were interviewed but fewer than 35 offered positions. Nursing leadership indicated that they believe they are hiring more qualified candidates. Based on unit observations, there are indications that the overall numbers of nursing staff may be insufficient. It is very apparent that there are an insufficient number of RNs to provide direct services as required by individuals and/or to supervise the care/services provided by non-licensed nursing staff. There were occasions when a unit was required to send one RN and one or two PTs (out of four or five staff) to the TLC despite the fact that over three-quarters of the individuals in care remained on the unit either because they did not have TLC schedules or they were returned to the unit. Moreover, out of the seven assigned day shift nursing staff members on one unit, three were required to be with individuals on 2:1 or 1:1, and one was required to go to the TLC, leaving three nursing staff members to provide services on the unit. Notably, two-thirds of the individuals remained on the unit during TLC hours, many with significant behavioral challenges. In most instances there was one RN on the unit. This RN was required to perform charge nurse duties, conduct groups, sometimes administer

			medications, attend IRP sessions, provide direct services to individuals e.g. conduct CINA, assessments of physical status changes, implementation of IRP interventions requiring RN skills, take actions to reduce the potential for behavioral emergencies and/or deal with these emergencies. This single RN is also required to supervise the care provided by non-licensed nursing care providers and complete significant documentation and reporting requirements. It is not humanly possible for one RN to accomplish all that is expected. This reality is evident in the findings of this report as well as in unit observations. There were a number of disengaged nursing staff, and a few, but significant, statements and behaviors that reflected understandable frustration but were not professional. These observations went unnoticed/unaddressed by the single RN on duty and reflected the need for staff coaching that is not possible at the current RN staffing level. It must be noted that on one unit where there were numerous Code 13s (involving an individual with extremely challenging behavior), both the Nursing Manager and the ADON were present to provide direct services and support. While this is laudable, relying on this level position for direct services is not acceptable and pulls these individuals away from other functions necessary to lead the nursing department. Although there are documents that indicate that SEH has a target of a 30% RN mix, it is likely that this reflects the CNE's exquisite sense of/respect for budget limitations and recruitment challenges rather than the actual nursing service requirements. It is critical that SEH develop a plan to increase the RN mix in order to assure the health and safety of the individuals served. As this consultant has said before (see Report 2), the required RN mix typically ranges from 30 – 50% (and sometimes higher) in order to meet individuals' requirements for nursing care. Currently, SEH has roughly a 25% RN mix. This is not adequate for any of the units, and is totally inadequate for admissions units and units caring for individuals who are medically frail

			or have challenging behaviors. To be clear, nursing leadership is making exceedingly good use of their currently limited RN resources. Pending adjustments to the RN mix, SEH should aggressively pursue opportunities to adjust the RN workload that are consistent with applicable regulations. **Compliance:** Partial. **Current recommendations:** 1. Evaluate whether or not there are sufficient positions to implement the target NCHPPD and an RN mix that is consistent with the needs of the individuals served (see Recommendation 5, September, 2009 and other reports). Develop a short and long term plan to resolve variances. 2. Evaluate staffing on a monthly basis to include: average NCHPPD provided by unit, and specified variance; average on-duty RN mix by unit, and specified variance; the number of occasions when nursing staff are pulled from one unit to another by role classification; the number, type, and percent of nursing position vacancies; turnover; overtime use; unscheduled leave use; 1:1 observations. Consider displaying these figures on one or two reports in order to support analysis and identify how these factors influence one another. Document the evaluation, actions taken, and effectiveness of these actions. 3. Add RN positions to provide a skill mix consistent with service needs. Develop a plan to adjust RN workload on an interim basis pending an adequate mix.

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

	X. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications		
LDL		By 12 months from the Effective Date hereof, SEH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with federal law and the Constitution of the United States.	**Summary of Progress:** 1. The hospital completed a reconciliation of the Restraint and Seclusion for Behavioral Reasons, the Use of Protective Devices, and the Involuntary Administration of Medication policies. 2. Seclusion and restraint use continues to be below benchmarking data in both the percent of individuals secluded or restrained, as well as in the total hours. 3. Ninety-one percent of the nursing staff have had seclusion and restraint training.
LDL			**Methodology:** <u>Interviewed</u>: 1. Michael Hartley, CNE 2. Bernard Arons, MD, Director of Medical Affairs 3. Shirley Quarles, Director of Nursing Education and Research 4. George Tanyi, ADON 5. Kwason Newton LPN 6. Althea Wright RN 7. Reba Brothers RN, NM 8. Ulrich Patterson RN 9. Tonya Williams Mitchell, LPN 10. Irene Stanard, RA 11. Paul Travis RA 12. Josephine Ugochukwu RN, NM 13. Michele Richardson RN 14. Phillip Akwar RN 15. Harold McKnight FPT 16. Caroline Ibijemilusi RN 17. Olufunke Bayulaiye RN 18. Fred Awosika RN 19. Nigist Ketema LPN 20. Ms. Baja RN

			21. Antoinette Saunders FPT 22. Detra Linden RN 23. Erdine Luzette King RN 24. Michele Richardson RN 25. Carol Hogan RN 26. Robert Johnson RN NM Note: PT/FPT/RA designation is based on staff self identification of role. Name tags no longer reflect role category. <u>Reviewed</u>: 1. Medical records of the following 30 individuals in care: CJB, HH, SS, AJ, LL, LD, MH, AWB, LC, KS, DB, TO, HA, AS, JC, RH, GM, YS, JW, TJ, AF, AHJ, RF, AR, CB, GC, EH, RM, AB, PW 2. SEH Compliance Report 5; April 9, 2010 3. SEH PRISM Report, April 2010 4. SEH Policy: Restraint and Seclusion for Behavioral Reasons, 101.1-04; revised March 30, 2010 5. SEH Policy: Involuntary Medication Administration, 201-5; revised March 30, 2010 6. SEH Nursing Procedure Manual: Care of Individuals in Restraints and/or Seclusion for Behavioral Reasons, PSS 500; revised 10/10/09 7. SEH Nursing Procedure Manual: Protective Measures, PSS 507; revised 10/10/09 8. SEH: Rights of Individuals Receiving Care: Restraint and Seclusion (Summary of the Restraint and Seclusion for Behavioral Reasons Policy); March 30, 2010 9. SEH Synopsis of Seclusion/Restraint Event Audits, August 2009 – January 2010 10. SEH List of patients who received PRN and STAT medications between 10-1-09 and 3-23-09 11. SEH Pharmacy and Medication Report (February 2010)

			12. Risk Trigger Indicators – SEH: Three or More Unusual Incidents Received within a 30 day Period; February 3 – March, 5, 2010; report date March 7, 2010. 13. SEH Policy: Medical Records, 601-02; revised April 7, 2010 14. SEH: Discipline Forms, Due Dates, and Where to File in Chart; (Updated, May 5, 2010) 15. SEH Nursing Division, Strategic Action Overview 09/09 – 04/10 16. SEH Nursing Assessment Update Audit Results (Mar – Apr 2010) 17. SEH, Nursing Procedure Manual: Guidelines for Nursing Basic Skills and Competency Assessment Process, SDR 302; revised 03/10/2010 18. Nursing Skills Lab Training Curriculum 19. SEH Competency Validation, Comp 402; Position Statement for RN and LPN Practice; revised 3/2010 20. SEH Nursing Department various competency documents including: New Employee 45 Day Competency Assessment; Psychiatric Nursing Skills Checklist; document describing "Executive Practice (Nurse Manager Competencies); Competencies for the Psychiatric Nurse; Standards of Practice and Competencies of Recovery Assistants at SEH; Nursing Orientation Competency Checklist; Medication Administration Competency Checklist; Nursing Pain Management Competency; Dysphagia Assessment/Choking Prevention Competency; Emergency Equipment Maintenance and Operation Competency; Insulin Administration Competency; Shift Charge Competency 21. IRP Mannual;4/10 22. Nursing Orientation – undated; program description and schedule 23. Training and Professional Development Course Catalog – undated; hospital wide course listings 24. Nursing Staff Education (table reflecting aggregate percentages of nursing staff trained in identified topics) ; 5-10-2010 25. SEH Nursing Procedure Manual: Guidelines for Nursing

			Documentation, COC- 302; revised 2/15/10 26. SEH Nursing Initial Assessment Audit Results 5-17-10 (for Jan – Apr, 2010) 27. SEH Policy: Medication Ordering and Administration, 206-09; revised August 13, 2009 28. SEH Nursing Policy: Using e-MAR for Medication Administration, Med 501; revised 4/2010 <u>Observed</u>: 1. Various unit operations e.g. interactions, comfort room use, medication administration on: 1 A, B, C, D, E, & G; 2 A & B 2. TLC 3. Change of Shift report on 2 B (D/E); 1 D (N/D)
	X.A	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications that cover the following areas:	Please see sub-cells for findings and compliance.
LDL	X.A.1	the range of restrictive alternatives available to staff and a clear definition of each and that the use of prone restraints, prone containment and/or prone transportation is expressly prohibited.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Train all nursing staff. Consider returning baseline training responsibility to the Nursing Education Department, and resolve barriers to unit staff attendance at required training. **Findings:** See VIII.D.1

			Recommendation 2, September 2009: Methodically review all policies addressing restraint/seclusion (R/S) as well as associated content in policies that address emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards. **Findings:** SEH reports that this has been completed. It appears that previous content issues in the hospital R/S policy have been resolved but not those in the involuntary medication administration policy. Specifically, the hospital policy for involuntary medication administration still contains the statement "…a detailed discussion of drugs used as a restraint…" referencing to the R/S policy (page 3 of 19). The nursing procedure for R/S has not been aligned with hospital policies and with required standards. (See previous report for examples). The hospital policy on medical or protective measures generally meets requirements. SEH should evaluate the degree to which the examples provide sufficient guidance for bed/side rail use. The nursing procedure on protective measures does not align with external standards e.g. bed/side rail use. It does not align with the hospital policy for medical or protective measures e.g. medical restraint is not included in the nursing procedure. **Recommendation 3, September 2009:** Ensure consistency between and among policies associated with [Recommendation 2]. **Findings:** See Recommendation 2 Finding above.

			Recommendation 4, September 2009: Ensure that the content on all forms is consistent with policies and supports staff to complete required documentation. **Findings:** SEH reports that the form revision is "in the queue" for Avatar modifications. **Recommendation 5, September 2009:** Consider technical assistance for policy refinements so that they can proceed quickly. **Findings:** The SEH Compliance Report did not address this recommendation or identify an alternative approach. Policy refinements are incomplete. **Recommendation 6, September 2009:** Revise audit tools as required by the actions [taken in response to Recommendations 1-5 above]. Continue monitoring. Involve clinical staff in analyzing findings, determining actions, and evaluating the effectiveness of actions taken. **Findings:** Audit tools may need revision once the forms are revised. R/S reports are being sent to Clinical Administrator (CA) and Nurse Manager (NM) of each unit. However, the feedback loop to leadership is not clear. This is essential if the CA and NM groups have ideas about changes that would enable them to meet review and documentation requirements. **Recommendation 7, September 2009:** Clarify and monitor use of the "quiet room" considering policy guidance

			for this concept as well as the concept of "time out". Explore alternative space(s) for these approaches. **Findings:** This has been clarified. In addition, the design of the new building greatly reduces the potential confusion relative to quiet room versus seclusion. There are both single rooms and established comfort rooms on the units. The latter were observed to be in use. **Recommendation 8, September 2009:** In the SEH R/S policy, consider moving sensory-based interventions from the examples of "moderate level of intervention" to the examples in "low level of intervention". Early use of these interventions tends to enhance their effectiveness. **Findings:** This has been done in the hospital policy. **Other findings:** Instead of a "staff member", the hospital policy for R/S use now requires that an RN "…shall, in person, continuously monitor, observe and regularly assess the individual throughout the R/S" (page 13 of 25). While *assessment* requires an RN, other trained and competent nursing staff can monitor and observe. Since SEH frequently has only one RN on duty per unit/shift, the requirement that an RN perform 1:1 monitoring should be reconsidered. If this is not changed, nursing administration will need to make specific provisions to assure that other individuals in care in the unit/"house" will have access to an RN as needed. SEH has created a document entitled "Rights of Individuals Receiving Care: Restraint and Seclusion" referred to as *Seclusion and Restraint Tips* or a *Summary of the Restraint and Seclusion for Behavioral*

			Reasons Policy. This is reportedly a "primer" created by the Risk Manager for treatment team members. Some content does not fully comport with the related policies. **Compliance:** Partial. **Current recommendations:** 1. Methodically review all policies (hospital and nursing) addressing restraint/seclusion as well as associated content in policies that address emergency involuntary psychotropic medication use. Identify and resolve all content that is inconsistent with standards. 2. Ensure that the content on all forms is consistent with policies/procedures and supports staff to complete required documentation. 3. Modify the audit tool in response to 1 and 2 above and continue monitoring. 4. Establish or define the feedback loop to leadership when unit staff who review data have ideas about how to meet requirements.
LDL	X.A.2	training in the management of the individual crisis cycle and the use of restrictive procedures; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** See VIII.D.1 and X.A.1. **Findings:** SEH reported that 91% of nursing staff and 69% of psychiatrists are current in R/S training; 66% of nursing staff and 55% of psychiatrists are current in the Non-violent Crisis Intervention training. **Recommendation 2, September 2009:**

			Align training curriculum and documentation of staff competencies with Exhibit 2 of the SEH R/S policy. **Findings:** Since SEH reported using the curriculum developed in August, 2009, it is not likely that it is aligned as recommended. **Other findings:** Both the records that were reviewed and unit observations revealed that staff continue to have a limited understanding of diagnoses, symptoms, and interventions necessary to limit the circumstances that give rise to crises. They frequently view behavior as willful and react in personalized ways. This is especially evident when individuals repeatedly engage in threatening, aggressive and/or assaultive behavior. **Compliance:** Partial. **Current recommendations:** See VIII.D.1
LDL	X.A.3	the use of side rails on beds, including a plan:	**Current findings on previous recommendations:** SEH reports substantial compliance. Based on document review, I find partial compliance. **Recommendation 1, September 2009:** Assure that relevant safeguards are in place for the patients who still use side rails with tapered ends. **Findings:** It was reported that there are new side rails to use with the furniture in the new building.

			Recommendation 2, September 2009: Integrate side rail use into the PRISM report. **Findings:** This has not been done. There continues to be no systematic monitoring of side rail use. **Recommendation 3, September 2009:** Revise the nursing policy to address the type of issues in the examples [identified in this cell in the previous report] to clarify accountability, as well as to align with other SEH policies and relevant external standards. **Findings:** Many of the previously reported issues have not been addressed. **Recommendation 4, September 2009:** Resolve barriers to integrating side rail use into the IRP. **Findings:** In the one chart that was reviewed (HH), the IRP addressed side rail use. **Recommendation 5, September 2009:** Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken. **Findings:** This is not being done. **Other findings:** SEH reported that no side rails had been used. However, when an

			individual's chart was reviewed for another matter, it was noted that side rails had been used since September, 2009 to prevent falls. **Compliance:** Partial. **Current recommendation:** Monitor side rail use and adherence to policy, analyze findings, determine actions to resolve identified trends, and evaluate the effectiveness of actions taken.
LDL	X.A.3.a	to minimize the use of side rails as restraints in a systematic and gradual way to ensure safety; and	**Current findings on previous recommendation:** SEH reports substantial compliance. Based on document review, I find partial compliance. **Recommendation, September 2009:** See X.A.3. **Findings:** See X.A.3. **Compliance:** Partial. **Current recommendation:** See X.A.3.
LDL	X.A.3.b	to provide that individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the	**Current findings on previous recommendation:** SEH reports substantial compliance. Based on document review, I find partial compliance. **Recommendation, September 2009:** See X.A.3.

		medical symptoms.	**Findings:** See X.A.3. **Other findings:** In the record that was reviewed, the IRP addressed side rail use and a plan to transition the individual to using a floor mat at the bedside. **Compliance:** Partial. **Current recommendation:** See X.A.3.
LDL	X.B	By 12 months from the Effective Date hereof, and absent exigent circumstances (i.e., when an individual poses an imminent risk of injury to self or others), SEH shall ensure that restraints and seclusion:	Please see sub-cells for findings and compliance.
LDL	X.B.1	are used after a hierarchy of less restrictive measures has been considered and documented;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Include data on staff injuries in the PRISM reports. Monitor staff injuries, identify trends, take actions to resolve trends, and evaluate the effectiveness of actions taken. **Findings:** These data are now included in the PRISM reports. However, trends are not yet identified.

			Recommendation 2, September 2009: Implement a system to concurrently review interventions used to prevent and/or manage behavioral emergencies when patients repeatedly experience those emergencies. **Findings:** There is no evidence that this is being done. For example, in five charts (six events) reviewed only one IRP was adjusted following R/S use. There was no evidence of treatment team debriefing. **Recommendation 3, September 2009:** See VIII.D.11 regarding RN staffing levels and use of NMs. **Findings:** A Nursing Manager was observed to be present and assisting staff members working with an individual whose behaviors were extremely challenging e.g. threatening and assaultive over a period of weeks. However, there are not a sufficient number of RNs on duty to provide real time intervention and coaching when actual or potential behavior emergencies emerge on the unit. **Recommendation 4, September 2009:** See VIII.D.1. Prioritize training on mental health diagnoses. **Findings:** See VIII.D.1 **Recommendation 5, September 2009:** Resolve barriers to the development of meaningful IRPs that address individuals' current needs. **Findings:** IRPs continue to fail to address actual and/or potential for behavioral

			emergencies. When there was documentation in the record that an individual in care identified comfort measures, this information was not integrated into the IRP. However, there was some evidence that nursing staff implemented these measures. **Other findings:** The SEH Compliance Report indicates that in less than half the R/S events, nursing staff used low or moderate level interventions. In my review of the charts, these levels of intervention were generally documented although "redirection" continues to be the most common intervention. Subsequent to R/S use, SEH reports that the treatment team addressed the episode in 18% of the IRPs. I found one IRP that addressed restraint use and no evidence of treatment team debriefing in any of the six events that were reviewed. Occasionally, nursing developed a milieu re-entry plan with the individual. **Compliance:** Partial. **Current recommendations:** 1. Examine audit questions and scoring guidelines to assure that all least restrictive interventions are considered, even if the interventions do not appear as examples in the R/S policy. 2. See VIII.D.1.

LDL	X.B.2	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation 1, September 2009:** Continue implementation of the EARN approach and accelerate the plan to extend the model to other units. **Findings:** All staff have reportedly been trained in the EARN approach. In addition, as a part of their data dashboard, Nursing Managers are required to provide oversight of/report on this initiative. **Recommendation 2, September 2009:** Finalize the R/S audit and refine instructions as needed. **Findings:** It appears that the audit tool has been finalized, though it may need adjustment when forms are revised. **Recommendation 3, September 2009:** Resolve inter-rater reliability issues and measure inter-rater reliability on a monthly basis. **Findings:** It appears that one person is doing all R/S audits at this time. Although this removes the potential for different interpretation among several reviewers, a mechanism to ensure continued fidelity to the audit purpose and requirements should be established. **Recommendation 4, September 2009:** Monitor the RMB 3 and RMB 6 patient mix and program development/mall integration.

			Findings: This has been resolved with the move to the new building. **Recommendation 5, September 2009:** Expand evening and weekend programming. **Findings:** Because of the very recent move to a new building, schedules for evening and weekend programming were not available on several units. **Other findings:** SEH reported that in 100% of the events reviewed (August – January 2010), R/S was used only when the individual posed imminent risk to others. My review was consistent with this finding. There were many patients observed to be on the admissions units during TLC time. Various explanations were offered that involved time intervals during which new individuals could not attend TLC activities. There were no substitute unit programs. In most instances, there were also insufficient nursing staff remaining on the unit to provide any unit based activities. No other disciplines were observed to be involved with unit based groups. **Compliance:** Partial. **Current recommendations:** 1. Develop unit/house based daily schedules that include TLC as well as evening and weekend programming at the earliest opportunity. 2. Monitor EARN implementation. 3. Re-evaluate nursing staff deployment to TLCs and policies relative to newly admitted individuals' attendance at TLCs to ensure sufficient nursing staff in all areas providing active treatment.

LDL	X.B.3	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** SEH reports substantial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation, September 2009:** Develop a mechanism to monitor for compliance. **Findings:** There was no evidence that R/S was used as a part of a behavioral intervention. **Compliance:** Substantial. **Current recommendation:** Maintain compliance with this provision.
LDL	X.B.4	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** Remove "target symptoms" from the Doctor's Order Form. **Findings:** SEH reports that the form revision is "in the queue for Avatar modifications". **Recommendation 2, September 2009:** Clarify the term "gradual release"; assure that the clarification is aligned with relevant regulations/standards and included in policies. **Findings:** See Recommendation 1 above.

			Recommendation 3, September 2009: See X.C.3. **Findings:** See X.C.3. **Other findings:** SEH reported that from August – October, 2009, 100% of the episodes were terminated when the individual was no longer an imminent danger. The same was true for 89% of the episodes occurring November 2009 – January 2010. With rare exception, my own reviews were similar. **Compliance:** Partial. **Current recommendation:** Proceed with planned form revision.
	X.C	By 12 months from the Effective Date hereof, SEH shall ensure that a physician's order for seclusion or restraint include:	Please see sub-cells for findings and compliance.
LDL	X.C.1	the specific behaviors requiring the procedure;	**Current findings on previous recommendation:** SEH reports substantial compliance. Based on document review, I find partial compliance. **Recommendation, September 2009:** See X.B.4 and X.C.3. **Findings:** SEH reported that specific behaviors requiring the procedure were

			documented in 100% of the episodes for the period of August, 2009 – January 2010. They acknowledge that this finding is based on reviewing the *Doctor's Order Form* that is in Avatar. However, one of the six episodes that I reviewed had no physician order or form. **Compliance:** Partial. **Current recommendation:** Proceed with form revision and continue monitoring.
LDL	X.C.2	the maximum duration of the order;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** Include this criterion in the R/S audit. **Findings:** This has not yet been included in the audit criteria. **Recommendation 2, September 2009:** Monitor this requirement, analyze trends, act to resolve identified trends, and evaluate effectiveness of actions taken. **Findings:** SEH reports that a review of the *Doctor's Order Form* revealed that the maximum duration of the order was present in the records reviewed, however they do not have data at this time due to pending revision of the audit tool. **Other findings:** With the exception of the seclusion use that did not have a physician order, all other records that I reviewed had the maximum duration

			specified in the order. **Compliance:** Partial. **Current recommendation:** Revise the audit tool and continue monitoring.
LDL	X.C.3	behavioral criteria for release which, if met, require the individual's release even if the maximum duration of the initiating order has not expired;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** Consider involving the Psychology Department for assistance in writing behavioral release criteria. **Findings:** The SEH Compliance Report did not address this recommendation. **Recommendation 2, September 2009:** Remove "target symptoms" from the *Doctor's Order Form*. **Findings:** SEH reports that the form revision is "in the queue for Avatar modifications". **Other findings:** SEH reports that there were individualized criteria for release in 100% of all episodes. However, they also report that "based on the review of a small subset of cases, it appears that in a number of cases, the criteria for release are not behavioral in nature." In the records that I reviewed, there were findings similar to this sub-set e.g. criteria for release were not sufficiently behavioral, and included such items as the need for "insight".

			Compliance: Partial. **Current recommendations:** 1. Involve physicians in identifying support necessary to write behavioral release criteria. 2. Proceed with planned form revision and continue monitoring.
LDL	X.C.4	ensure that the individual's physician be promptly consulted regarding the restrictive intervention;	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, I concur. **Recommendation, September 2009:** Clarify policy expectations relative to who orders seclusion/restraint, and if "order" and "consult" are one in the same, and align audit accordingly. **Findings:** The policy states that the "attending" or "treating" physician can order seclusion/restraint. **Other findings:** SEH reports that the physician was consulted in 100% of the R/S episodes from August through October, but in only 44% of the episodes from November – January 2010. The drop is attributed to problems with the audit question. There were similar problems identified with the audit tool during the last review. SEH plans to address this when the audit tool is revised, however it isn't clear when this will be accomplished. **Compliance:** Partial.

			Current recommendation: Proceed with plans to revise audit tool.
LDL	X.C.5	ensure that at least every 30 minutes, individuals in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** See X.A.1. **Findings:** See X.A.1. **Recommendation 2, September 2009:** Revise the *Levels of Observation Flow Sheet* form to support staff to document requirements and to align with the SEH goal of providing a recovery-oriented, trauma-informed treatment setting. **Findings:** SEH reports that the form revision is "in the queue for Avatar modifications". **Other findings:** SEH audit revealed that the individual was advised of release criteria every 30 minutes in 67% of the episodes. **Compliance:** Partial. **Current recommendations:** 1. See X.A.1. 2. Proceed with planned form revision and continue monitoring.
LDL	X.C.6	ensure that immediately following an individual	**Current findings on previous recommendation:**

		being placed in seclusion or restraint, there is a debriefing of the incident with the treatment team within one business day;	SEH reports noncompliance. Based on document review, I concur. **Recommendation, September 2009:** Explore and resolve barriers to compliance. **Findings:** The SEH Compliance Report did not address this recommendation or alternative actions. Debriefing is still not being done as required. Specifically, .SEH reported that for the period of August through October 2009, a treatment team debriefing was held in 15% of the events. From November, 2009 – January, 2010, debriefing was held in 6% of the events. **Other findings:** There was no evidence of debriefing in the records that I reviewed. In one out of six episodes, the IRP was updated. **Compliance:** Noncompliance. **Current recommendation:** Involve treatment teams to explore and resolve barriers to compliance.
LDL	X.C.7	comply with 42 C.F.R. Part 483, Subpart G, including assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints; and	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** Explore and resolve barriers to documenting the assessment. Consider asking physicians if it would be helpful to include an assessment component on one of the existing forms. **Findings:** The SEH Compliance Report did not address this recommendation and

			no alternative approaches were identified. There is evidence that the issue has not been resolved. Specifically, SEH reported that from November, 2009 – January, 2010 there was documented evidence of a face-to-face assessment within one hour in 50% of the episodes; this is a drop from 82% reported for the August - October, 2009 time period. My chart review findings roughly correspond with the lower finding. In some instances there was an MD note, but there was no evidence in the note of an actual face-to-face assessment. Rather, the note contained a reiteration of nursing observations/documentation of what was reported to the physician. **Recommendation 2, September 2009:** Continue monitoring. **Findings:** See Recommendation 1 above. **Other findings:** None. **Compliance:** Partial. **Current recommendations:** 1. Explore and resolve barriers to documenting the assessment. Consider asking physicians if it would be helpful to include an assessment component on one of the existing forms. 2. Assure that the audit question distinguishes the presence of an MD note from evidence of a face-to-face assessment.
LDL	X.C.8	ensure that any individual placed in seclusion or restraints is monitored by a staff person who has completed successfully competency-based	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur.

		training regarding implementation of seclusion and restraint policies and the use of less restrictive interventions.	**Recommendation, September 2009:** See VIII.D.1. **Findings:** See VIII.D.1 **Other findings:** See VIII.D.1 **Compliance:** Partial. **Current recommendation:** See VIII.D.1
LDL	X.D	By 12 months from the Effective Date hereof, SEH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** Resolve barriers to tracking emergency involuntary medication. **Findings:** These have not been resolved. However, SEH reports that the Pharmacy and Therapeutics Committee recently forwarded to the Medical Staff Executive Committee a recommendation relative to the definition of STAT. If accepted, this recommendation is expected to enable an AVATAR report that will track emergency involuntary medication use. **Recommendation 2, September 2009:** Develop an audit tool to monitor adherence to policy, analyze findings, act to resolve trends, evaluate the effectiveness of actions.

			Findings: This has not been done. **Other findings:** See X. F SEH reports that when they compare nursing's 24 hour report with the unusual incident data base, there is evidence that R/S is being reported accurately. However, there is still no database relative to emergency involuntary medication administration. The Pharmacy and Therapeutics Committee has made a recommendation that reportedly will enable reports to be produced and SEH is urged to pursue this as quickly as possible. Limited RN resources are being significantly burdened by cumbersome reporting requirements e.g. completing unusual incident reports for R/S use, medication refusals, and (according to some documents) administration of emergency involuntary medication. Now that SEH is entirely on an EMR, there should be an immediate review of all documentation and reporting requirements to eliminate duplication, enhance efficiency, and redirect limited RNs to individuals in care and activities required by this agreement. SEH should identify and aggressively pursue opportunities to extract data directly from AVATAR rather than require nursing staff and/or other clinicians to spend time generating numerous reports. **Compliance:** Partial. **Current recommendation:** Review all documentation and reporting requirements. Identify and pursue opportunities to extract data directly from AVATAR whenever

			possible.
LDL	X.E	By 12 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols to require the review of, within three business days, individual treatment plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of treatment plans, as appropriate.	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, I concur. **Recommendation, September 2009:** Determine and resolve barriers to timely and relevant IRPs. **Findings:** No individuals met the threshold for seclusion or restraint use. However, a number of individuals repeatedly engaged in assaultive behavior. Their IRPs did not adequately address this behavior. **Other findings:** SEH reportedly implemented a system that tracks several high risk indicators. Based on thresholds, the Director of Medical Affairs is notified. He, or a designee, meets with the team, and enters recommendations into AVATAR with a notification to Risk Management that the review has been conducted. Clinical administrators are responsible to consider the recommendations in the next IRP. **Compliance:** Partial. **Current recommendation:** Continue implementation of the system and associated monitoring.
	X.F	By 12 months from the Effective Date hereof, SEH shall develop and implement policies and/or protocols regarding the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	Please see sub-cells for findings and compliance.

LDL	X.F.1	such medications are used on a time-limited, short-term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review and unit observations, I concur. **Recommendation 1, September 2009:** Develop reports that monitor the use of emergency involuntary psychotropic medication administration. **Findings:** No reports have been developed. **Recommendation 2, September 2009:** Develop an audit tool to monitor adherence to policy requirements. **Findings:** No audit tools have been developed. **Recommendation 3, September 2009:** Determine which position/body will review and analyze findings, take actions to address trends, evaluate the effectiveness of actions taken, and document the process. **Findings:** The SEH Compliance Report did not address this recommendation. However, it appears that the Pharmacy and Therapeutics Committee has conducted some data review. **Other findings:** The data in the cover table that reports the numbers of patients who received PRN or STAT psychotropic medications is confusing and merits review (Number of Patients with PRN and STAT Medications, October 2009 – March 23, 2010). Nevertheless, the accompanying 225-page document that lists the name of the patient and the name of

			each medication administered on a PRN or STAT basis revealed that a number of patients repeatedly received STAT IM psychotropic medications over a period of weeks. In addition, the SEH Pharmacy and Medication Report for February, 2010 ("Possible Involuntary Emergency Medication Orders", further identified as "parenteral tranquilizers"), revealed that during a five month period (October, 2009 – February, 2010) an average of 34 patients per month had three or more STAT orders. During this same time period, there was reportedly a monthly average of 64 possible involuntary emergency medication events for a monthly average of 27 patients. Taken together, these reports highlight the need for SEH to quickly develop a mechanism to monitor the use of emergency involuntary psychotropic IM medications. In the records reviewed, (AR, CB, CJB, RF) there was no evidence that the IRPs were adjusted when individuals repeatedly received emergency involuntary medications. **Compliance:** Partial. **Current recommendations:** 1. Develop reports to monitor the use of emergency involuntary psychotropic medication administration. 2. Develop an audit tool to monitor adherence to policy requirements. 3. Determine which position/body will review and analyze findings, take actions to address trends, evaluate the effectiveness of actions taken, and document the process.
LDL	X.F.2	a physician assess the individual within one hour of the administration of the emergency involuntary psychotropic medication; and	**Current findings on previous recommendation:** SEH reports partial compliance. Based on document review, I concur. **Recommendation, September 2009:**

			See X.F.1. **Findings:** See X.F.1. Policy expectations regarding a physician assessment within an hour are clear. **Other findings:** There were occasionally physician notes that described the clinical thinking associated with ordering particular STAT medications. These notes sometimes included a review of current regular meds. However, in nearly all the reviewed events, there was no clear evidence that the physician had actually assessed the individual in person within an hour of involuntary medication administration. Most physician notes were a reiteration of behavior previously documented by nursing as having been reported to the physician prior to receiving the order for the STAT medication. **Compliance:** Partial. **Current recommendations:** 1. See F.X.1 2. Assure that the audit question distinguishes the presence of an MD note from evidence of a face-to-face assessment.
LDL	X.F.3	the individual's core treatment team conducts a review (within three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four-week period, determines whether to modify the individual's treatment plan, and implements the	**Current findings on previous recommendations:** SEH reports partial compliance. Based on document review, I concur. **Recommendation 1, September 2009:** See X.F.1 and X.E.

		revised plan, as appropriate.	**Findings:** See X.F.1 and X.E. **Recommendation 2, September 2009:** Determine and resolve barriers to timely and relevant IRPs. **Findings:** Barriers have not been resolved. **Other findings:** Although SEH reported that they are tracking this requirement through the high risk trigger process, there was only documentation of clinical action following the event. There was no evidence of data aggregation or analysis. Specifically, the *Risk Trigger Indicators Report* reflected follow up such as "referred to treatment team", "assessed by GMO". There is no evidence that trends are being identified and addressed. For example, the "follow up" documented on an individual involved in five physical assaults, one of which resulted in another patient sustaining a fractured nose, was "treated by GMO", "sent to ER", and "counseled". There was no evidence that the individual's treatment was reviewed, and no evidence that recommendations were provided to the team and/or implemented. **Compliance:** Partial. **Current recommendation:** Develop a comprehensive system to address this requirement, including documentation of actions taken and systematic tracking of the outcomes.
LDL	X.G	By 18 months from the Effective Date hereof,	**Current findings on previous recommendation:**

		SEH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	SEH reports partial compliance. Based on document review, staff interviews, and unit observations, I concur. **Recommendation, September 2009:** See VIII.D.1 and X.C.8. **Findings:** See VIII.D.1 and X.C.8. **Other findings:** With the exception of nursing, it appears that applicable hospital staff have not been identified. No aggregate reports were provided for non-nursing staff. **Compliance:** Partial. **Current recommendation:** See VIII.D.1 and X.C.8.

	XI. Protection from Harm		
BJC		By 36 months from the Effective Date hereof, SEH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Settlement Agreement and with District of Columbia statutes governing abuse and neglect. SEH shall not tolerate any failure to report abuse or neglect. Furthermore, before permitting a staff person to work directly with any individuals served by SEH, the Human Resources office or officials responsible for hiring shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility.	**Summary of Progress:** 1. Early in May 2010, the staff and individuals in care moved into a state-of-the-art new, beautiful hospital that provides a clean and pleasant physical environment. Many features of the new hospital show a concern for safety in the design. 2. The hospital has revised its incident management policies to eliminate the previously identified unclear definitions. The policies clearly articulate the obligation of all staff to report suspected A/N/E. Investigations are completed by staff members committed to their work and who have received training in investigations. 3. The Performance Improvement Department has begun the tracking of recommendations for corrective actions from incident investigations and those made by hospital committees. 4. The hospital has undertaken initial steps toward a comprehensive effort to identify individuals in high risk situations through the identification of 29 Risk Indicators. Once these have been approved by the Executive Committee, over the next nine months, the hospital will identify individuals who reach these indicators. The hospital will need to create a guidance document to clarify expectations for how IRP teams are to proceed when an individual reaches one of the indicators. Presently the hospital follows a procedure that includes the review of the IRPs of individuals involved in three or more incidents in 30 days by the Medical Director who additionally meets with the treatment team and makes treatment recommendations. 5. Staff members are cleared through a criminal background check prior to hiring if the staff member does not hold a license. Licensed staff undergo a criminal background check as part of the licensing process; SEH does not repeat the procedure.

	XII. Incident Management		
BJC		By 24 months from the Effective Date hereof, SEH shall develop and implement, across all settings, an integrated incident management system. For purposes of this section, "incident" means death, serious injury, potentially lethal self harm, seclusion and restraint, abuse, neglect, and elopement.	**Summary of Progress:** 1. The hospital has reviewed and revised the policies governing the identification, reporting and investigation of incidents to eliminate previously identified unclear and overlapping definitions. 2. SEH has hired a new Director of Performance Improvement and Risk Manager, freeing the former staff in these positions from responsibilities for two substantial leadership roles. 3. The Unusual Incident reporting form was revised to separate restraint use from seclusion use, so that discrete data for each can be produced. Further changes in the form are planned, e.g., a listing for sexual assault which presently must be written in under "Other." 4. The Risk Manager has developed plans to expand the Unusual Incident Database to include the determination of investigations and to separate restraint use and seclusion use. 5. In an effort to catch under-reporting the Risk Manager reviews the 24 hour nursing report each day. 6. The use of the face sheet on investigations not only provides the reader with essential information at a glance it also guides the investigator to consider such matters as the removal of staff, the weighing of evidence using the preponderance standard and the correct identification of incident types. 7. In the investigations reviewed, disciplinary action was taken in response to staff misconduct.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Morse, Director, Performance Improvement 2. A. Kahaly, Risk Manager 3. T. Lee, Investigator 4. J. Taylor, PID, Policy Development

			5. C. Vidoni-Clark, Director of Treatment Services 6. S. Stone, Program Administrator for Transitional TLC <u>Reviewed</u>: 1. Revised Incident Management Policies: 301-01, 302.1-03 and 302.4-09 2. 16 investigation reports 3. Listing of individuals who were the aggressor in multiple incidents and those who were victims in multiple incidents 4. PID Table of Investigation Recommendations 5. Reporting Unusual Incident Power Point training presentation 6. FY 2009 Trend Analysis report 7. April 2010 PRISM report 8. Risk Management and Safety Committee minutes-November 09-April 10 9. Performance Improvement Committee minutes-August 09-April 10 10. IRPs of 11 individuals for reference to incidents 11. Disciplinary actions and background clearance information for selected staff members 12. A/N/E training data
BJC	XII.A	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement comprehensive, consistent incident management policies, procedures and practices. Such policies and/or protocols, procedures, and practices shall require:	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Revise policy 301-01 to remove the incompatible definitions of sexual assault. **Findings:** This policy no longer contains the problematic definition. Policy 301-01 titled Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care was revised on March 30, 2010. It no longer contains a definition of sexual assault. Since this is an abuse policy, appropriately, sexual incidents between individuals in care are not

			addressed. These incidents could be sexual assaults. **Recommendation 2, September 2009:** Amend the definition of Unprofessional Relationship to ensure it is not so broad as to include activity that would constitute sexual abuse. **Findings:** This problematic definition has been narrowed to borrowing from or lending money to an individual in care or his/her family and prohibiting non-professional socialization. **Other findings:** The present policies governing incidents provide clear and appropriate guidance for staff. **Compliance:** Partial. The hospital has met expectations in revising policies. Further work is needed to meet expectations for implementing consistent incident management, procedures and practices. **Current recommendation:** Monitor the application of the Incident Management policies.
BJC	XII.A.1	identification of the categories and definitions of incidents to be reported and investigated, including seclusion and restraint and elopements;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Continue current practice of reviewing UI reports for accuracy. **Findings:** In several investigations reviewed, the investigation face sheet contained errors. For example, the investigation of an altercation between two staff members (9/29/09) is identified as physical abuse on the face sheet. The face sheet of the investigation of erratic

			driving and inappropriate behavior (3/10/10) provides no synopsis of the allegation. **Recommendation 2, September 2009:** Make the necessary revisions in policy recommended in XII.A and emphasize in training the difference between sexual abuse and sexual assault. **Findings:** As noted, the policy in question has been revised to correct the problematic definitions. **Other findings:** Policy 302.1-03 entitled Unusual Incident Reporting and Documentation provides definitions of the incident types. It defines sexual abuse and sexual assault and makes the distinction clear. Restraint and seclusion are defined as incidents. The definition of restraint covers mechanical and physical restraint and the use of drugs as restraint—the act of immobilizing or reducing the ability of an individual to move his/her arms, legs, body or head freely. The definition of seclusion includes the involuntary confinement of an individual in an area where he/she is physically prevented from leaving but also confinement that the individual believes he/she cannot leave at will. Policy 301-01 defines the improper use of restraint and seclusion as abuse. **Compliance:** Substantial. **Current recommendation:** Monitor the application of the Incident Management policies.

BJC	XII.A.2	immediate reporting by staff to supervisory personnel and SEH's chief executive officer (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Ensure that the failure to report as prescribed in hospital policy is identified in investigation reports and appropriate action ensues. **Findings:** In the investigation that substantiated physical and verbal abuse of AH (incident date 10/7-8/2009) both named staff members were identified as having failed to report the incident. Both staff members were terminated for this sustained abuse. **Other findings:** Policy 301-01 clearly states "employees or contract workers must report any suspected incidents of individual in care abuse, neglect, or exploitation to their supervisor and must submit a completed unusual incident form for investigation by the Risk Manager." The policy further states that failure to report will be grounds for corrective or adverse action, up to and including dismissal. Incidents are recorded on a standardized form that has been recently revised to separate restraint from seclusion (so that frequencies can be calculated for each) and add additional incident types. **Compliance:** Substantial. **Current recommendation:** Continue current practice of identifying failure to report allegations of A/N/E in the manner prescribed in policy.
BJC	XII.A.3	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or	**Current findings on previous recommendation:**

		serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;	**Recommendation, September 2009:** Implement the policy provision related to removing staff when named in an A/N/E allegation even-handedly or amend the policy to permit specified exceptions. **Findings:** Policy 301-01 states that upon notification of an allegation of A/N/E an employee shall be immediately removed from any individual in care areas, assigned to other duties pending the outcome of the investigation or placed on administrative leave. It provides an alternate procedure that permits upon the written request of the employee's supervisor, the Assistant Director of Nursing and the applicable Executive Staff member to consult with the Risk Manager to determine whether the staff may be permitted to provide clinical services. If it is determined that removal is not necessary, the employee will not have contact with the alleged victim. **Other findings:** In three of the 12 investigations of A/N/E reviewed, the named staff member was removed. In another two of the 12 incidents a specific staff member was not named and could not be identified. In the remainder of the cases, there is no documentation in the investigation report that the named staff member was removed. **Compliance:** Partial. **Current recommendations:** When a staff member is named in an allegation of A/N/E, the investigation should document that the decision to not remove the staff member was made with the agreement of the Risk Manager and as prescribed by Policy 301-01.

<table>
<tr>
<td>BJC</td>
<td>XII.A.4</td>
<td>adequate training for all staff on recognizing and reporting incidents;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2009:
Implement current plan to enrich annual A/N/E training for experienced staff members.

Findings:
Presently annual A/N/E is a live instructor one-hour competency-based training using a 16 slide Power Point. The competency test is composed of five questions, three of which are true/false. Orientation training on A/N/E is a live instructor 1.5 hour competency based training that includes five case studies.

Other findings:
The hospital provided requested information on the number of staff members who are not current on annual A/N/E training. Eliminating staff members on extended sick leave, 220 staff are not current as shown below.

<table>
<tr><th>Department</th><th># staff not current</th></tr>
<tr><td>Housekeeping and Facilities and Maintenance</td><td>28</td></tr>
<tr><td>Nursing</td><td>140</td></tr>
<tr><td>Communications and Medical Records</td><td>5</td></tr>
<tr><td>Nutrition Services</td><td>9</td></tr>
<tr><td>Psychiatry</td><td>13</td></tr>
<tr><td>Psychology</td><td>4</td></tr>
<tr><td>Rehabilitation and Social Work</td><td>4</td></tr>
<tr><td>Security</td><td>4</td></tr>
<tr><td>Program Assistants</td><td>5</td></tr>
<tr><td>GMO & Medical Affairs-other</td><td>6</td></tr>
<tr><td>Staff Assistants & Chaplain</td><td>2</td></tr>
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The review of A/N/E training for 11 staff members revealed findings not inconsistent with the data above.

Staff member	Background clearance date	A/N/E training date
_O	Background check obtained during licensing process	2/12/09
_E	Same as above	2/12/09
_H	Same as above	2/12/09
_P	Same as above	2/5/09
_P	Same as above	3/23/10
_C	Same as above	No date provided
_J	2/28/08	4/2/10
_P	Background check obtained during licensing process	3/26/10
_W	10/3/08	5/7/10
_O	Background check obtained during licensing process	3/18/09
_O	Background check obtained during licensing process	2/13/09

The hospital noted that employees hired prior to August 08 were not required to have CBCs completed. CBCs are not completed on licensed staff as that is part of the licensing process.

Compliance:
Partial. After providing initial training of all staff member, the hospital now is establishing for providing annual A/N/E to staff members.

			Current recommendation: Continue efforts to ensure that all staff members receive annual A/N/E training and pass the competency test.
BJC	XII.A.5	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to SEH and District officials;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** Orientation training on A/N/E for new staff members cites the responsibility for reporting under DC law, SEH policy and the DOJ Settlement Agreement. It identifies all employees and contractors as mandatory reporters. The hospital reported that 20 of the 21 new employees have completed training on reporting suspected A/N/E. **Compliance:** Substantial, as related to the content of Orientation Training. **Current recommendation:** Continue current practice.
BJC	XII.A.6	posting in each unit a brief and easily understood statement of how to report incidents;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** The posters in the Annex Units and in the Therapeutic Learning Center send individuals who wish to voice a concern to the Consumer Rights Advocate/Peer Advocate. **Compliance:**

			Substantial. **Current recommendation:** Continue current practice.
BJC	XII.A.7	procedures for referring incidents, as appropriate, to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** The face sheet of the investigations reviewed specifically requires the investigator to document whether there had been an arrest in the case. The Reporting Suspected A/N/E policy requires that criminal action be reported to the Metropolitan Police Department, regardless of the wishes of the persons involved. **Other findings:** One of the investigations reviewed required a referral to law enforcement. In the incident involving the assault on a staff member, a police report was filed. This incident occurred on January 15, 2010 when a male individual stayed behind on the unit (he said he was in the bathroom) when the other individuals left for the dining room. This individual attacked a female staff member as she exited the laundry room, pinned her down on her back, punched her, had his hands around her neck, tried to put his mouth on hers, and attempted to pull off her pants. The staff victim was transported to a community hospital ER for treatment. **Compliance:** Substantial, based on a limited sample of investigations. **Current recommendation:**

			Continue to address the question of law enforcement referral in each investigation of A/N/E and whenever criminal activity is involved.
BJC	XII.A.8	mechanisms to ensure that any staff person, resident, family member, or visitor who, in good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by SEH and/or the District, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** Policy 302.1-03 uses the same language as in this section of the Settlement Agreement to advise staff of the right of individuals, staff members and others to report A/N/E without fear of retaliatory action. **Other findings:** The 10/7-8/10 incident of physical and verbal abuse of AH was made known to hospital leadership in a letter written by an anonymous staff member who stated that he/she was not signing the letter because "I do not want to lose my job." The investigation states that during an initial interview a PNA (psychiatric nursing assistant) stated that she did not see the fight between the individual in care and one of the named staff members. Following this interview, which was conducted on the unit in question, the PNA approached the Risk Manager saying she wanted to recant part of her interview responses and respond truthfully. The investigation report documents the PNA as stating, "Staff members saw me talking with you and heard some of my responses. I know some staff members would give me problems if they heard me tell you what actually happened." The Risk Manager conducted a second interview of this PNA in the Risk Manager's office where the PNA acknowledged witnessing the named staff member push AH. The investigation concludes with substantiated findings of verbal and physical abuse and

			numerous recommendations which include additional training for staff on reporting A/N/E. It does not include a recommendation to ensure that the PNA is not subjected to any form of retaliation by other unit staff. **Compliance:** Partial, based on limited information. The investigation cited above suggests a need for more attention to the possibility that staff and individuals who report incidents are vulnerable to retaliation and the need for actions to protect them. **Current recommendation:** Advise staff who report A/N/E and express fear of retaliation to contact the Risk Manager immediately should they experience retaliation or threats.
BJC	XII.B	By 24 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement policies and/or protocols addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall:	**Current findings on previous recommendation:** **Recommendation, September 2009:** Make the recommended revisions in the incident reporting policy. **Findings:** As noted above, the Incident Management policies were revised effective March 30, 2010. **Other findings:** The review of investigations found that SEH is not meeting its policy standard of completing investigations as defined in Policy 302.4-09: Unusual Incident Investigation. This policy states that the Risk Manager should complete the investigation within five workdays. Assuming the policy intends that the written report would be completed shortly thereafter, the hospital has to improve the timeliness of completed investigation reports. Some of the delays in

the cases cited in the table below are related to the change in work assignments of the former Risk Manager and PID Director and the appointment of other persons to fill these positions. Specifically, the former Risk Manager had begun some investigations and then was appointed Assistant Director of Nursing. She was unable (given the duties of her new position) to complete these investigations for several months. Investigations that fit this description are identified with an asterisk.

Incident Type	Date	Received in RM	Closed
Medical variance	2/19/10	3/18/10	4/7/10
Abuse/Neglect/ Exploitation	unknown	2/17/10	3/25/10
A/N/E	1/5/10	1/7/10	3/25/10
*Physical Abuse: Staff on Staff, Patient Neglect	9/29/09	9/29/09	5/23/10
*A/N/E	12/15/09	12/15/09	5/23/10
A/N/E	2/22/10	2/22/10	4/7/10
A/N/E	12/10/09	12/14/09	3/25/10
A/N/E	12/10/09	12/17/09	3/25/10
A/N/E	12/10/09	12/17/09	3/17/10
A/N/E	1/14/10	1/14/10	3/25/10
*A/N/E	10/7-8/09	10/9/09	5/23/10
Erratic driving and inappropriate behavior	3/10/10	3/11/10	5/26/10
Physical injury, Psychiatric emergency, Attempted sex assault	1/15/10	NA	3/11/10

			<table><tr><td>*A/N/E, unauthorized leave</td><td>10/28/09</td><td>10/28/09</td><td>5/23/10</td></tr><tr><td>*A/N/E</td><td>11/1/09</td><td>11/2/09</td><td>5/23/10</td></tr><tr><td>*A/N/E</td><td>10/29/09</td><td>11/2/09</td><td>5/23/10</td></tr><tr><td>*A/N/E</td><td>10/18/09</td><td>10/22/09</td><td>5/23/10</td></tr></table> SEH is planning to hire an additional investigator to assist the Risk Manager and the present investigator. **Compliance:** Partial. **Current recommendation:** Take any measures possible to expedite the complete and timely investigation of incidents.
BJC	XII.B.1	require that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;	**Current findings on previous recommendation:** **Recommendation, September 2009:** See findings and recommendations in XII.B.3. **Findings:** See XII.B.3 **Other findings:** All investigations of A/N/E are completed by either the Risk Manager or an investigator, both of whom are independent of any unit or discipline. Please see XII.B.3 for discussion of those investigations that raised concerns regarding their completeness. Several of the investigations reviewed identified failure to follow specific hospital policies. These included nursing policies and use of abusive, offensive or offensive language and rudeness by staff

			members to staff members and lack of proper courtroom etiquette. See XII.B.3 for an instance where a violation of policy was not identified. **Compliance:** Partial. **Current recommendation:** Provide close supervision of investigation to ensure their completeness.
BJC	XII.B.2	require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Ensure that all staff members who may be required to conduct investigations in the future are suited to the task by skill and temperament. **Findings:** Both the current Risk Manager and the investigator have received competency based investigation training. The training certificate for the Risk Manager showing completion of 18 hour training was presented. Documents (e.g., completed investigations) and interviews with the Risk Manager supported his suitability for the position he holds. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
BJC	XII.B.3	include a mechanism which will monitor the performance of staff charged with investigative responsibilities and provide	**Current findings on previous recommendations:** **Recommendation 1, September 2009:**

		technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents; and	*Identify specific findings to support recommendations made in investigation reports*. **Findings:** All of the recommendations in the investigations reviewed could be traced back to findings of fact. **Recommendation 2, September 2009:** *Ensure that all parties who may have direct knowledge of an incident are questioned*. **Findings:** MB alleged on 10/18/09 that the named staff member yelled at him for changing the channel on the TV. He added that the named staff member never asks but always "orders us." He alleged that he and the other individuals wanted to see a show other than the news. No individuals were interviewed, although it would appear that at least several should have heard the named staff member and might have provided information about her demeanor in general. **Other findings:** All of the investigations sampled followed hospital policy and were approved by the Director of Performance Improvement. However, several investigations raised issues related to adherence to investigative practice: • In the investigation of verbal abuse of MB (10/18/09), the investigator did not provide a synopsis of each interview, but rather described the consensus of a discussion with the relevant clinical team about the unit milieu. • The face sheet of the investigation of a staff-on-staff assault leading to neglect of individuals in care identifies the incident type as staff-to-staff abuse. Hospital policy defines the victim of abuse

			as an individual in care, not a staff member. The investigation makes no determination about the allegation of neglect. • The investigation of verbal abuse of GW (12/15/09) concluded that the named staff member's verbal responses to GW were abusive. It further determined that the named staff member engaged in posturing behavior (confronting GW with "hands up in a boxer's stance") and this also constituted abuse. The determination did not reference the named staff member's refusal to respond to the RNs instructions repeated several times to leave the scene. This should have been noted as a violation of hospital policy. • The investigation of neglect of MM and TJ (February 22, 2010) who were left unattended in the music room uncovered a quite distinctive description of the staff member who left them without ensuring therapy staff were present. There was no attempt documented to identify this staff person and ascertain the veracity of the allegation that he/she was responsible. • The investigation of the circumstances under which JM was left alone on a ward (December 10, 2009) states on page 4 that JM was left sleeping in the dining room and on page 5 that she was left sleeping in the day room. The conclusion section of the report is incomplete. It concludes that the evidence "supports the allegation in the following ways:" No further narrative appears. • The investigation of the erratic driving and inappropriate behavior of a staff member transporting individuals determined that the staff member was "going in and out of lanes, speeding, hitting the brakes hard." Staff believed his driving "posed a threat to their personal safety and the safety of the individuals in care." Despite this strong finding, the investigation failed to recognize that these behaviors met the definition of neglect—an action or failure to act by an employee or contract worker that impairs or creates a substantial risk of impairment to the, mental, or emotional condition of an individual in care—and did not make a finding of substantiated neglect.

			• WJ made an allegation that the named staff member used vulgar language in responding to him [I don't want to hear that ___."] and threatened to "have [him] moved back to where [he] came from." The allegation of verbal abuse was substantiated. However, the rationale does not reflect the definition of verbal abuse—a verbal action that subjects the individual to ridicule, humiliation, contempt scorn, harassment, threats of punishment. Rather, the rationale for substantiation is that the action "appears to have been performed as a measure of discipline against the patient." **Compliance:** Partial. **Current recommendations:** 1. Link the determination rationale to the relevant section/phrase in the incident type definition as provided in hospital incident policies. 2. Ensure that all persons who may have witnessed an incident are interviewed. 3. Identify violations of hospital policy in investigations and provide appropriate recommendations to remediate shortcomings in performance.
BJC	XII.B.4	include a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Promulgate the expectation that parties responsible for the implementation of recommendations from incident investigations will report on the status of implementation to PID. Designate responsibility within PID for maintaining a log/database tracking the recommendations and responses back.* **Findings:** The Director of Performance Improvement has established a log that

			tracks programmatic and systemic investigation recommendations. During the site visit this log was put on a shared drive so that all staff in PID have access to it. This shared drive will be an integral component of the Performance Improvement Director's plan to assign Quality Improvement Coordinators to specific houses and disciplines. The Coordinators will share the relevant recommendations and engage the house or discipline in responding. This plan is one component of the hospital's Corrective Action Plan dated May 15, 2010. **Recommendation 2, September 2009:** *PID should undertake an independent review of at least a sample of recommendations reported as successfully implemented.* **Findings:** PID plans to review the effective implementation of a sample of recommendations. As noted, the first step—collecting recommendations has begun. The Performance Improvement Committee initiated in January 2010 the Closed Loop Project. Information will be collected on the current status of recommendations on an Access database. The next initiative will be to assess and document the effectiveness of the recommendation on the database. **Recommendation 3, September 2009:** *Consider the advisability of using electric razors rather than disposable or straight razors. If this is not possible, introduce a razor log that is initialed by the staff member keeping track of the razors.* **Findings:** The question of razors was raised on two houses toured: Shields House (1F) and Howard House (1G). Staff on Shields House said they have a supply of double edged safety razors (each etched with a number) but they are not being used presently because the wooden box for hanging each below its number–a method that permits staff to keep track of

			razors as they are distributed and returned-- has not yet been moved to the new building. In the absence of razors, staff explained, men go to the barber twice a month to be shaved. At Howard House, staff presented a razor tracking sheet showing that three men are using razors--#14, 18 and 22. A full supply of razors is kept in a shoe box in a locked cabinet from which the three are taken when requested. Staff reported that the other men are shaved by the barber. **Other findings:** The Performance Improvement Committee (PIC) minutes indicate awareness of deficiencies in ensuring implementation of recommendations made by the Sentinel Event Review Committee (SERC) following its review of serious incidents. Specifically, the August 09 minutes state that QI will develop a process for PID monitoring of SERC recommendations. January 2010 minutes note that SERC recommendations do not have consistent follow-up, and the March 10 minutes state that SERC recommendations will be tracked by PIC. The SERC recommendations made following the review of the death of RH were added to the PID database for follow-up, according to the April minutes. **Compliance:** Partial. **Current recommendations:** 1. Implement the plan to assign Quality Improvement Coordinators to specific houses and disciplines to ensure recommendations made in incidents reach the responsible staff members and to facilitate implementation. 2. Ensure SERC recommendations are tracked, approved and implemented effectively, as these relate to the most serious incidents in the hospital.

BJC	XII.C	By 24 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, SEH shall implement such action promptly and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendation:** **Recommendation, September 2009:** See recommendations [in the above cell in the previous report]. **Findings:** The hospital has yet to implement procedures to systematically identify, track, and monitor implementation of programmatic and remedial actions taken in response to incidents. **Other findings:** During the review period, SEH had at least four incidents where individuals were left unaccounted for. In one incident an individual left behind perpetrated a serious assault on a staff member. In the other incidents, individuals were found on the unit after all of the other individuals had left. The corrective action for these incidents was to have an accountable head count conducted when individuals leave the unit and when they return. Review of the implementation of this measure on the units visited yielded findings that fail to ensure that this type of incident will not recur. Specifically, in Shields House there was a check out sheet, but no check in when individuals returned. Other units had no separate check sheet at all and were using the Security check sheet. The Security check sheets reviewed were not completed up to the hour and in several instances the staff member was not using the legend provided. For example, reading the sheet one would believe an individual was in Seclusion (S on the legend) when actually the individual was sleeping. In contrast, the procedure for accounting for individuals in the Therapeutic Learning Centers appeared to meet its purpose. **Compliance:** Noncompliance.

			Current recommendations: 1. Develop and promulgate a hospital wide policy, accompanied by prescribed forms, for accounting for individuals. 2. Implement as quickly as possible plans for PID staff to ensure that recommendations reach the relevant staff members and assist in implementing the recommendation and in monitoring their effectiveness.
BJC	XII.D	By 24 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or resident.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** The Unusual Incident data base can identify all investigations in which a staff member was named and likewise all investigations in which a particular individual in care played a central role. The present Unusual Incident database does not include a field for the determination (substantiated or not substantiated). The Performance Improvement Department has plans to expand this database to include this information. **Compliance:** Substantial. **Current recommendation:** Proceed with plans to expand the UI database to include the investigation disposition.
BJC	XII.E	By 24 months from the Effective Date hereof, SEH shall have a system to allow the tracking and trending of incidents and results of actions taken. Such a system shall:	*SEH has provided tracking and trending data for the incident variables required by this section of the Settlement Agreement. The hospital not have reached substantial compliance because it does not have a system for identifying and tracking actions taken in response to the*

trends and patterns identified.

Current findings on previous recommendations:

Recommendation 1, September 2009:
Identify and undertake procedures for monitoring recommendations from investigations.

Findings:
As noted above, the Performance Improvement Director is logging recommendations from incident investigations on a shared drive with a plan for facilitating follow up through the deployment of Quality Improvement Coordinators.

Recommendation 2, September 2009:
Evaluate the success of initiatives undertaken to address tracking and trending data.

Findings:
The FY2009 Trend Analysis report dated November 30, 2009 produced by the Performance Improvement Department, Office of Monitoring Systems states that a total of 1425 incidents were reported—an average of 119 per month. The monthly totals ranged from a high of 157-158 in October 08 and March 09 to a low of 96-98 in May and June. Other FY 2009 incident data included:

Number of individuals. . .	
Served in SEH for at least one day	804
Involved in at least one incident	540
Involved in two incidents	103
Involved in 3-5 incidents	96
Involved in 6-10 incidents	50
Involved in more than 10 incidents	27

Reported as alleged aggressors in one or more incidents	252
Reported as alleged aggressors in 2-10 incidents	105
Involved in more than 10 incidents as the alleged aggressor	10

Recommendation 3, September 2009:
Define the components of the Violence Reduction Initiative and plan for its implementation.

Findings:
The Violence Reduction Initiative lists the work completed as of February 2010 as follows:

- Received approval as a standing subcommittee and obtained support of the Performance Improvement Committee
- Core membership defined
- Developed and shared findings related to hospital-based violence
- Developed a guidance document for the subcommittee
- Coordinated a work group membership drive.
- Conducted and reviewed findings of a survey tool.

Other findings:
In summary, the hospital presently tracks the number of selected types of incidents and the rates of occurrence each month in the bi-monthly PRISM report. These incidents include the use of restraint and seclusion, elopement, medication variances and adverse drug reactions. The PRISM report also presents the number of individuals in care who were injured and the injury rate by month. The same information for staff injuries is provided. The hospital titles this data "Key Performance Indicators" and the Performance Improvement Committee reviews it.
The PRISM report for April 2010 tracks total incidents and number of (unique) individuals involved by month from October 09 through April

			2010. For the one year period May 09 through April 10, the PRISM report tracks incident data on elopements, patient injuries, medication variances, adverse drug reactions, likely involuntary emergency medications, restraint and seclusion use. The April PRISM report shows the number of individuals injured in April as 23, twice the monthly average of 11 for the preceding 11months. This suggests that implementation of a Violence Reduction Initiative would benefit the hospital at this time. In contrast, SEH used no restraint or seclusion in April. The hospital took disciplinary action in sustained cases of staff misconduct selected for review. Specifically, as a result of the investigation of the sustained allegation of physical and verbal abuse of AH, two staff were terminated. Similarly, termination is proposed in the sustained finding of abuse of GW. In the sustained allegation of verbal assault (staff on staff), a suspension is proposed in response. Administrative action is pending against four staff members for their actions/inaction related to the death of RH. **Compliance:** Partial. The hospital has tracked and trended various incident variables, but not the actions taken in response. **Current recommendations:** 1. Identify a listing of specific actions to reduce violence, such as increased recreational activities, incentives to houses which reduce violence, formation of a Peacemaker's group among individuals in care, and implement the actions as resources become available. The specific actions are suggestions only; the hospital should adopt activities that fit its needs and resources. 2. Consider a kick-off event for the Violence Reduction Initiative that garners enthusiasm from individuals and staff. 3. Continue current practice of tracking and trending incidents.

<table>
<tr><td></td><td></td><td></td><td>Include the tracking of corrective measures, as planned.</td></tr>
<tr><td>BJC</td><td>XII.E.1</td><td>Track trends by at least the following categories:</td><td>Please see sub-cells for findings and compliance.

This section of the Settlement Agreement requires the hospital to track and trend data. The hospital has demonstrated its ability to track and trend data and present it in a useful format. These efforts will be more meaningful when the hospital demonstrates its use of the data to drive decisions related to programmatic and systemic issues.</td></tr>
<tr><td>BJC</td><td>XII.E.1.a</td><td>type of incident;</td><td>Current findings on previous recommendation:

Recommendation, September 2009:
Continue current plans for making incident data specific to a unit (Unit PRISM) available to units hospital-wide.

Findings:
PID staff explained that a unit/house specific PRISM report is not presently available. Unit/house leadership is expected to review the hospital-wide monthly PRISM report for trends and patterns. The development of a unit/house specific dashboard is one component of the hospital's Corrective Action Plan dated May 15, 2010, indicating the hospital intends to continue to work toward implementation.

Other findings:
The FY 2009 Trend Analysis identifies incidents by type and provides a frequency by month. It further provides the percent of the total number of incidents represented by each type. This data indicates that six incident types each represented more than 10 percent of the 1425 total incidents:

<table>
<tr><td>Type</td><td>% of total</td><td>Monthly average #</td></tr>
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<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><td></td><td></td><td>of incidents</td></tr>
<tr><td>Assaults/altercations</td><td>31.8</td><td>38</td></tr>
<tr><td>Physical Injury</td><td>17.7</td><td>21</td></tr>
<tr><td>Other</td><td>13.0</td><td>15</td></tr>
<tr><td>Medical Emergency</td><td>11.2</td><td>13</td></tr>
<tr><td>Psychiatric Emergency</td><td>10.9</td><td>13</td></tr>
<tr><td>Falls</td><td>10.2</td><td>12</td></tr>
</table>

The Performance Improvement Committee minutes for April 2010 note that the PRISM incident data "does not reflect any negative trends. PID will continue to monitor and focus on the possibility of under-reporting of UIs [Unusual Incidents]."

Compliance:
Substantial.

Current recommendations:
1. Consider issuing a house-specific PRISM report on a regular periodic basis.
2. Include a review of the concerns expressed to the Consumer Rights Advocate/Peer Advocate to ensure that all allegations of abuse and neglect are reported through the proper channels.
3. Ensure that the IU database correctly identifies the incident type in those cases where this might have changed during the course of an investigation.
</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.b</td>
<td>staff involved and staff present;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2009:
Identify in investigation reports a review of the named staff member's incident history.

Findings:
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<td>None of the investigation reports reviewed contained an incident history of the named staff member.

Other findings:
The hospital has the capacity to produce a listing of individuals involved in incidents. The Risk Manager explained that the identification of staff members involved in multiple incidents is hindered by the lack of a drop down menu of staff names, multiple spellings of the same name, and no first name on the incident reporting form for staff with the same last name.

Compliance:
Partial.

Current recommendation:
Review the incident history of named staff members to identify patterns of behavior.</td>
</tr>
<tr>
<td>BJC</td>
<td>XII.E.1.c</td>
<td>individuals involved and witnesses identified;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2009:
Document in investigation reports a review of the individual's incident history.

Findings:
In the investigations reviewed, documentation of the individual's incident history was sometimes present, but not consistently, as shown below. This review occurred in half of the 14 relevant investigations.

<table>
<tr><th>Incident type</th><th>Date reported</th><th>Individual's incident history referenced</th></tr>
<tr><td>Neglect allegation</td><td>11/2/09</td><td>No</td></tr>
<tr><td>Verbal abuse alleg.</td><td>10/22/09</td><td>No</td></tr>
</table>
</td>
</tr>
</table>

Physical abuse alleg.	2/8/10	No
Neglect	2/7/10	Yes
Verbal abuse alleg.	11/2/09	No
Neglect	1/15/10	Yes
Neglect	10/28/09	No
Physical, verbal and emotional abuse	10/09/09	No
Neglect	1/14/10	Yes
Physical abuse	12/17/09	Yes
Emotional abuse alleg.	12/17/09	Yes-limited to a one month review
Neglect	12/14/09	Yes
Neglect	2/22/10	Yes
Verbal abuse	12/15/09	No

Other findings:
In response to a request, the hospital produced a listing of individuals who have been aggressors in multiple incidents and those who have been victims in the period March 1—May 24, 2010. Those with the highest frequency are shown below:

Individual	# incidents	Incident type
MT	6	Physical assault of peers and staff
AA	4	Physical assault
MB	4	Physical and sexual assault (peers & staff)
JJ	4	Physical assault
RS	4	Physical assault
VS	4	Physical assault, medical emergency and falls
CW	4	Physical assault and

		property destruction
GR	3	Victim of physical assault
EF	2	Victim of physical assault
GV	2	Victim of neglect and fall
JJ	2	Victim of physical assault
TJ	2	Victim of physical assault
MP	2	Medical emergency, fall
RR	2	Victim of physical assault
SS	2	Victim of physical assault and psychiatric emergency
WW	2	Victim of physical assault and lesser peer aggression

The hospital identifies those individuals who have been involved in three or more incidents in 30 days and has established a protocol whereby the Medical Director reviews their IRP, meets with the treatment team and makes treatment recommendations. See XIII.B.1 for a further explanation.

Compliance:
Partial. This compliance rating acknowledges the hospital's identification of some individuals whose behaviors put them at risk and the procedure for the review by the Medical Director. This is viewed as a first step in the creation of a structure of hierarchical review of the treatment of at risk and high risk individuals.

Current recommendations:
1. Implement as planned the Risk Indicator performance improvement initiative described in the next section of the report. This will include, but not be limited to, identifying individuals who are repeat victims and aggressors.
2. Ensure Risk Indicators consider not only the frequency of an occurrence but also the severity.

BJC	XII.E.1.d	location of incident;	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Continue to produce the trending and pattern data required by the Settlement Agreement. **Findings:** The FY 2009 report provides a bar graph indicating incident location on the campus and by unit. Consistently during the period October 08-September 09, the RMB building was the scene of the greatest number of incidents, ranging from a low of 41% of the total incidents in April 09 to a high of 66% in July 09. Percentage of incidents occurring at the John Howard Pavilion ranged from a low of 23% in April 09 (when the number of incidents in the mall increased over previous months) to 42% in November 08. During the FY 2009 review period, over one third of the incidents took place in RMB-3, RMB-4 and RMB-6. This type of information will be available to the houses on a more frequent basis when the hospital provides a monthly/bi-monthly PRISM-like report specific to each house. **Recommendation 2, September 2009:** *Link specific actions undertaken to patterns identified.* **Findings:** The Violence Reduction Initiative was conceived in response to the realization that acts of aggression occur nearly daily at the hospital. The move to the new hospital saw individuals assigned to houses based on their individual treatment needs and strengths. Units were not moved as a single entity. This was done, in part, to disperse individuals who were in conflict.

			Compliance: Substantial. **Current recommendations:** 1. Implement plans to provide teams with house-specific incident data on a regular periodic basis. 2. Identify and track responses to the location data provided to teams.
BJC	XII.E.1.e	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** According to the FY 2009 Trend Analysis report, 13% of incidents occurred during the night shift, with the highest number occurring at 6:00 AM when individuals are rising; the day shift saw 47% of the incidents; and the evening shift accounted for 40%, with incidents decreasing after 4:00 PM. **Compliance:** Substantial. **Current recommendation:** Identify and track responses to the time of day incident data provided to teams.
BJC	XII.E.1.f	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Apply the SERC procedures to serious incidents as this procedure is particularly successful in identifying contributing factors and*

			identifying corresponding recommendations. **Findings:** During the review period, the Sentinel Event Review Committee has reviewed one incident—the death of RH. **Recommendation 2, September 2009:** *Continue with plans to implement procedures for tracking the implementation of recommendations from the investigations on a regular basis*. **Findings:** This work continues in the planning stage. See XII.B.4 for a description of plans and initial implementation steps already in place for monitoring the implementation of incident recommendations. **Other findings:** The review of the IRPs by the Medical Director of individuals involved in three or more incidents in 30 days has uncovered factors contributing to the incidents in a number of cases. Please see XIII.B.1. **Compliance:** Partial. **Current recommendations:** 1. Continue the review of individuals involved in multiple incidents by the Medical Director. 2. Identify contributing factors in investigations when possible.
BJC	XII.E.1.g	actions taken.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Keep a tighter task tracking form for the Risk Management and Safety

			Committee minutes. **Findings:** The current minutes of the Risk Management and Safety Committee are formatted in table form with columns for the item under discussion, the discussion/recommendations, follow-up actions, responsible person and status ("continuing" or "done"). All follow-up actions identified in the minutes from January 2010 through the present are in "continuing" status. The PID log of incident recommendations put on the shared drive during our tour does not yet capture information regarding implementation (actions taken). **Compliance:** Partial. **Current recommendation:** Move beyond planning to review the implementation of actions taken in response to specific incidents and in response to incident patterns and trends to include actual audits.
BJC	XII.E.2	Develop and implement thresholds for injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level, and that will be documented in the individual's medical record with explanations given for changing/not changing the individual's current treatment regimen.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Clearly set the expectation that incidents will be reviewed and documented at each IRP meeting and the recovery plan adjusted as appropriate. **Findings:** Review of the IRPs of 11 individuals found that 10 did not reference recent incidents, even in those instances when the individual reached the Risk Trigger of 3 or more incidents in 30 days, as shown in the table below. In most instances the IRP in some manner addressed the

behavior/cause of the incident.

Indiv-idual	Incident Date (s)	Incident type	IRP reference
GV	4/19/10	Neglect-failure to address incontinence	IPR 4/20—No mention of incontinence in Focus 2
MT	3/2,3,6, 27, 31 and 5/7	Aggression	IRP 4/9-No specific mention of incidents. Present status cites a "proclivity to strike out at others."
RS	3/29, 4/2,20,28	Aggression	IRP 5/20—Present status does not address aggression. Objective 1.1: Will demonstrate improvement by the absence of aggression.
DA	2/5, 19, 24	Falls	IRP 5/6/10: Does not mention falls
AA	2/4, 3/2,3	Aggression	IRP 3/25/10—No specific mention of incidents. Objective 2: Will refrain from engaging in aggressive behavior AEB learning to conduct himself in an adaptive manner.
MB	2/17,3/4,7, 9	Aggression	IRP 4/13/10—No specific mention of incidents. Objective 1.1: Refrain from engaging in behavior that places him at risk AEB a decrease in incidents of

						aggression, sexually provocative behavior and intrusiveness.
			GR	3/2,5	Victim	IRP 3/23—No mention of victimization
			FS	2/17,18 and 3/3	Refusal of Vital Signs	IRP 4/9/10—No specific mention of incidents. Objective 1: Cooperate with treatment to include taking meds.
			GS	2/25,22,24	Aggression	IRP 3/11/10—Mentions the specific incidents in Present Status
			MT	2/27,3/2,3	Physical aggression	IRP 4/9/10—No mention of specific incidents. Objective 1: Manage psychosis w/o striking out or being disruptive.
			DJ	2/4,12,18	SIB	IRP 5/6—No mention of specific incidents. Objective 1:…(among many actions…) will not ingest objects, not swallow or stick objects in eyes or ears.

Other findings:
Please see XIII.A and XIII.B for a description of the hospital's plans for monitoring high risk situations.

Compliance:
Noncompliance. The Settlement Agreement requires the IRP team to document in the individual's record the review of the specific incident/event with an explanation for changing/not changing the

			individual's current treatment regimen. This specific documentation was not present in the records sampled. **Current recommendation:** Provide a guidance document that clearly indicates for IRP teams the hospital's expectations for referencing incidents in an individual's IRP and revising the IRP as necessary.
BJC	XII.E.3	Develop and implement policies and procedures on the close monitoring of individuals assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the individual's medical record.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Identify a number of behavioral and medical high-risk indicators and identify those individuals who meet the criteria.* **Findings:** The hospital has identified 29 high risk indicators that will be presented to the Executive Committee for approval. It has also developed a deployment schedule for the necessary data gathering to support the system. **Recommendation 2, September 2009:** *Develop a progressive structure of clinical review that ensures review by an interdisciplinary team of senior clinicians for those individuals whose behavior and/or medical condition warrants it.* **Findings:** This recommendation has not yet been implemented. As noted earlier, the hospital does not yet have a guidance document that describes a structure of clinical review that creates as standard procedure the review by senior clinicians of the treatment of individuals whose medical or behavioral conditions persist or whose behaviors cause substantial harm to self or others. The hospital has, however, advanced its review of individual's who reach Risk Trigger Indicators to

			include a review and response by the Medical Director. See XIII.B.1 for more information. **Compliance:** Partial. **Current recommendation:** Take steps to move the plan forward for identifying individuals in high risk situations and securing an appropriate clinical response.

	XIII. Quality Improvement		
BJC		By 36 months from the Effective Date hereof, SEH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include compliance with this Settlement Agreement.	**Summary of Progress:** 1. The hospital put into place in March a review protocol for individuals who have reached specific limited risk triggers that requires the Medical Director to review the IRPs of the individuals who reach these triggers, meet with the team, and make recommendations as appropriate. 2. SEH has identified 29 Risk Indicators and thresholds for which it plans to develop audit tools and monitor in the succeeding months, according to a deployment schedule it has developed. 3. The Performance Improvement Committee has identified several areas for performance improvement and it is tracking progress toward correction. Several initiatives will be presented to the Executive Committee shortly for approval. 4. As described in the section above, the hospital produces a bi-monthly PRISM report that documents by month over a one-year period the occurrence rates of Key Performance Indicators. 5. On an annual basis, the hospital produces a Trend Analysis report. See the section above, for a description of selected contents of that report.
BJC			**Methodology:** <u>Interviewed</u>: 1. J. Morse, Director of Performance Improvement 2. A. Kahaly, Risk Manager 3. Won-Ok Kim, Director of Patient Statistics and Research <u>Reviewed</u>: 1. Roadmap to High Risk Indicator Notification and Tracking 2. Risk Indicators, Thresholds, and Interventions document 3. Performance Improvement Projects 2010 document

BJC	XIII.A	Track data, with sufficient particularity for actionable indicators and targets identified in this Agreement, to identify trends and outcomes being achieved.	*The hospital has made progress toward meeting this portion of the Agreement over the last six months. As detailed in the succeeding cells, the hospital has developed plans for implementation of a risk management system that identifies 29 high risk behavioral and medical conditions. The development of a guidance document explaining the purpose and plan for the system and the approval of the Executive Committee are necessary prior to implementation. In the meantime, the hospital initiated in March 2010 a procedure for the Medical Director to review the IRPs of individuals who have been involved in three or more incidents in a 30 day period, meet with their treatment teams and make treatment recommendations.* **Current findings on previous recommendation:** **Recommendation, September 2009:** Identify additional high risk behavioral and medical indicators and procedures for alerting teams that an individual has met one of the indicators and the expectation of a response from the team. **Findings:** The Director of Performance Improvement has developed a deployment schedule for monitoring Risk Triggers. When fully implemented, this schedule will provide data on high risk situations that can be tracked over time. The schedule identifies the hospital policies that presently govern 25 behavioral and medical triggers. Further, the schedule lays out a plan for developing audit tools to monitor these triggers over the next nine months. At the time of the tour, the hospital was monitoring restraint and seclusion (two or more incidents in 24 hours, three or more in 30 days and any episode lasting more than 12 hours), three or more unusual incidents in 30 days, and three or more episodes of emergency medication administrations in 24 hours. Future plans include:

			• In three months, SEH plans to monitor medication variance, IRP non-adherence, diabetes, MRSA and skin integrity. • The schedule for six months hence includes monitoring of body weight, body mass index, Stat medications, PRN medications, Now medications, seizures and tardive dyskinesia. • Illicit substances, bowel dysfunction, communicable diseases, dysphagia, Hep C and polydipsia are scheduled for monitoring in nine months. **Compliance:** Partial. **Current recommendation:** Implement the plan for monitoring high risk situations as outlined on the deployment schedule when approvals have been obtained, a guidance document has been developed and staff training has been provided.
BJC	XIII.B	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Continue current auditing and expand this activity as resources permit.* **Findings:** In addition to the deployment schedule discussed above, PID has identified thresholds for each Risk Indicator which will trigger a review. For example, under the Risk Indicator "Aggression to Self" individuals will be identified who display 1. Aggression to self resulting in injury, 2. Two or more aggressive acts to self in seven consecutive days, 3. Four or more aggressive acts to self in 30 consecutive days. A total of 29 Risk Indicators have been broken down into measurable triggers. Specific required interventions have been identified for each Risk Indicator. For example, for the A/N/E Risk Indicator, the

			required interventions are the completion of the Unusual Incident report and revision or update to the IRP. As noted previously, the hospital will introduce this data gathering over the next nine months. Both the deployment schedule and the Risk Indicators will be submitted to the Executive Committee for approval, according to the April Performance Improvement Committee minutes. **Recommendation 2, September 2009:** *Develop policies necessary for the implementation of a quality management system for addressing the treatment needs of high risk individuals*. **Findings:** While the hospital has taken first steps in collecting additional data on recommendations from investigations and various committees and has plans for identifying individuals at high risk for selected behavioral and medical conditions (Risk Indicators), there is presently no guidance document or set of documents that lay out for staff providing care to individuals the purpose and plan for the Risk Indicator performance improvement initiative. **Compliance:** Partial. **Current recommendations:** 1. Obtain the approval of the Executive Committee for the Risk Indicator performance improvement initiative. 2. Begin work on a guidance document that expansively describes the Risk Indicator performance improvement initiative. 3. Implement the Risk Indicator performance improvement initiative when staff training has been provided and other resources are available.

BJC	XIII.B.1	the action steps recommended to remedy and/or prevent the reoccurrence of problems;	**Current findings on previous recommendation:** **Recommendation, September 2009:** Adapt the principles of the SERC review process in addressing incidents not serious enough to come to that committee's attention. **Findings:** In March, the hospital augmented the review of the Risk Trigger Indicator "three or more unusual incidents within 30 days" to include a review by the individual's IRP by the Medical Director and a meeting with the treatment team. Specifically, the task tracking form identifies the individual, the incident type and date, a short summary of the incident, the immediate response, and a sizeable note by the Medical Director. In the period, February 17-March 18, 2010 four individuals reached this Risk Trigger Indicator. The Medical Director responded in May 2010 on behalf of each of the four individuals. • MB was the aggressor in five incidents. The Medical Director noted that MB's behavior resulted from his delusional ideas or hallucinations, and he is improving on a particular medication that requires 4-6 months to reach full efficacy. The Medical Director recommended that the individual continue on the medication, comply with lab requirements, and engage in medication education. • The Medical Director noted that CL's improvement after two assaults, one as victim and one as the aggressor, was due to reduction in tension within the ward milieu. • Delusions contributed to JM's involvement in three physical assaults, according to the Medical Director, and a medication adjustment has contributed to his improvement. • GR was the victim of two assaults. The Medical Director's review determined that the victimization was most likely due to his anxiety and psychomotor agitation.

			The document entitled, "Risk Trigger Event System" (March 19, 2010) states that PID "will track the recommendations" made by the Medical Director. This tracking has not yet begun. **Other findings**: In addition to recommendations from investigations, the log created by the PI Director and placed on the shared drive also tracks recommendations made by various hospital committees. It identifies the responsible party. The plan calls for monitoring implementation and reporting to the findings to the Performance Improvement Committee. **Compliance:** Partial. **Current recommendations:** 1. Standardize the language used for this initiative, i.e., Risk Trigger Events v Risk Trigger Indicator v Risk Indicator in the guidance document. 2. Ensure the Medical Director's review of the IRP and meeting with the team occurs in a timely manner.
BJC	XIII.B.2	the anticipated outcome of each step; and	*The hospital will not be able to meet this requirement of the Settlement Agreement until it has produced a guidance document that fully describes the intent, purpose and procedures for addressing the treatment needs of individuals in high risk situations.*
BJC	XIII.B.3	the person(s) responsible and the time frame anticipated for each action step.	*See cell above.*
BJC	XIII.C	Provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** *Identify high risk behavioral and medical indicators and procedures for*

			the review of the individuals who reach an indicator. **Findings:** The Performance Improvement Committee has identified several issues which it believes with improve the quality of life of the individuals in care and to which it is directing its attention. These include: • The development and use of a medical transfer form to be used when individuals are transferred internally and when transferred to and from external facilities. The April PIC minutes state that the form is currently in use and will be presented to the Executive Committee for approval. • The Medical Director will submit new processes and procedures to optimize medical services to the PIC at its May meeting. • The PIC is monitoring the progress of the Violence Reduction Initiative and the EARN initiative. • Education for staff on policies and procedures that have been recently revised, e.g. incident management policies were revised in March. • The review of PRISM data did not identify any troubling trends, but PID will monitor for under-reporting of incidents. • A proposal for restructuring the committee structure at SEH will be forwarded to the Executive Committee for approval. • The Risk Indicator initiative will be discussed again in May and then forwarded to the Executive Committee for approval **Recommendation 2, September 2009:** *Continue to expand the internal audits performed by PID*. **Findings:** See the Risk Indicator performance improvement initiative referenced in XIII.A and XIII.B. In addition to having PID monitor for under-reporting, the Risk Manager reviews the 24 hour nursing report to

			ensure that events which should be reported as incidents are so reported. PID and specific disciplines have undertaking the auditing of specific areas of treatment such as the use of restraint and seclusion, discharges and transfers. **Compliance:** Partial. **Current recommendation:** Continue to identify areas for improvement and ensure the effective implementation of remedial actions.
BJC	XIII.C.1	disseminating corrective action plans to all persons responsible for their implementation;	*Absent a guidance document describing the intent, purpose and procedures for identifying individuals in high risk situations and providing a structured review of treatment that guarantees the consultation of senior clinicians when specific conditions are met, the hospital cannot meet this portion of the Settlement Agreement.*
BJC	XIII.C.2	monitoring and documenting the outcomes achieved; and	*The hospital is not yet able to meet this Enhancement Plan requirement. See other findings and recommendations.*
BJC	XIII.C.3	modifying corrective action plans, as necessary.	*The hospital is not yet able to meet this Enhancement Plan requirement. Before the hospital can modify corrective action plans because they have proved ineffective, it must develop procedures for systematically logging recommendations and following them through to implementation.*
BJC	XIII.D	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve SEH's quality/performance goals, including identified outcomes.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Expand audits to identify performance problems and provide the guidance and training necessary to effect correction.

			Findings: As noted in XIII.C, the Performance Improvement Committee has identified a number of areas for performance improvement which it believes will positively impact the quality of life of individuals. The committee is following these initiatives through to effective implementation. The PI Department is planning the implementation over the next nine months of a comprehensive system for addressing individuals in high risk situations, as described in earlier cells in this section of the report. **Compliance:** Partial. **Current recommendation:** Continue making progress toward implementation of the various PI initiatives described in earlier cells.

	XIV: Environmental Conditions		
BJC		By 36 months of the Effective Date hereof, SEH shall develop and implement a system to regularly review all units and areas of the hospital to which residents have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, including the following:	**Summary of Progress:** 1. The staff and individuals moved into the beautiful new hospital in May 2010. Thirty-four individuals are still living in the RMB building in units on the third floor now referred to as Annex A and Annex B. Two units on the second floor of this building will be renovated to accommodate these individuals. 2. The new hospital has been constructed with the elimination of suicide hazards as a priority consideration. 3. All individuals questioned indicated that they had supplies of personal hygiene supplies and clothing, including underwear. 4. Individuals in the new hospital voiced pleasure at having a choice of several areas in which to relax and watch television. Several voiced appreciation for a private room. 5. Elopements have declined significantly in the review period as compared with the prior six months.
BJC			**Methodology:** <u>Interviewed</u>: 1. Several individuals in care 2. A. Venson, Director of Facilities and Security 3. R. Winfrey, Chief of Safety and Security 4. Several staff members during the tour <u>Reviewed</u>: 1. Staffing data for the period 4/11-25/2010 2. Monthly Safety Assessment tool 3. Environmental Survey Report (October-December 09) 4. BERT manual (Building Emergency Response Team) <u>Toured</u>: 1. Shields House, Howard House, and Dix House

			2. Annex A and Annex B 3. Therapeutic Learning Center (forensic)
BJC	XIV.A	By 36 months from the Effective Date hereof, SEH shall attempt to identify potential suicide hazards (e.g., seclusion rooms and bathrooms) and expediently correct them.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Include a discussion of suicide hazards in orientation training. **Findings:** The hospital did not respond to this recommendation. **Other findings:** The seclusion rooms in the new hospital are equipped with cameras that are monitored from the nurses' station. Direct observation of the seclusion room is also possible from the nurses' station. The new hospital has been constructed with the elimination of suicide hazards as a priority consideration. I observed no obvious suicide hazards during the tour of the new hospital. Individuals housed in the RMB Annexes are not afforded the safety features built into the design of the new hospital. Particular attention to the physical and therapeutic environment of these units will be necessary until the individuals are housed in newly renovated surroundings or in the new hospital. See also XIV.F. **Compliance:** The environmental conditions in the new hospital were in substantial compliance with this portion of the Settlement Agreement at the time of the tour. The two RMB Annexes were not as the obvious suicide hazards in the bathrooms remained. **Current recommendation:** Maintain vigilance in identifying suicide hazards.

BJC	XIV.B	By 36 months from the Effective Date hereof, SEH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Continue current practice. **Findings:** The monthly Patient Safety Assessment form provides space for the person inspecting to identify any contraband uncovered during the review. For the review period, the hospital reported there were 39 incidents of contraband, 33 of which were related to cigarettes, lighters or matches. **Compliance:** Substantial, based on limited information. **Current recommendation:** Maintain vigilance in removing contraband that poses a threat to the safety of staff and individuals.
BJC	XIV.C	By 24 months from the Effective Date hereof, SEH shall provide sufficient professional and direct care staff to adequately supervise individuals, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide individuals with a safe environment and adequately protect them from harm.	**Current findings on previous recommendation:** **Recommendation, September 2009:** Determine if the shortage of RN coverage evident in the sample time period is representative of a larger problem. If yes, develop and implement a plan to address this staffing issue. **Findings:** Review of the staffing data for the 15 day period (April 11-25, 2010) for the 15 units in the hospital revealed that only two of 675 shifts did not have an RN (4/23 NOC shift on RMB 4 and RMB 5). In contrast, 96 shifts had two or more RNs.

At the time of the tour, staffing was described as adequate by the staff present in the RMB Annexes. Annex A, which houses 18 individuals, had nine staff on duty, including one RN and one LPN. Annex B with 16 individuals was staffed by two RNs and six additional staff.

Other findings:
PRISM data indicates that in the review period the number of elopements decreased dramatically from the previous six months as shown below.

Month	# elopements reported
May 09	6
June 09	12
July 09	4
Aug 09	12
Sept 09	6
Oct 09	12
Nov 09	3
Dec 09	4
Jan 10	4
Feb 10	1
March 10	3
April 10	3

Pleasant secure courtyards with seating are available to individuals in the new hospital.
The Environmental Survey Report for October-December 09 documents the review of seven items directly related to safety: staff wear ID badges, fire exits locks are operable, corridors are unobstructed, no extension cords, fire response equipment and electrical panels are unobstructed, a fire evacuation map is posted on

			the unit and areas are free of trip hazards. Fourteen units (74%) were rated as acceptable on all of the standards. Four units were rated as problematic and one unit (JHP-6) was rated unacceptable. Thirteen of fourteen units were rated acceptable for general unit cleanliness and general unit maintenance. RMB-3 was rated unacceptable in these categories. BERT training was provided to selected staff on May 25, 2010. This protocol requires Lead Monitors to be thoroughly familiar with the building, the location of exits, the Fire Evacuation Plan, and the activation of the fire alarm system. Lead Monitors must know of any employees who may need assistance in an emergency. In an emergency, they must ensure the safe and timely evacuation of all persons, verify the evacuation of all spaces, including restrooms and be aware of any individual with a specific disability and the type of assistance they need. See also XII.C for problems in accounting for individuals as they exit and enter the residential units. The hospital agreed to correct this problem as soon as possible. **Compliance:** Substantial. This compliance rating is based on the review of staffing data for a two-week period, the secure outdoor courtyards available to individuals in the new hospital, and the elopement data showing a substantial reduction in elopements. **Current recommendation:** Continue current practice.
BJC	XIV.D	By 36 months from the Effective Date hereof, SEH shall ensure that the elevators are fully repaired. If possible, non-ambulatory individuals	**Current findings on previous recommendation:** **Recommendation, September 2009:**

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<td>should be housed in first floor levels of living units. All elevators shall be inspected by the relevant local authorities.</td>
<td>Continue current practice.

Findings:
The elevators in the new building and in the Annex were working fine during the tour.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
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<td>BJC</td>
<td>XIV.E</td>
<td>By 12 months from the Effective Date hereof, SEH shall review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2009:
Address the discrepancy between the fire drill log and the fire investigations cited above. Ensure the log is completed immediately following the drill.

Findings:
The hospital provided the fire drill recording sheets for the review period.

<table>
<tr><th>Date/Time</th><th>Location</th><th>Staff and individuals evacuated</th><th>Evacuation time</th><th>Drill Score</th></tr>
<tr><td>4/2/10 Day</td><td>RMB</td><td>198</td><td>2:10</td><td>10</td></tr>
<tr><td>2/16/10 Evening</td><td>RMB</td><td>197</td><td>2:50</td><td>10</td></tr>
<tr><td>12/9/09 Day</td><td>JHP</td><td>213</td><td>2:45</td><td>10</td></tr>
<tr><td>11/18/09 Evening</td><td>JHP</td><td>199</td><td>2:50</td><td>10</td></tr>
</table>

Other findings:</td>
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			The fire evacuation plan for the new building was under review at the time of the tour. The new hospital is equipped with a sprinkler system. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
BJC	XIV.F	By 36 months from the Effective Date hereof, SEH shall develop and implement procedures to timely identify, remove and/or repair environmentally hazardous and unsanitary conditions in all living units and kitchen areas.	**Current findings on previous recommendations:** **Recommendation 1, September 2009:** Redirect the efforts of staff assigned responsibility for the oversight of individuals' personal needs to include duties to ensure the individual has a supply of clean clothing and a full complement of personal hygiene supplies. **Findings:** All individuals questioned reported having adequate clothing and personal hygiene supplies. **Recommendation 2, September 2009:** Address such problems as refusing to launder clothing and throwing clothing in the trash as treatment issues. **Findings:** These issues did not surface during this review. **Recommendation 3, September 2009:** Continue the consumer survey and consider the advisability of addressing the issues brought forward in concert with a council of individuals.

			Findings: This recommendation is still under consideration and will be implemented now that the hospital has moved into the new building. The hospital hopes to hold the first meeting of a council of individuals in June 2010. **Other findings:** The new hospital was clean and fresh. Furniture is new and while moveable is heavy enough that it cannot be thrown. Outdoor furniture is bolted to the concrete. On Annex A, one bathroom had no toilet paper or holder. Staff reported that these were removed because an individual plugged the toilet with paper. When asked to identify the individual so I could review the clinical record to see whether this was handled as a treatment issue, staff called the Ward Manager who explained to me (on the phone) that there no longer was an individual on the unit with that offending behavior, as he had moved to the new hospital. The paper and holders were installed that same day. The bathrooms on Annex A and Annex B are not free of suicide hazards. Specifically, the toilet stall uprights are not flush to the wall and the hinges are not continuous. **Compliance:** The environmental conditions in the new hospital were in substantial compliance with this requirement of the Settlement Agreement at the time of the tour. The two Annexes were not. **Current recommendations:** 1. Encourage individuals and staff to help maintain the new hospital environment. 2. Ensure vigilant oversight of the environment on Annex A and Annex

			B.